STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235270	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Haven Nursing and Rehabilitation Community	850 Phillips South Haven, MI 49090

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP), resulting in the potential for increased risk of respiratory infection among all residents in the facility.Findings include:On 12/16/2025 starting at 9:25 AM, a tour of the kitchen found possible stagnant domestic water lines. One hot water fixture was capped off, by the coffee area, with no evidence of routine flushing. Two other water lines were protruding from the wall back by the walk-in cooler door, with no evidence the lines were regularly flushed. When asked if the maintenance director was here today, [NAME] KK stated that he has been off a couple weeks. When asked if she ever saw anyone regularly in the kitchen flushing these water lines, [NAME] KK didn't think so. On 12/15/25 at 1:22 PM, an interview with NHA A found that the Legionella information should be in the maintenance office. On 12/15/25 at 2:55 PM, observation of the 200-hall soiled utility room found a hopper with brown and yellow debris in the bowl and water sitting low in the hopper bowl (indicating stagnant water that has not been flushed or used recently). As the surveyor turned on the cold and hot water fixtures from the over hopper sink, brown and discolored water came out of the faucet for a couple seconds before running clear. Further review of the hopper found that momentarily brown and discolored water came out of the spray wand when used and tested. A record review of the facility entitled document, Legionella Plan Overview Control Measures and Corrective Actions, not dated, found that Maintenance or designee will conduct free chlorine testing monthly. log results of monthly samples taken from 2 cold water fixtures and at least 3 hot water fixtures. Under the section Risk Analysis: the document states that, The facility doesn't have dead ends or plumbing concerns. The only plumbing areas that could contain stagnant water have been identified in vacant resident rooms that have been vacant more than 30 days. No logs or documentation on ongoing free chlorine test were observed.A further record review of the facility entitled document, Water Pathogen Risk Reduction, not dated, found the following resources, .areas of stagnant water encourage biofilm growth and reduce temperature and level of disinfectant. Further review of the document found Biofilm is Germs and the slime they secrete that stick to and grow on any continually moist surface, furthermore, Biofilm provides housing, food, and security for many different types of germs, including Legionella.No documentation showing an annual review was found.

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 and interviews, the facility failed to maintain a safe, functional, sanitary, and comfortable environment resulting in an increased potential for contamination and a possible decrease in the satisfaction of living for all residents. Findings include: On 12/15/25 at 9:30 AM, observation of sheet pans stacked and stored under the counter found deposits of black encrusted grease was prevalent on the inside seems and corners of the pans. An interview with [NAME] KK found that this is the cleanest they can get the pans after scrubbing. On 12/15/25 9:55 AM, observation of the overhead sprayer, next to the dish machine, found that when in the hanging position the sprayer laid below the overflow rim of the sink, creating a cross connection between the domestic potable water and wastewater. When asked if maintenance takes care of items in the kitchen, [NAME] KK stated that they do, however our Maintenance Director is not able to be in today. On 12/15/25 at 2:55 PM, observation of the cushioned chair in the family room found excess accumulation of trash, food crumbs, wrappers, and debris under the cushion. On 12/15/25 at 3:01 PM, observation of the furniture in the front lobby showed accumulations of trash, crumbs, crushed potato chips, and other food debris. Further review found numerous scratched off [NAME] tickets, nail clippers, a package of taco sauce, and a receipt to the grocery store. On 12/15/25 at 3:13 PM, observation of the 400-hall shower room found excess accumulation of black debris and staining on the floor and wall juncture between the commode and the wall. The area was roughly a one foot by two-foot surface. On 12/15/25 at 3:20 PM, observation of the 400-hall linen room found a heavy accumulation of dust and debris under the wire rack used for clean linen storage. Further observation found used gloves, paper trash, and packages of crackers. On 12/15/25 at 3:32 PM, an interview with NHA A found that the facility has been working on repairs and updates and has a plan to repaint all resident rooms over the next year. When asked to speak with Housekeeping Supervisor R, NHA A stated she was not able to make it in today. On 12/15/25 at 9:51 am, the blinds hanging in the window in room [ROOM NUMBER] were observed to be broken. On 12/15/25 at 9:58 am and 3:30 pm, 12/16/25 at 8:15 am and 2:45 pm, and 12/17/25 at 8:28 am and 10:03 am, the front of the three-drawer dresser in the corner of the room near the bathroom in room [ROOM NUMBER] was observed to have a cream colored, milk-like substance dried in a splatter pattern on two of the three drawer fronts. The wall on the right when entering room [ROOM NUMBER], behind the head of both beds, between the positioning of the two beds, was observed to have several areas of spillage, white in color, cream in color, brown in color, and pink in color. The spillage was noted to have the appearance of dripping towards the floor with noted streaks on the wall. The enabler bar of the first bed on the right side of the bed was noted to have a pink in color dried substance on the top of the bar. The garbage can on the far side of the room from the door was (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	noted to be soiled on the outside with dark colored substances. On 12/15/25 at 11:32 am and 12/16/25 at 7:53 am the fall mat on the floor next to the bed in room [ROOM NUMBER] was noted to be soiled with dirt, debris, and spotted with dried cream-colored milk-like substance. In an interview on 12/16/25 at 1:06 pm, Housekeeper (HK) L was outside of room [ROOM NUMBER] and reported every room should be cleaned every day. HK L reported cleaning fall mats were part of the daily cleaning when doing the floor. When queried, HK L reported she cleaned it today, but did not recall if she cleaned it the day before. In an observation and interview on 12/17/25 at 10:03 am, HK AA was observed cleaning room [ROOM NUMBER]. HK AA reported it was housekeeping's responsibility to clean dressers, walls, floors, beds, tables, and any other areas in the rooms. HK AA reported it was all staff's responsibility to clean up spills, but housekeeping was responsible for cleaning the resident rooms. HK AA reported the rooms were deep cleaned about once a month. HK AA reported he was assigned to the same rooms, and he cleaned his assigned rooms every day. When the noted dirty areas, the dresser, wall, enabler bar, and garbage can in room [ROOM NUMBER] were pointed out the HK AA he reported those areas should have been cleaned, and he would clean them now. In an interview on 12/17/25 at 10:20 am, Housekeeping /Laundry Supervisor (HLS) R reported each room should be cleaned daily and deep cleaned once a month. HLS R reported her expectations were that her staff visually observe every room for areas that my need to be addressed, such as dressers, walls, enabler bars. HLS R reported when a room was deep cleaned, it should include, dressers, bed frame, walls, curtains, and all surfaces. During an observation on 12/15/2025 at 10:34 AM, observed cobwebs in the corners of the windowsill in room [ROOM NUMBER]. During an observation on 12/15/2025 at 11:15 AM room [ROOM NUMBER] had an ash type of substance and/or drywall/plaster dust on the windowsill. The transition strip between the tile in the room and the laminate flooring in the hallway was missing, and the tile was chipped and broken at the door when it transitioned to the hallway laminate flooring. The floors were stained with dirt and debris and possibly dirty as they were so stained. Outside of the room, along the wall on the left side of the entry there was dried dark brown liquid material splattered over the wall and the rubber baseboard. During an observation on12/15/2025 at 11:22 AM, room [ROOM NUMBER] the floor had scattered dirt and debris, between the bed and the recliner there was a pile of wrappers, dirt, hair accumulated there, the tile floor in the room was stained and had dried liquid stains indicating it had not been mopped. The entry door had built up black dirt and debris, appeared also to have dirt and debris strip stuck to adhesive on the floor. During an observation on 12/15/2025 at 11:50 AM room [ROOM NUMBER] the door to the room had a space of approximately 6 inches long where the wood door splintered and come off the door near where the doorknob was located. room [ROOM NUMBER] had scraps along the wall with paint missing, the tile at the entry way was stained and appeared soiled. The transition strip was missing between the transition from tile to laminate flooring in the hallway. During an observation on 12/15/2025 at 12:00 PM room [ROOM NUMBER] observed the wallpaper (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	peeled away from the wall like something had torn it away. There were black marks on the walls where bed or wheelchairs bumped into the wall. The tile floors were stained and appeared dirty and dingy. The resident's tray table was soiled with dried food and dried liquid. See photo. During an observation on 12/15/25 at 12:18 PM, room [ROOM NUMBER] observed built-up black dirt and debris caked up along the entryway appeared adhered to a strip on adhesive on the floor where the missing transition piece was missing from the floor. The wood door had a piece of wood broken off from the door by the bottom hinge. The floors in the room appeared stained with dirt and debris. See photo. During an observation on 12/15/2025 at 4:12 PM, room [ROOM NUMBER] had a fall mat on the floor next to bed 2 along the window and it had dirt/debris footprints from one end to the other. There was a fall mat folded up by the first bed and the sides had been cracked and broken open exposing foam. The first bed was discolored, stained, and uninviting. During an observation on 12/16/2025 at 9:00 AM room [ROOM NUMBER] had the fall mat by the first bed in the corner which had the sides broken open and the foam was exposed. During an observation on 12/16/2025 at 11:44 AM room [ROOM NUMBER] had the built-up black dirt and debris caked up along the lining the transition piece on the floor from tile to laminate flooring. The wall inside the room to the left had scrapped paint off the wall and black streaks along it to the bathroom door. See photo. During an observation on12/16/2025 at 11:44 AM, outside of room [ROOM NUMBER] the base board still had dried splashed brown liquid on it. During an observation on 12/16/2025 at 11:46 AM room [ROOM NUMBER] had the same build up on the transition piece as well as rust spots on the door frame with missing paint on both sides of the door. The bathroom door has scraps on it and missing paint as well. The tile in the room appeared soiled but needed to be stripped and waxed. In an interview on 12/16/2025 at 11:48 AM Housekeeper AA reported when a room was completed for cleaning the housekeeping staff completed a checklist for each room. It would be noted on the sheet. Housekeeper AA reported that when there was a concern for a tray table, he would inform Housekeeping & Laundry Supervisor R, and she would inform maintenance the tray table needed to be replaced. During an observation on 12/16/2025 at 11:49 AM room [ROOM NUMBER] had dried liquid spots on the floor with dirt and debris as well as footprints on the floor. The transition piece had built up dirt and debris caked on it, and up to the corner where the walls met there was dirt and debris, and the floor appeared dirty due to staining on the floor. During an observation on 12/16/2025 at 11:51 AM room [ROOM NUMBER] observed approximately 6 inches of a piece of the door missing, exposing wood by the doorknob and the trim along the wall on the right side at entrance was not secured and coming off. During an observation on 12/16/2025 at 11:56 AM room [ROOM NUMBER] had paint scrapped off the door frame, the transition piece was missing from tile to laminate flooring with the tile broken and chipped at the ends. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 12/16/2025 at 11:57 AM, the heater across from room [ROOM NUMBER] had a missing piece of rubber base board from it with exposed dried glue splotches splattered across the bottom 6 inches the length of the vent which was approximately 5 feet long. See photo During an observation on 12/16/2025 at 11:58 AM room [ROOM NUMBER] was missing the transition piece from tile to laminate floor in the hallway. There was black dirt and debris cake along the side of the transition piece. The tile was broken jagged pieces at the ends of them where the tile met the laminate flooring from the hallway. The door frame had dried liquid dripped down it. There were scraps of paint off the frame. During an observation on 12/16/2025 at 1:55 PM, room [ROOM NUMBER] the tile in the room was dirty and dingy, the transition strip was missing with the tile broken and chipped. The area along the wall had dirt and debris and black markings along it, see photo. In an interview on 12/17/2025 at 9:31 AM, Housekeeping & Laundry Supervisor R reported when the housekeepers notice something that needs to be fixed, they would tell the maintenance director. When queried if there was a work order or electronic submission form, she reported there was a work order form but mostly the communication was verbal. This writer and Housekeeping & Laundry Supervisor R observed a wall in room [ROOM NUMBER] which had paint scrapped off and black marks along the wall to the bathroom door, she reported those concerns should be reported to the maintenance director. Housekeeping & Laundry Supervisor R touched the rubber bumper guard along the wall as it appeared splattered with dirt and debris and reported it was dried wax. Observed the transition strip at the doorway for the transition from tile to laminate flooring and there was built up black dirt and debris hardened which would need to be scrapped up off the floor. Housekeeping & Laundry Supervisor R reported the housekeepers should address the build up there and take care of it. This writer and Housekeeping & Laundry Supervisor R observed room [ROOM NUMBER]'s floor which was visibly soiled and had not been swept. Housekeeping & Laundry Supervisor R reported the floor should have been addressed. Housekeeping & Laundry Supervisor R reported if a resident refused to allow housekeeping staff to come in and clean the staff were instructed to return at a later time, few hours later, and request to clean the room again. This writer and Housekeeping & Laundry Supervisor R observed room [ROOM NUMBER] and there was the dried caked on buildup of black dirt and debris at the transition strip, inside the door to the right the corner had dirt and debris as well as room [ROOM NUMBER] which had scraps on the wall with missing paint and there was no transition strip with the ends of the time broken and chipped.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 1. a dignified dining experience for 2 (Resident #1 and Resident #19); 2. an environment that promoted resident dignity in 1 (Resident #25) of 16 residents reviewed for dignity, resulting in the potential for a reasonable person to experience feelings of embarrassment, loss of self-worth, and a negative psychosocial outcome for the residents impacting their quality of life.Findings include:Resident #1 Review of a Resident Face Sheet revealed Resident #1 was a male who admitted to the facility on [DATE] and had pertinent diagnoses which included: delayed milestone in childhood, need for assistance with personal care, feeding difficulties, and encephalopathy (a disease that affects the brain's function). Review of a Minimum Data Set (MDS) assessment for Resident #1, with a reference date of 11/14/25 revealed a Self-Care Assessment- Eating- Resident #1 was dependent, relying on staff to feed Resident #1 his meals. On 12/15/25 at 1:15 pm, Certified Nurse Assistant (CNA) S was observed standing next to Resident #1's wheelchair, next to the table, while she fed Resident #1 his lunch meal. Review of Care Plan for Resident #1 revealed .Status of eating ability: x1 assist. In an interview on 12/17/25 at 2:20 pm, CNA S reported Resident #1 was dependent on staff to eat, he had to be fed. CNA S reported she should not have been standing when she was assisting residents to eat in the dining room. CNA S reported staff was to sit when they were feeding residents. CNA S confirmed that she had stood next to Resident #19 when she was feeding him his lunch meal. Resident #19 Review of a Resident Face Sheet revealed Resident #19 was a male who admitted to the facility on [DATE] and had pertinent diagnoses which included: Anoxic brain damage (brain damage caused by a lack of oxygen), dementia, and quadriplegia (paralysis of all 4 limbs). Review of a Minimum Data Set (MDS) assessment for Resident #19, with a reference date of 09/24/25 revealed a Self-Care Assessment- Eating- Resident #19 was dependent, relying on staff to feed Resident #19 his meals. On 12/15/25 at 1:09 pm, Resident #19 was observed sitting in his wheelchair in the dining room at a table with two other male residents, who were eating. Resident #19 did not have a tray in front of him. On 12/15/25 at 1:15 pm, CNA S was observed serving Resident #19 his lunch meal. The meal was placed on the table in front of Resident #19, and the plate was left covered. The other two male residents at the table were observed eating their meals. On 12/15/25 at 1:20 pm, CNA EE was observed preparing Resident #19's lunch meal tray. CNA EE was observed standing between Resident #19's wheelchair and the table while she fed Resident #19 his lunch meal. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/16/25 at 12:12pm, CNA HH was observed standing between Resident #19's wheelchair and the table while she fed Resident #19 his lunch meal. On 12/16/25 at 12:13 pm, CNA HH was observed standing between Resident #19's wheelchair and the table while she fed Resident #19 his lunch meal. CNA HH was then observed answering a telephone call on her smart watch, speaking out loud in the dining room, conversing with Human Resources Director (HRD) E. The discussion lasted several minutes, included a discussion about open shift coverage, all while CNA HH continued to feed Resident #19 and did not acknowledge him while she provided him assistance with his meal. In an interview on 12/17/25 at 2:20 pm, CNA HH reported prior to her starting to feed Resident #19, the day before, she had already made the decision she would feed two residents at two different tables, and she had no intention of sitting while she did that. In an interview on 12/17/25 at 10:50 am, Director of Nursing (DON) B reported staff should be sitting down when they are feeding a resident. DON B reported she expected staff to feed one resident at a time and should sit down when they do it. Review of facility policy Dignity with a reviewed date of 01/25 revealed .to care for residents in a manner and in an environment that promotes maintenance or enhancement of each residents' quality of life, dignity and respect.Dignity means that in their interactions with residents, staff carries out activities that assist the Resident to maintain and enhance his/her self-esteem and self-worth.Social services will monitor and observe for the following practices: .promoting resident's independence and dignity with dining. Using the reasonable person concept, though both Resident #1 and Resident #19 had decreased ability to verbally express their own thoughts due to their mental diagnoses, Resident #1 and Resident #19 had the potential to feel shame and/or embarrassment and/or experience a loss of self-worth. As both residents had a court appointed guardian, no family was available to interview as to the presumed feelings of Resident #1 and Resident #19. According to Your Rights and Protections as a Nursing Home Resident revealed, .At a minimum, Federal law specifies that nursing homes must protect and promote the following rights of each resident. You have the right to .Be Treated with Respect: You have the right to be treated with dignity and respect, as well as make your own schedule and participate in the activities you choose . https://downloads.cms.gov/medicare/your_resident_rights_and_protections_section.pdf Resident #25: Review of an admission Record revealed Resident #25 was a male with pertinent diagnoses which included altered mental status, cognitive communication deficit ((progressive degenerative brain disorder resulting in difficulty with thinking and how someone uses language), Parkinson's disease, dementia, depression, mood disorder, and the need for assistance with personal care. Review of current Care Plan for Resident #25, revised on 5/27/2021, revealed the focus, . (Resident #25) a [AGE] year-old male with a DX (diagnosis) of Parkinson's disease. He tires easily, prefers to self-direct his activities and stays in his room. [NAME] enjoys listening to music, at times attending musical entertainment, watching TV and movies, flavored coffee social, ice cream social, sitting at the nurse's station play with his fidget toys, being around animals, going outside when the weather (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	permits, visiting with family and friends, and doing anything dealing with motorcycles. He needs reminders of activities and assistance to/from activities. Staff should continue to offer one-on-one visits PRN (as needed). Continue POC (plan of care) . with the intervention .Adjust activities to accommodate resident's energy level and tolerance Assist resident PRN with locating a favorite TV channel/show .Encourage/invite resident to activities that suit his prior interest or are compatible with his prior life interests/hobbies .Offer 1-1 visits PRN to provide companionship as resident is able to tolerate .Offer activities such as reading poetry or scripture, gentle hand massages, reminiscing/storytelling, singing, listening to music, etc .Offer resident variety of materials such as books, magazines, puzzles, word searches, coloring books, etc . During an observation on 12/15/25 at 09:05 AM, Resident #25 was seated at the nurse's station with no water, no activities, just a fuzzy blanket. During an observation on 12/15/2025 at 10:15 AM, Resident #25 was sitting at the nurse's station desk still in his wheelchair, with the fuzzy blanket. Director of Nursing (DON) B reported he recently had a gradual dose reduction of a medication, and he had more personality. She did not notice he did not have any activities and nor did she offer him any activities of his interest, offer to take him to activities, or offer to lie him down in his room. During an observation on 12/15/2025 at 2:11 PM, Resident #25 was being assisted to eat by a staff member, he had not drunk the fluids on his tray but did have an open drink supplement. This writer observed resident for several minutes and he did not attempt to drink the supplement; the staff member left the supplement on the table but did not offer him a drink nor did she assist him with a drink. Resident #25 was left to sit at the table in the dining room independently with no other staff or resident interaction. During an observation on 12/16/2025 at 1:59 PM, Resident #25 was seated at the nurse's station with no activities or one to one visit. No music was playing, no television in sight. During an observation on 12/17/2025 at 9:23 AM Resident #25 was seated at the desk and he had a fidget [NAME] on the table in front of him. Using the reasonable person concept, though Resident #25 had decreased ability to verbally express his own thoughts due to his medical diagnoses, any reasonable person would likely feel a decreased sense of self-worth, anxiety, frustration, and confusion in the situations observed.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to address and resolve grievances reported in Resident Council Meetings as stated during a confidential Resident Council meeting resulting in unresolved concerns, unmet resident needs and frustration. Findings include:During a confidential Resident Council meeting on 12/16/2025 at 11:07 AM, 9 of 9 residents stated that management didn't follow up on concerns that they brought up in Resident Council meetings and individual concerns that came from the meetings.Two residents stated that they weren't sure if the Grievance official was Nursing Home Administrator (NHA) A or Social Services Director (SSD) P.One resident stated that SSD P doesn't respond to grievances. She said talking to SSD P about grievances was like talking to the wall since she doesn't do anything with them.9 of 9 residents stated that they don't like the food here and they don't get what they order. They said they have brought it up in Resident Council and nothing had changed. One resident said The food is horrible. Nothing will change since follow-up on concerns isn't being completed. Review of Resident Council Minutes dated 8/27/2025 revealed . Old business: (List follow-up on last month's minutes and identify staff person responsible): all issues and concerns have been reviewed and continue to be reviewed. New business.Dietary: All residents replied ?could use improvement. There is no flavor. The gravy is too thin, the toast was hard, the presentation could be better.'. There were no concern forms associated with this Resident council meeting. Review of Resident Council Minutes dated 9/17/2025 revealed . Old business: (List follow-up on last month's minutes and identify staff person responsible): all issues and concerns have been reviewed and continue to be reviewed. New business.Dietary: All residents stated, ?The food is horrible, no flavor, needs to be plated better.' Everyone would like fried chicken and fresh fruit. There were no concern forms associated with this Resident Council meeting.Review of Resident Council Minutes dated 10/15/2025 revealed . Old business: (List follow-up on last month's minutes and identify staff person responsible): all issues and concerns have been reviewed and continue to be reviewed. New business.Dietary: All residents ?Needs much improvement. Food has no flavor. There is no sauce for the noodles. We are still getting items that are listed on our dislikes list. Plating is horrible. Would like salt and pepper on our trays. Why are we only getting small portions?'. There were no concern forms associated with this Resident Council meeting.Resident Council Minutes dated 11/17/2025 revealed .Officers in Attendance: (NHA A). Residents in Attendance: Administrator went to west dining room at scheduled time of resident council meeting and no residents were present. Administrator spoke with (Resident #54). Concerns to be addressed via ambassador rounds. Old business: To be discussed at December resident council. New business.concerns to be addressed via ambassador rounds.During an interview on 12/16/2025 at 2:10 PM, Dietary Director (DD) G stated that he knew about some food concerns that came up here and there and said I don't have any specifics items I can work with to fix. DD G said he only received 1 concern form related to food and that was in June when he first started at the facility. DD G also stated that he didn't hear anything from Resident Council about the food or receive concerns forms from the meeting. DD G reported that he had a Food Committee meeting monthly after Resident Council and at those meetings the residents typically don't give him any information to work with. When discussing that the residents at resident council stated, the food is horrible and they don't get what they order, DD G mentioned that he would need more details from the residents to fix their concerns. During an interview on 12/16/2025 at 2:36 PM, NHA A stated that she couldn't locate the concern forms from Resident Council since it wasn't in SSD P's' grievance book. NHA A reported that follow-up from Resident Council probably wasn't documented since concerns were delegated to the department head and they checked in with the residents on ambassador rounds. NHA A stated that SSD P was the Grievance Official at the facility and she was on vacation this week. Review of the Resident Council Meeting Policy with a review date of 1/2025 revealed .5. Council meetings are scheduled monthly or more frequently if requested by residents or theAdministrator. The date, time, and location of the meetings are noted on the Activities Calendar. 6. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Resident Council Concern Form will be utilized to track issues and their resolutions. The form will be forwarded to appropriate Department Manager. 7. The Administrator reviews the Resident Council Minutes and Concerns. The Administrator is responsible to sign the concern form stating they have been made aware of the concern and are satisfied with the plan of action. 8. Responses are presented at the next meeting, or sooner if indicated. 9. The Facility Continuous Quality/Performance Improvement Committee will review the data from Resident Council as part of their review. Issues documented from Resident Council maybe referred to the Committee for action or recommendation taken as needed.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview and record review, the facility failed to notify residents of where to find grievance forms and how to file a grievance as stated during a confidential Resident Council meeting resulting in unresolved concerns, unmet resident needs and frustration. Findings include:During a confidential Resident Council meeting on 12/16/2025 at 11:07 AM, 7 of 9 residents stated that they don't know where grievance forms were located and how to file one. They also stated that they didn't know who to go to with concerns. 9 of 9 residents stated that management doesn't follow up on individual concerns that they bring up. Two residents stated that they weren't sure if the Grievance official was Nursing Home Administrator (NHA) A or Social Services Director (SSD) P.One resident stated that SSD P doesn't respond to grievances. She said talking to SSD P about grievances was like talking to the wall since she doesn't do anything with them.During an interview on 12/16/2025 at 12:21 PM, Certified Nursing Assistant (CNA) GG stated that he didn't know where grievance forms were located. CNA GG said he would let the nurse know if there was a resident concern and then the nurse would follow up with the resident. During an interview on 12/16/2025 12:22 PM, Registered Nurse (RN) U stated that she wasn't sure where grievance forms were located and thought they were outside of SSD P's office. RN U said staff can help resident's fill out the form. During an observation on 12/16/2025 at 12:30 PM, grievance forms could not be located outside SSD P's office. During another interview on 12/16/2025 12:40 PM, RN U stated that she thought grievance forms were located outside SSD's office. This surveyor walked throughout the facility with RN U and grievance forms were located on the wall at the corner of 200 and 300 Hall and SSD's office was located in the middle of 300 Hall. It was observed that the grievance forms were hanging on the wall in a wire basket and which was not labeled with what the forms were or any information identifying who the Grievance official was or who to turn the forms into. During an interview on 12/17/2025 at 8:45 AM, CNA X stated that she would let the nurse know if a resident had a complaint because she didn't know where grievance forms were located. CNA X said she thought the forms were located by the SSD's office and the nurses' station. During an interview on 12/17/2025 at 8:47 AM, Licensed Practical Nurse (LPN) Z stated that grievance forms were located at the nurses' station. LPN Z also said that she thought the Grievance Official was NHA A. During an interview on 12/16/2025 at 2:36 PM with NHA A, this surveyor discussed how the residents in the confidential Resident Council meeting and some staff weren't sure where grievance forms were located and who to go to with concerns. NHA A stated that SSD P was the Grievance Official at the facility and was on vacation this week. NHA A reported that she was going to take over as Grievance Official now. Review of the Grievances/Concerns Policy dated 1/2025 revealed . Purpose: To support each resident's right to voice grievances and to ensure that a policy is in place to process grievance. Providing prompt actions to resolve grievances/concerns and to keep the resident apprised of progress towards resolution. The Administrator is the Grievance Officer who is responsible and will oversee the implementation of the facility grievance process, receiving and tracking grievances through to their conclusion in conjunction with the Social Service Director. Procedure: Upon admission, Social Services or designee will inform residents and resident representative of their right to voice grievances with respect to treatment received as well as a lack of treatment received during their stay in the facility and how to file or submit a compliant/ grievance. 1. Residents will be informed of the oral and written methods for communicating concerns to staff. Postings will be placed in prominent locations throughout the facility notifying of their right to file a grievance / compliant. Information provided includes: Right to File a Grievance Anonymously Contact information of the Grievance Official Whom a grievance can be filed with, name(s) of person. Reasonable expected time frame for completion of review/investigation. 2. The Social Services Director will coordinate the facility system for collecting grievances and tracking those grievances for timely and appropriate (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	response. 3. Administrator and Social Service Director will lead investigation; maintaining confidentiality of all information associated with grievances and ensure residents are protected from discrimination or reprisal. 4. Upon receipt of grievance, an immediate action will be implemented to prevent further potential violation of any resident right while the alleged violation is being investigated. 6. Social Services will instruct facility staff to submit to the Social Services Director that all grievances received will be investigated within seventy-two hours (72) hours following receipt of the complaint. Within seven (7) days following the receipt of the complaint, the facility will inform the complainant with the results of the investigation in writing. 7. Grievances submitted to the Social Services Director who will provide a copy to the appropriate department head for resolution. Social Service will present grievances in theInterdisciplinary Team morning meeting to discuss and determine resolution. 8. The Social Services Director will report to the facility administrator during morning meeting the status of all grievances. 9. On a monthly basis, social services will analyze the grievance tracking system for trends or patterns in facility practices which lead to grievances. Identifiable trends will be addressed through the facility Continuous Quality Performance Improvement Committee an QAPI program. 10. Social Services and / or the Staff Development Coordinator will train staff upon hire and throughout employment on how to receive grievances voiced by residents and/or family members. Training will include at a minimum the following content: Listening without becoming defensive, Diffusing an emotionally charged resident or family member, The need to take all voiced grievances seriously, What to do with grievances voiced, When to put a grievance in writing.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to employ an Activity Director who possessed the required qualifications resulting in the potential for unmet met psychosocial needs, feelings of boredom, isolation, and a lack of person-centered activities. This citation has the potential to impact any resident who relies on the activities program to support their leisure involvement.Findings include:Review of certification standards of the National Certification Council for Activity Professionals revealed ADC (Activity Director Certified) Certification ensures an individual has the knowledge and skills to lead and direct an activities and life enrichment department. ADC Certification validates the competencies necessary to be an Activity Director including leadership, management, advocacy, care planning and documentation.Review of Participating in Activities You Enjoy as You Age, published by the National Institute on Aging, 3/28/22, revealed: Research has shown that older adults with an active lifestyle: Are less likely to develop certain diseases. Participating in hobbies and other social activities may lower risk for developing some health problems, including dementia, heart disease, stroke, and some types of cancer . Studies looking at people's outlooks and how long they live show that happiness, life satisfaction, and a sense of purpose are all linked to living longer. Studies suggest that older adults who participate in activities they find meaningful, .say they feel happier and healthier . When people feel happier and healthier, they are more likely to be resilient .Positive emotions, optimism, physical and mental health, and a sense of purpose are all associated with resilience .research suggests that participating in certain activities, such as those that are mentally stimulating or involve physical activity, may have a positive effect on memory - and the more variety the better.Resident #59 (R59)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R59 was a [AGE] year-old man who was admitted to the facility on [DATE]. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R59 was cognitively intact (13 to 15 cognitively intact).During an interview on 12/15/2025 at 9:43 AM, R59 stated that there wasn't an Activity Director at the facility for about a month and some staff helped here and there with activities. R59 said that the calendar hadn't been followed during that time and the facility was doing the best they could. R59 stated that he loves going to religious services/church on Sundays and only attended 1 service on a Sunday since he was admitted to the facility. R59 reported that his main interest was attending church and he only attended BINGO since the residents liked him calling the numbers. Review of the November 2025 and December 2025 calendar revealed that there were 6 total church services scheduled every Sunday since R59 was admitted to the facility. Review of R59's Activity assessment dated [DATE] revealed . Is resident active in religion: yes. (R59) is a [AGE] year-old male. He prefers to self-direct his activities and stays in his room. (R59) enjoys reading, writing, watching TV, keeping up with the news, listening to all types of music especially country, jazz, and rock, arranging music, playing in a band, performing music at facilities, working on the internet, participating in religious services.Review of R59's Care Plan revealed .He (R59) prefers to self-direct his activities and stays in his room. (R59) enjoys reading, writing, watching TV, keeping up with the news, listening to all types of music especially country, jazz, and rock, arranging music, playing in a band, performing music at facilities, working on the internet, participating in religious services. Date initiated 11/4/2025.Goal: Attempt to accommodate/adapt to offer meaningful, satisfying and pleasurable activities to meet resident's individual needs. Resident will appear comfortable and satisfied with his daily facility activities/routine. Resident preferences will be honored to the extent possible. Approach: Encourage/invite resident to activities that suit his prior interest or are compatible with his prior life interests/hobbies.Review of R59's MDS Section F for Activities revealed .How important is it to you to listen to music you like? Very important.How important is it to you to participate in religious services or practices? Very important. Review of R59's November 2025 Activity Log through POC (Point of Care that staff documents in) revealed that he (continued on next page)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	attended activities for 3 days since admission on [DATE] and none of them were church services.Review of R59's December 2025 Activity Log which was typed on a word document indicated R59 did not attend any church services provided by the facility and R59 led church services with a few residents on 12/7/2025 and 12/14/2025. During another interview on 12/17/2025 at 11:12 AM, R59 said he loves music and played the guitar in 2 different bands. He stated that he played with the church when they came in the 1 time since he has been at the facility. R59 reported since the church service has only occurred on 1 Sunday, he gathered some residents a few times on other Sundays in the chapel and they would sing some hymns and read a few passages from the bible. R59 stated it wasn't an official devotion and staff didn't help get residents to the chapel. During an interview on 12/17/2025 at 11:10 AM, Licensed Practical Nurse (LPN) Z stated that the church hasn't come to the facility on Sundays in months.During an interview on 12/17/2025 at 11:07 AM, Registered Nurse (RN) U stated that they haven't had activities besides BINGO on the weekends. RN U said that church hasn't been coming in for months. RN U reported that the previous Activity Director (AD) was supposed to look into why the church hadn't been coming in on Sundays but then she quit and no one looked into it. RN U said that the new AD just started on 12/15/2025. During an interview on 12/17/2025 at 11:34 AM, Certified Nursing Assistant (CNA) S stated that they only have a few activities on weekends. CNA S said that churches come in on Sunday, but she hasn't seen them in a long time. During an interview on 12/17/2025 at 9:28 AM, Human Resource Director (HRD) E stated that the new AD (AD F) just started at the facility on 12/15/2025. HRD E said that AD F was not certified as an AD and the facility would be signing her up and pay for her to take the Activity Director certification course.During an interview on 12/17/2025 at 11:35 AM, AD F stated she started as AD on 12/15/2025 and does not have her certification as an AD yet but she worked as a CNA at the facility before becoming the AD. AD F stated she was made aware of R59 wanting to attend church and how they haven't been coming on Sundays and she said she set up a meeting with the church, R59 and her to discuss this concern. During another interview 12/17/2025 at 11:53 AM, HRD E stated that AD F was training with their sister facility's AD and AD F would officially be done with training and be full time in the building on 12/29/2025, then then they would sign her up for the certification class. During an interview on 12/17/2025 at 12:30 PM, Nursing Home Administrator (NHA) A stated the previous AD left the faciity on [DATE] and after she left, they had an assistant that filled in for activities. NHA A said that they were aware that AD F wasn't certified but their sister facility was overseeing activities and training AD F who just started on 12/15/2025. NHA A stated that AD F was going to the sister facility on 12/18/2025 to train with the AD there and would officially be done with training and be full time at the facility on 12/29/2025. NHA A reported that AD F was a CNA at the facility so she has experience. Review of the Activity Program Staffing Policy dated 6/2017 revealed Policy: Our activity programs are staffed with personnel who have completed a job-specific orientation training and experience to meet the needs and interests of each resident. Procedure: 1. Our activity programs are under the direct supervision of a qualified professional who: Is a qualified therapeutic recreation specialist or an Activities Professional who: Is licensed or registered, if applicable, by the state in which practicing; AND Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; OR Has two (2) years of experience in a social or recreational program within the last five (5) years, one (1) of which was full-time in a therapeutic activity program; OR Is a qualified occupational therapist or occupational therapy assistant; OR Has completed a training course approved by the state.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide food at a palatable temperature to 1 (Resident #75) of 4 residents and all residents who consume food resulting in the potential for decreased food consumption and potential nutritional decline.Findings include: Resident #75: Review of Face sheet for Resident #75 revealed, Review of a Face Sheet revealed Resident #75 was a male with pertinent diagnoses which included diabetes, gout (a painful inflammatory arthritis from uric acid crystals in joints), and kidney disease. Review of Care Plan for Resident #75, revealed, the focus, .Resident is at Nutritional / Hydration risk r/t (related to) admitted with hx (history) of chronic lymphedema (swelling from lymph fluid buildup, caused by damaged lymph nodes, leading to heaviness, tightness, and limited movement) RLE (Right Lower Extremity), high blood pressure, deep vein thrombosis (a serious condition where a blood clot forms in a deep vein), diabetes, stage 4 kidney disease, rheumatoid arthritis (a chronic autoimmune disease where the immune system attacks joint linings, causing pain, swelling, and stiffness and can lead to systemic issues affecting the heart lungs and eyes) Diuretic therapy in place . with the intervention .Offer available substitutes if resident has problems with the food that is served .Honor food preferences within acceptable dietary limits for resident's quality of life concerns .Offer substitutes if consumes less than 50% of meal . In an interview on 12/15/2025 at 10:34 AM, Resident #75 reported he had concerns with the temperature of the food. Resident #75 reported every Thursday the residents receive biscuits and gravy and the ones the residents received this last Thursday were stone cold. Resident #75 reported 5 out of 7 days the meals were cold, especially breakfast. In an interview on 12/16/2025 at 8:40 AM, Resident #75 reported the scrambled eggs and bagel were both cold this morning. On 12/15/25 at 9:59 AM, an interview with [NAME] KK found that lunch starts at 11:45 AM. On 12/15/25 at 11:43 AM, an interview with [NAME] KK found that they are a little behind schedule and still need to finish up a few things before service. On 12/15/25 at 12:40 PM, lunch service started. At this time, an interview with [NAME] KK found that the do not currently do test trays or tray audits on meals. On 12/15/25 at 1:05 PM, a regular test tray was placed as one of the first trays on the second 300 hall cart. On 12/15/25 at 1:13 PM, the cart was on the 300 hall and trays were being delivered. On 12/15/25 at 1:28 PM, all trays on the cart had been delivered and the test tray was back in the conference room with the following temperatures of hot food: vegetable soup 128F. On 12/15/25 at 2:05 PM, Observation of the 400-hall found resident lunch trays being delivered by (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff. At this time, observation of a meal tray residing in room [ROOM NUMBER], found a couple bites eaten from the sandwich, and the soup still with its top on. With the residents' permission, a temperature of the soup was found to be 122F when taken with a rapid read thermometer.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2563732Based on interview and record review the facility failed to ensure as needed (PRN) psychotropic medications (a medication that alters a person's mental state) included a stop date not exceeding 14 days for 1 (Resident #68) of 6 residents reviewed for unnecessary medications.Findings include:Resident #68Review of a Resident Face Sheet revealed Resident #68 was a male who admitted to the facility on [DATE] and had pertinent diagnoses which included: schizoaffective disorder (a mental health condition including hallucinations and delusions, bipolar disorder (a mental health condition that includes extreme mood swings), and anxiety disorder.Review of a Minimum Data Set (MDS) assessment for Resident #68, with a reference date of 09/08/25 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #68 was cognitively intact.Review of Physician Orders for Resident #68 revealed .Hydroxyzine HCl tablet, 50 mg, amt (amount) 1 tablet; oral, special instructions; give 50 mg po (by mouth) q6 hours (every 6 hours) prn; anxiety with a start date of 7/11/25 and a discontinued (DC) date of 8/5/25 and again with a start date of 08/06/25 and a DC date of 9/8/25.In an interview on 12/17/25 at 10:38 am, Director of Nursing (DON) B reported PRN psychotropic medications were limited to 14 days. DON B reported the hydroxyzine was an antihistamine that was also used to treat anxiety. DON B reported Resident #68 took hydroxyzine for anxiety and would require a 14 day stop date. DON B reported the provider could extend the time frame for as needed use for a psychotropic medication with rationale. DON B reviewed Resident #68's hydroxyzine orders and confirmed there should have been stop dates for 14 days for both orders.No documentation including a provider rationale to extend Resident #68's hydroxyzine PRN use longer than 14 days was provided by the time of exit.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement care plan interventions for 1 (Resident 7) of 16 sampled residents reviewed for care plan intervention implementation resulting in the potential for the development of pressure ulcers.Findings include:Resident #7Review of a Resident Face Sheet revealed Resident #7 was a female who admitted to the facility on [DATE] and had pertinent diagnoses which included: Type 2 diabetes (a disease when the body cannot regulate insulin use and blood sugar), history of falling, and severe protein-calorie malnutrition. Review of a Review of a Minimum Data Set (MDS) assessment for Resident #7, with a reference date of 11/26/25 revealed a Brief Interview for Mental Status (BIMS) score of 2/15 which indicated Resident #7 was severely cognitively impaired. (BIMS score 0-7 indicates severe cognitive impairment).On 12/15/25 at 9:45 am, Resident #7 was observed in bed, with her heel directly on the mattress under the blankets, with no pillow for elevating heels of the bed. Observed in the room were a bolster (a padded piece of equipment that a person can rest their legs on to remove pressure from the heel) and a pair of padded boots. Review of Care Plan for Resident #7 revealed .at risk for skin breakdown.with interventions of elevation of heels. with a start date of 4/30/25.In an interview on 12/15/25 at 11:00 am, Certified Nurse Assistant (CNA) EE reported Resident #7 could assist with repositioning a little but did not reposition herself. On 12/15/25 at 11:21 am and 3:30 pm, Resident #7 was observed in bed, with her heel directly on the mattress under the blankets, with no pillow for elevating heels of the bed. Observed in the room were a bolster and a pair of padded boots.On 12/16/25 at 08:30 am and 11:15 am Resident #7 was observed in bed, with her heel directly on the mattress under the blankets, with no pillow for elevating heels of the bed. Observed in the room were a bolster and a pair of padded boots.In an interview on 12/16/25 at 11:19 Licensed Practical Nurse (LPN) Y entered Resident #7's room, pulled back the blankets on the bed to expose Resident #7's feet lying directly on the mattress. LPN Y reported Resident #7's feet should not be on the mattress; they should be elevated. LPN Y reported Resident #7 should be wearing the padded boots. LPN Y was observed applying the padded boots to Resident #7's bilateral (both) feet. LPN Y stated with her heels, yeah, she really needs the boots to be on.In an interview on 12/16/25 at 11:26 am, CNA S reported Resident #7 should be wearing the padded boots on both feet when she was in bed. CNA S reported she had not applied the boots to Resident #7's feet in the last two days. CNA S reported she was unsure if Resident #7 was to wear the padded boots or not.Review of Evaluation of Braden Scale (standardized assessment tool used to estimate a patient's risk of developing pressure ulcers) for Resident #7 dated 8/4/25 at 4:40 pm revealed .Score:11 Level High Risk (6-9 very high risk, 10-12 high risk, 13-14 moderate risk, 15-18 mild risk, 19-23 no risk).In an interview on 12/16/25 at 11:29 am, Director of Nursing (DON) B stated I'm going to go look at what is in her (Resident #7) room.In an interview on 12/16/25 at 11:37 am, DON B reported Resident #7 was to have her feet elevated off the mattress as she allowed. DON B reported Resident #7 did not need more specific interventions as she did not have any wounds and she was not at risk for skin breakdown. DON B reported she removed the boots from Resident #7's feet because her feet should be elevated on a pillow. DON B reported she did not know where the boots came from. Review of Care Plan for Resident #7 revealed no noted documentation regarding padding boots for bilateral feet.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow professional standards of nursing practice for physician notification of a change in condition and medication administration for 1 of 1 residents (Resident #2) reviewed for medication administration resulting in the withholding of a medication without a physician's order and the potential for affected resident not maintaining or achieving their highest practical physical well-being.Findings include: Review of Fundamentals of Nursing ([NAME] and [NAME]] revealed, Professional standards such as Nursing: Scope and Standards of Practice [ANA, 2010) .apply to the activity of medication administration. To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these six rights: 1.The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]: Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 39307-393131. Elsevier Health Sciences. Kindle Edition. Resident #2: Review of a Face Sheet revealed Resident #2 was a male with pertinent diagnoses which included diabetes with foot ulcer, Stage 4 pressure ulcer left buttock, Stage 3 pressure ulcer right buttock, osteomyelitis (serious bone infection where germs have reached the bone through the bloodstream), sepsis (life threatening medical emergency where the body's extreme response to an infection triggers a chain reaction causing widespread inflammation, tissue damage, organ failure, and potentially death) and paralysis from the chest down. Review of Care Plan for Resident #2 dated on 7/13/24, revealed the focus, .Potential for episode(s) of hypo/hyper glycemia (hypoglycemia - blood glucose drops too low depriving cells, especially the brain, of energy causing shakiness, sweating, dizziness, confusion. Hyperglycemia - too much glucose in the blood usually because the body lacks enough insulin, symptoms include thirst, frequent urination, blurred vision, stomach pain, headache, difficulty concentrating) r/t (related to) DX (diagnosis) diabetes. Patient does not follow his diabetic diet . with the intervention .Administer diabetic medication(s) as ordered. Observe for effectiveness and any adverse side effects .Observe for signs of hyperglycemia: increased thirst; increased urination; increased appetite followed by lack of appetite; nausea, vomiting. In an interview on 12/15/2025 at 2:12 PM, Resident #2 reported he did not receive his long-lasting insulin last night as the facility didn't have the insulin in the medication cart or in the back up refrigerator. Resident #2 reported he had been told the facility had ordered the insulin and was told it should be at the facility today (12/15/25) for administration tonight. Review of Medication Administration Record (MAR) for December 2025, revealed, Resident #2 had not received degludec insulin on 12/11/25, 12/12/25, 12/13/25, 12/14/25. Nurse's initials of those assigned to administer the insulin were enclosed in parentheses which indicated the medication was not administered. Review of MAR December 2025, revealed, .12/11/2025 Prior to bed Not Administered: Other Comment: on order from pharmacy (RN J) .12/12/2025 Prior to bed Not Administered: Drug/Item Unavailable Comment: delivery pending from pharmacy (LPN V .12/13/2025 Prior to bed Not Administered: Drug/Item Unavailable Comment: pharmacy delivery pending (LPN V) .12/14/2025 Prior to bed Not Administered: Drug/Item Unavailable Comment: delivery pending .(LPN V) . Review of the medical record revealed the provider was not contacted or informed when the degludec insulin became unavailable to provide direction and/or new orders to the nurse on duty when there was no degludec insulin to administer. In an interview on 12/16/2025 at 12:06 PM, LPN Z reported for any medication which was not available in the medication cart or the backup box, the nurse would contact the pharmacy right away as well as the nurse would contact the provider to let them know and seek direction and/or obtain a new order for the medication to be replaced or placed on hold. LPN Z reported there was a form the pharmacy had the nurse fill out when pulling from the backup box. LPN Z reported the nurse could check with the local pharmacy to see if they had the medication needed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN Z reported for insulin it would depend on if it was on back order and if the facility was going to receive it prior to administration time, and it depended on the resident and the blood sugar readings and other diagnoses. LPN Z reviewed the medical record and reported the insulin was not placed on hold by the provider and there was no note the provider was contacted. In an interview on 12/17/2025 at 9:08 AM, Registered Nurse (RN) J reported the nurse had a form we fill out and faxed to the pharmacy to get permission to pull the medication from the lock box in the medication room. If the medication was in stock the nurse would pull it from there, if it was not in stock, there was a tab in the medical record to record it was not given, and the nurse would indicate not in stock option. RN J reported the provider would be notified and a progress note would be entered into the medical record to communicate with other nursing staff. RN J reported if the insulin was not in stock, she would contact the pharmacy to check if there were any long lasting insulin the facility had in stock which would be comparable to the prescribed insulin. RN J reported for Resident #2 he was prescribed an insulin she had been unfamiliar with, she went to get the insulin, and it was not in the cart, she looked in the cart for it and then went to check the medication refrigerator for extra and was unable to locate the degludec insulin. RN J reported she had seen there was an order placed for the insulin to come from the pharmacy, but it didn't come when she worked, she was not able to administer the insulin. RN J reported she should have contacted the provider to see how the provider wanted to proceed. RN J reported that if the resident did not receive his insulin, he could have high blood sugars, had a seizure, or went into a coma. In an interview on 12/17/2025 at 3:09 PM, Licensed Practical Nurse (LPN) V reported the degludec insulin was out and she had tried to call the pharmacy and was told the insulin would be in the tote delivered by pharmacy that night, and the insulin did not come, and she had contacted them again. LPN V reported she was told it would be coming, and it would be a different insulin but comparable to the degludec insulin. LPN V reported she had worked the previous Friday, Saturday, and Sunday. LPN V reported the insulin was not in Sunday's tote either and pharmacy reported the medication was temporarily out of stock and would be delivered the next day, Monday (12/15/25). LPN V reported she should have contacted the provider to see if there could be a substitute medication the provider wanted to administer on that first night she worked and the insulin was not available, she reported she thought it would be okay until the insulin came in and then each time it didn't' come in and she still did not contact the provider. LPN V reported when she checked Resident #2's blood sugar levels were in the 200s and she repeated she thought it would be okay. LPN V reported she held herself to a certain standard and she should have called the provider right away. In an interview on 12/17/2025 at 10:03 AM, Director of Nursing (DON) B reported if a medication was not in the medication cart, the nurse was to look in the back up box to see if the medication was in there. DON B reported the nurse would contact the provider when they found there was no medication and it had not arrived in the pharmacy tote, as well as document in the medical record the medication was not available. DON B reported Resident #2 did not receive the long-lasting insulin from 12/11 until 12/15 as noted in the medication administration record. DON B reported if a resident did not receive the long-lasting insulin he could have hyperglycemia, altered mental status, DKA (diabetes ketoacidosis - severe life-threatening diabetes complication the body lack insulin, causing it to burn fat for fuel, producing acidic ketones that build up in the blood leading to dehydration, potential coma or death). DON B reported a progress note would be entered per the policy as well as to communicate with other staff, proof what was documented was done, and the nurses were trained to document the provider was contacted and what was communicated. DON B reported prior to the missed degludec insulin doses Resident #2, from 12/2/25 to 12/11/25, had multiple blood sugar ranges from mid to lower 100s, and in the 200 range. From 12/11/25 to 12/17/25, Resident #2 had a few readings in the 100 range, most in the 200 range, and one in the 300 range.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide individualized activities based on resident preferences, needs, and abilities for 1 resident (Resident #59) of 16 residents for activities, resulting in potential for social isolation, decreased connectedness to the resident's environment, and decreased overall well-being.Findings include: Review of Participating in Activities You Enjoy as You Age, published by the National Institute on Aging, 3/28/22, revealed: Research has shown that older adults with an active lifestyle: Are less likely to develop certain diseases. Participating in hobbies and other social activities may lower risk for developing some health problems, including dementia, heart disease, stroke, and some types of cancer. Studies looking at people's outlooks and how long they live show that happiness, life satisfaction, and a sense of purpose are all linked to living longer. Doing things that you enjoy may help cultivate those positive feelings. Studies suggest that older adults who participate in activities they find meaningful, .say they feel happier and healthier. When people feel happier and healthier, they are more likely to be resilient, which is our ability to bounce back and recover from difficult situations. Positive emotions, optimism, physical and mental health, and a sense of purpose are all associated with resilience.research suggests that participating in certain activities, such as those that are mentally stimulating or involve physical activity, may have a positive effect on memory - and the more variety the better. Resident #59 (R59)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R59 was a [AGE] year-old man who was admitted to the facility on [DATE]. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R59 was cognitively intact (13 to 15 cognitively intact).During an interview on 12/15/2025 at 9:43 AM, R59 stated that there wasn't an Activity Director at the facility for about a month and some staff helped here and there with activities. R59 said that the calendar hadn't been followed during that time and the facility was doing the best they could. R59 stated that he loves going to religious services/church on Sundays and only attended 1 service on a Sunday since he was admitted to the facility. R59 reported that his main interest was attending church and he only attended BINGO since the residents liked him calling the numbers. Review of the November 2025 and December 2025 calendar revealed that there were 6 total church services scheduled every Sunday since R59 was admitted to the facility. Review of R59's Activity assessment dated [DATE] revealed . Is resident active in religion: yes. (R59) is a [AGE] year-old male. He prefers to self-direct his activities and stays in his room. (R59) enjoys reading, writing, watching TV, keeping up with the news, listening to all types of music especially country, jazz, and rock, arranging music, playing in a band, performing music at facilities, working on the internet, participating in religious services.Review of R59's Care Plan revealed .He (R59) prefers to self-direct his activities and stays in his room. (R59) enjoys reading, writing, watching TV, keeping up with the news, listening to all types of music especially country, jazz, and rock, arranging music, playing in a band, performing music at facilities, working on the internet, participating in religious services. Date initiated 11/4/2025.Goal: Attempt to accommodate/adapt to offer meaningful, satisfying and pleasurable activities to meet resident's individual needs. Resident will appear comfortable and satisfied with his daily facility activities/routine. Resident preferences will be honored to the extent possible. Approach: Encourage/invite resident to activities that suit his prior interest or are compatible with his prior life interests/hobbies.Review of R59's MDS Section F for Activities revealed .How important is it to you to listen to music you like? Very important.How important is it to you to participate in religious services or practices? Very important. Review of R59's November 2025 Activity Log through POC (Point of Care that staff documents in) revealed that he attended activities for 3 days since admission on [DATE] and none of them were church services.Review of R59's December 2025 Activity Log which was typed on a word document indicated R59 did not attend any church services provided by the facility and R59 led church services with a few residents on 12/7/2025 and (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/14/2025. During another interview on 12/17/2025 at 11:12 AM, R59 said he loves music and played the guitar in 2 different bands. He stated that he played with the church when they came in the 1 time since he has been at the facility. R59 reported since the church service has only occurred on 1 Sunday, he gathered some residents a few times on other Sundays in the chapel and they would sing some hymns and read a few passages from the bible. R59 stated it wasn't an official devotion and staff didn't help get residents to the chapel. During an interview on 12/17/2025 at 11:10 AM, Licensed Practical Nurse (LPN) Z stated that the church hasn't come to the facility on Sundays in months.During an interview on 12/17/2025 at 11:07 AM, Registered Nurse (RN) U stated that they haven't had activities besides BINGO on the weekends. RN U said that church hasn't been coming in for months. RN U reported that the previous Activity Director (AD) was supposed to look into why the church hadn't been coming in on Sundays but then she quit and no one looked into it. RN U said that the new AD just started on 12/15/2025. During an interview on 12/17/2025 at 11:34 AM, Certified Nursing Assistant (CNA) S stated that they only have a few activities on weekends. CNA S said that churches come in on Sunday but she hasn't seen them in a long time. During an interview on 12/17/2025 at 11:35 AM, AD F stated she started as AD on 12/15/2025 and does not have her certification as an AD yet but she worked as a CNA at the facility before becoming the AD. AD F stated she was made aware of R59 wanting to attend church and how they haven't been coming on Sundays and she said she set up a meeting with the church, R59 and her to discuss this concern. During an interview on 12/17/2025 at 12:30 PM, Nursing Home Administrator (NHA) A stated that the previous AD left the faciity on [DATE] and after she left, they had an assistant that filled in for activities. Review of the Activity Programming Policy with a review date of 6/2017 revealed Policy: Activity programs designed to meet the needs of each resident are available on a daily basis. Our activity programs are designed to encourage maximum individual participation and are person-appropriate to the individual resident. 2. Our activity program consists of individual and small and limited large group activities that are designed to meet the needs and interests of each resident and include, as a minimum .at least one evening activity is offered per week Group Activities are offered on Saturday, Sunday and holidays. 7. Individualized and group activities provided will: reflect the schedules, choices and rights of the residents, are offered at hours convenient to the residents, including evenings .weekends .

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure services and assistive devices were provided to maintain adequate vision in 1 (Resident #24) of 1 resident reviewed for vision services resulting in inadequate glasses, outdated prescription, and the potential for vision strain. Findings include:Resident #24Review of a Resident Face Sheet revealed Resident #24 was a male who admitted to the facility on [DATE] and had pertinent diagnoses which included: Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side (stroke). Review of a Minimum Data Set (MDS) assessment for Resident #24, with a reference date of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11/15 which indicated Resident #24 was moderately cognitively impaired.In an observation and interview on [DATE] at 9:51 AM, Resident #24's glasses were noted to be missing the left lens. Resident #24 demonstrated where the frame of his glasses, near the nose piece on the left side, was broken completely through. Resident #24 reported the lens was in the drawer, and it would not stay in the frame. Resident #24 reported his glasses broke a while ago and the facility had not gotten them fixed yet. Resident #24 reported he had asked for his glasses to be fixed several times.Review of Social Service note for Resident #24 dated [DATE] at 3:38 pm revealed .Resident broke his glasses. Writer tried ordering new glasses, but his RX (prescription) has expired. (Name Omitted/optometry service) explained that the RX expired d/t (due to) resident refusing to see the optometrist. Resident will be seen at next visit to renew his RX.In an interview on [DATE] at 2:12 pm, Director of Nursing (DON) B reported that Social Service Director (SSD) P was responsible for vision services for residents in the building. DON B reported she thought vision services were offered quarterly.In an interview on [DATE] at 10:33 am, DON B reported Resident #24 had a history of refusing to see optometry. DON B reported that Resident #24 refused to be seen on [DATE]. When queried, if there had been any other appointments scheduled, or attempts to have his glasses repaired, DON B stated That's a good question, SSD P would coordinate that.In an interview on [DATE] at 2:45 pm, NHA A reported vision services were available as needed for the residents of the building. SSD P had communicated with her via text message that Resident #24 had repeatedly refused attempts to repair his glasses and services from optometry to acquire a new prescription for glasses. NHA A reported Resident #24 was scheduled for a visit with optometry on [DATE].Review of a letter addressed to SSD P and dated [DATE], revealed .list of residents we suggest being seen by our optometrist.on [DATE]th. Resident #24 was noted to be on the list.No other documentation was provided by the time of survey exit demonstrating any scheduled optometry appointments, any refusal of services, or any attempts made to repair/replace Resident #24's glasses after [DATE] when Resident #24's glasses were noted to be broken.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure proper treatment to maintain good foot health for 1 (Resident #5) of 1 resident reviewed for foot health, resulting in the potential for injury, unmet care needs and/or complications from chronic conditions that affect foot health.Findings include:Resident #5Review of a Resident Face Sheet revealed Resident #5 was a male who admitted to the facility on [DATE] and had pertinent diagnoses which included: Cerebral infarction (stroke) with left side weakness, type 2 diabetes (chronic condition resulting in high blood sugar levels due to ineffective insulin production or use), and hypertension (high blood pressure). Review of a Minimum Data Set (MDS) assessment for Resident #5, with a reference date of 10/02/25 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #5 was cognitively intact.In an interview on 12/15/25 at 12:26 pm, Resident #5 reported he was concerned with his fingernails and toenails being clipped. Resident #5 reported he offered to do it himself, but the staff would not provide him with clippers or scissors.In an interview on 12/16/25 at 1:54 Resident #5 reported his nails were too long and he couldn't stand it. Resident #5 reported he was told several months ago he had diabetes, and he now needed to see a podiatrist (specialized foot doctor) for his foot care. Resident #5 reported occasionally someone looks at his feet, but no one had ever cut his toenails.On 12/16/25 at 1:54 pm, Resident #5's fingernails were observed to be long and extending well past the ends of his fingers. Resident #5's toenails on his right foot were observed to be long, extending beyond the ends of his toes and curing along the curvature of the toes; the great toenail extended beyond the end of the toe, was noted to be broken, jagged, and long.In an interview on 12/16/25 at 3:31 pm, Licensed Practical Nurse (LPN) Z reported nail care was completed with showers but could be done anytime it was needed. LPN Z reported CNA (certified nurse assistants) were not allowed to cut the nails of residents who had diabetes. LPN Z reported nurses could cut the nails of residents who had diabetes and those residents could be seen by the podiatrist for foot and nail care.Review of shower sheets: for Resident #5 from 11/25/25, 11/27/15, 12/02/25, and 12/04/25 revealed no documentation regarding nail care.In an interview on 12/17/25 at 10:21 am, CNA W who was working as the shower aide, reported that nail care could be done during showers. CNA W reported activities aides were who provided nail care to the residents. CNA W reported she did not cut the nails of residents who had diabetes. CNA W reported she would tell the nurse when a resident who had diabetes needed their nails cut. When queried, CNA W reported she did not document on the shower sheet if a resident needed nail care, if she cut nails or not, nor when she notified the nurse when a resident needed nail care she could not complete. CNA W stated I should probably start putting that on the shower sheets.In an interview on 12/17/258 at 10:27 am, Director of Nursing (DON) B reported resident's nails should be evaluated with every shower and bed bath. DON B reported CNAs should provide nail care, except to a resident who has diabetes, then nail care was done by the nurse or podiatrist. When queried, regarding Resident #5 nail care DON B was unsure if he had seen the podiatrist.In an interview on 12/17/25 at 10:28 am, Nursing Home Administrator (NHA) A reported Resident #5 signed consent to be treated by (Name Omitted) podiatrist on 9/25/25.Review of (Name Omitted) Consent for services for Resident #5 revealed .podiatry.I wish to use the service. signed by Resident #5 and dated 9/25/25.In an interview on 12/17/25 at 3:45pm, NHA A reported Resident #5 refused services by Podiatry provider. NHA A reported Resident #5's nails had been cut the nurse today.Review of Resident #5's medical record revealed no noted documentation regarding services of podiatry occurring or refusal of podiatry services. No documentation was provided regarding Resident #5 being seen by podiatry services, refusal of podiatry services, completion of nail care, or refusal of nail care by the time of exit.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure hydration was readily available for 1 resident (Resident #25) of 1 resident, resulting in the potential for decline in function, fluid and electrolyte imbalance, dehydration, the development of skin breakdown, urinary tract infections, and altered mental status. Findings include: According to Bunn (2019), .Older people are more at risk of developing low-intake dehydration because, with age, kidney function decreases and muscle mass drops, reducing water stores in muscle. Older people may also develop difficulties remembering to drink, accessing drinks, and swallowing. If an older person is concerned about continence or needs help to get to the toilet, they often choose to drink less, thereby increasing their risk of low-intake dehydration. The risk of dehydration is increased in care homes residents because they are more likely to experience these problems, relying on staff to help with drinking.Residents rarely helped themselves to, or asked for, drinks, which puts the onus on nursing and care staff.Tips for improving hydration in care homes: Offer more drinks more frequently.Do not rely on residents asking for, or helping themselves to, drinks, but proactively offer them.If drinks are not finished, offer more frequent drinks.Improve continence support and access to toilets.Involve all care home staff in promoting residents' hydration. https://cdn.ps.emap.com/wp-content/uploads/sites/3/2019/09/054-058_RevDehydration-CT1.pdf Resident #25: Review of an admission Record revealed Resident #25 was a male with pertinent diagnoses which included altered mental status, cognitive communication deficit ((progressive degenerative brain disorder resulting in difficulty with thinking and how someone uses language), Parkinson's disease, dementia, depression, mood disorder, and the need for assistance with personal care. Review of current Care Plan for Resident #25, revised on 6/2/2021, revealed the focus, .(Resident #25) is at Nutritional / Hydration risk r/t (related to) hx (history) of UTI (urinary tract infection), Parkinson's, COPD, FE anemia, GERD, CAD (cardiovascular disease), HLD (high cholesterol), dementia, Antipsychotic therapy in place. Hx of wt (weight) fluctuations . with the intervention .Encourage fluids at bedside and with activities within ordered parameters if applicable .Observe for s/s (signs and symptoms) of fluid imbalance: edema, shortness of breath, dry mucous membranes, dry skin, poor skin turgor (your skin loses elasticity and doesn't snap back quickly after being pinched .key sign of dehydration) .Offer refreshments between meals .Observe labs . Review of Lab Results dated 9/23/25 revealed, .BUN Level (Blood Urea Nitrogen used to assess kidney function, hydration, and liver health) Score of 30. Normal range was 8-23 .BUN/Creatinine Ratio (used to assess kidney health, hydration, and protein metabolism) Score of 41. Normal range was 6-20 . During an observation on 12/15/25 at 09:05 AM, Resident #25 was seated at the nurse's station with no water, no activities, just a fuzzy blanket. During an observation on 12/15/2025 at 10:15 AM, Resident #25 was sitting at the nurse's station desk still in his wheelchair, with the fuzzy blanket and no water. Staff did not notice he did not have any fluids in front of him nor did anyone offer to obtain something for him to drink. During an observation on 12/15/2025 at 2:11 PM, Resident #25 was being assisted to eat by a staff member, he had not drunk the fluids on his tray but did have an open drink supplement. This writer observed resident for several minutes and he did not attempt to drink the supplement; the staff member left the supplement on the table but did not offer him a drink nor did she assist him with a drink. Resident #25 had consumed less than 25% of his meal, ate approximately 25% of pasta dish, did not eat any vegetables, nor his dessert. During an observation on 12/15/2025 at 4:12 PM, Resident #25 was lying in his bed in his room and there was a smaller sized Styrofoam cup with a straw on his dresser which was across the room and clearly out of reach. During an observation on 12/16/2025 at 9:00 AM, Resident #25 was lying in his bed, and his tray table was parallel with the right wall, there was water on the table but was out of reach for Resident #25 while he was in bed. During an observation on 12/16/2025 at 1:59 PM, Resident #25 was seated at the nurse's station, and he had a small clear plastic cup which had about an inch of clear fluid in the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bottom of the cup. During an observation on 12/17/2025 at 9:23 AM Resident #25 was seated at the desk and he didn't have any fluid to drink. Resident #25's mouth was dry appearing and he had white coating on his tongue, skin was very dry appearing without good skin turgor. In an interview on 12/17/2025 at 10:17 AM, Director of Nursing (DON) B reported signs of symptoms of dehydration was poor skin turgor, altered mental status, dark urine, and foul-smelling urine. If the resident was not able to say they were thirsty, the staff would check for dry mucous membrane, frothy or thick saliva. DON B reported the staff pass fluids each shift and provide fluids as needed. However, in the event the fluid was gone and the resident would like more, the staff should provide the resident with more fluids. DON B reported if a resident was not able to express the need for fluids it is the staff's responsibility to off fluids when they enter the room at least every 2 hours, and in addition some people cannot drink much they would be offered mouth swabs/mouth care.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medications were administered at the correct dose per the physician's order for 1 (Resident #2) of 2 residents reviewed for significant medication errors, resulting in the potential for adverse effects. Findings include: Review of the Fundamentals of Nursing revealed, The National Coordinating Council for Medication Error Reporting and Prevention [2018] defines a medication error as any preventable event that may cause inappropriate medication use or jeopardize patient safety. Medication errors include inaccurate prescribing, administering the wrong medication, giving the medication using the wrong route or time interval, administering extra doses, and/ or failing to administer a medication. Preventing medication errors is essential." [NAME]. [NAME] A.: Perrv. [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p.605). Elsevier Health Science. Kindle Edition. Resident #2: Review of a Face Sheet revealed Resident #2 was a male with pertinent diagnoses which included diabetes with foot ulcer, Stage 4 pressure ulcer left buttock, Stage 3 pressure ulcer right buttock, osteomyelitis (serious bone infection where germs have reached the bone through the bloodstream), sepsis (life threatening medical emergency where the body's extreme response to an infection triggers a chain reaction causing widespread inflammation, tissue damage, organ failure, and potentially death) and paralysis from the chest down. Review of Care Plan for Resident #2 dated on 7/13/24, revealed the focus, .Potential for episode(s) of hypo/hyper glycemia (hypoglycemia - blood glucose drops too low depriving cells, especially the brain, of energy causing shakiness, sweating, dizziness, confusion. Hyperglycemia - too much glucose in the blood usually because the body lacks enough insulin, symptoms include thirst, frequent urination, blurred vision, stomach pain, headache, difficulty concentrating) r/t (related to) DX (diagnosis) diabetes. Patient does not follow his diabetic diet . with the intervention .Administer diabetic medication(s) as ordered. Observe for effectiveness and any adverse side effects .Observe for signs of hyperglycemia: increased thirst; increased urination; increased appetite followed by lack of appetite; nausea, vomiting.In an interview on 12/15/2025 at 2:12 PM, Resident #2 reported he developed a wound on his right-side bottom area, where the leg and the buttock met due to having him off load his left side due to a pressure ulcer and the staff had him lying on his right side. Resident #2 reported he did not receive his long-lasting insulin last night as the facility didn't have the insulin in the medication cart or in the back up refrigerator. Resident #2 reported he had been told the facility had ordered the insulin and was told it should be at the facility today for administration tonight. Review of Progress Notes dated 12/15/2025 at 03:28 AM, .This writer contacted (Medication Pharmacy Provider). regarding DEGLUDEC insulin (long lasting insulin). not arriving in tonight's delivery. Pharmacy will send brand Stating because generic is out of stock Insurance should cover cost. (Medication Pharmacy Provider) also stated medication would be delivered stat (life threatening or urgent situation that requires the order to be prioritized and administered as quickly as possible). (tomorrow) if approved by insurance . Review of Medication Administration Record (MAR) for December 2025, revealed, Resident #2 had not received degludec insulin on 12/11/25, 12/12/25, 12/13/25, 12/14/25. Nurse's initials of those assigned to administer the insulin were enclosed in parentheses which indicated the medication was not administered. Review of MAR December 2025, revealed, .12/11/2025 Prior to bed Not Administered: Other Comment: on order from pharmacy (RN J) .12/12/2025 Prior to bed Not Administered: Drug/Item Unavailable Comment: delivery pending from pharmacy (LPN V .12/13/2025 Prior to bed Not Administered: Drug/Item Unavailable Comment: pharmacy delivery pending (LPN V) .12/14/2025 Prior to bed Not Administered: Drug/Item Unavailable Comment: delivery pending .(LPN V) . Review of the medical record revealed the provider was not contacted or informed when the degludec insulin became unavailable to provide direction and/or new orders to the nurse on duty when there was no degludec insulin to administer. In an interview on 12/16/2025 at 12:06 PM, LPN Z reported for any medication (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	which was not available in the medication cart or the backup box, the nurse would contact the pharmacy right away as well as the nurse would contact the provider to let them know and seek direction and/or obtain a new order for the medication to be replaced or placed on hold. LPN Z reported there was a form the pharmacy had the nurse fill out when pulling from the backup box. LPN Z reported the nurse could check with the local pharmacy to see if they had the medication needed. LPN Z reported for insulin it would depend on if it was on back order and if the facility was going to receive it prior to administration time, and it depended on the resident and the blood sugar readings and other diagnoses. LPN Z reviewed the medical record and reported the insulin was not placed on hold by the provider and there was no note the provider was contacted. In an interview on 12/17/2025 at 9:08 AM, Registered Nurse (RN) J reported the nurse had a form we fill out and faxed to the pharmacy to get permission to pull the medication from the lock box in the medication room. If the medication was in stock the nurse would pull it from there, if it was not in stock, there was a tab in the medical record to record it was not given, and the nurse would indicate not in stock option. RN J reported the provider would be notified and a progress note would be entered into the medical record to communicate with other nursing staff. RN J reported if the insulin was not in stock, she would contact the pharmacy to check if there were any long lasting insulin the facility had in stock which would be comparable to the prescribed insulin. RN J reported for Resident #2 he was prescribed an insulin she had been unfamiliar with, she went to get the insulin, and it was not in the cart, she looked in the cart for it and then went to check the medication refrigerator for extra and was unable to locate the degludec insulin. RN J reported she had seen there was an order placed for the insulin to come from the pharmacy, but it didn't come when she worked, she was not able to administer the insulin. RN J reported she should have contacted the provider to see how the provider wanted to proceed. RN J reported that if the resident did not receive his insulin, he could have high blood sugars, had a seizure, or went into a coma. In an interview on 12/17/2025 at 3:09 PM, Licensed Practical Nurse (LPN) V reported the degludec insulin was out and she had tried to call the pharmacy and was told the insulin would be in the tote delivered by pharmacy that night, and the insulin did not come, and she had contacted them again. LPN V reported she was told it would be coming, and it would be a different insulin but comparable to the degludec insulin. LPN V reported she had worked the previous Friday, Saturday, and Sunday. LPN V reported the insulin was not in Sunday's tote either and pharmacy reported the medication was temporarily out of stock and would be delivered the next day, Monday (12/15/25). LPN V reported she should have contacted the provider to see if there could be a substitute medication the provider wanted to administer on that first night she worked and the insulin was not available, she reported she thought it would be okay until the insulin came in and then each time it didn't' come in and she still did not contact the provider. LPN V reported when she checked Resident #2's blood sugar levels were in the 200s and she repeated she thought it would be okay. LPN V reported she held herself to a certain standard and she should have called the provider right away. In an interview on 12/17/2025 at 10:03 AM, Director of Nursing (DON) B reported if a medication was not in the medication cart, the nurse was to look in the back up box to see if the medication was in there. DON B reported the nurse would contact the provider when they found there was no medication and it had not arrived in the pharmacy tote, as well as document in the medical record the medication was not available. DON B reported Resident #2 did not receive the long-lasting insulin from 12/11 until 12/15 as noted in the medication administration record. DON B reported if a resident did not receive the long-lasting insulin he could have hyperglycemia, altered mental status, DKA (diabetes ketoacidosis - severe life-threatening diabetes complication the body lack insulin, causing it to burn fat for fuel, producing acidic ketones that build up in the blood leading to dehydration, potential coma or death). DON B reported a progress note would be entered per the policy as well as to communicate with other staff, proof what was documented was done, and the nurses were trained to document the provider was contacted and what was communicated. DON B reported prior to the missed degludec insulin doses Resident #2, from 12/2/25 to 12/11/25, had multiple blood sugar ranges from mid to (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lower 100s, and in the 200 range. From 12/11/25 to 12/17/25, Resident #2 had a few readings in the 100 range, most in the 200 range, and one in the 300 range.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview the facility failed to properly store controlled substance medications in a secure manner in 1 of 2 medication rooms.Findings include:On 12/17/25 at 8:29 am, the lock on the medication storage refrigerator in the medication room on the west unit of the facility was observed hanging in place on the latch and was not secured. The lock was not locked.On 12/17/25 at 8:29 am, Registered Nurse (RN) DD was observed handling the lock, flipping the lock to remove it from the latch on the refrigerator, and opening the refrigerator door. RN DD did not use a key to unlock the refrigerator.On 12/17/25 at 8:29 am, RN DD reported there was a controlled substance stored in the refrigerator.On 12/17/25 at 8:33 am, RN DD was observed replacing the lock on the latch of the refrigerator and not locking the lock. RN DD exited the medication room leaving the refrigerator unlocked.In an interview on 12/17/25 at 8:38 am, RN DD reported the refrigerator in the medication room should be always locked.In an interview on 12/17/25 at 9:09 am, Director of Nursing (DON) B reported her expectations were that the refrigerators in the medication rooms were to be always locked.In an interview on 12/17/25 at 9:10 am, RN DD confirmed the refrigerator was unlocked and she did not lock the refrigerator when she exited the medication room. RN DD reported she returned to the medication room and locked the refrigerator.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure resident food choices were obtained and honored for 1 (Resident #75) of 4 residents reviewed for meal services, resulting in resident dissatisfaction with their meal experience and the potential for inadequate food/fluid intake. Findings include:Resident #75: Review of Face sheet for Resident #75 revealed, Review of a Face Sheet revealed Resident #75 was a male with pertinent diagnoses which included diabetes, gout (a painful inflammatory arthritis from uric acid crystals in joints), and kidney disease. Review of Care Plan for Resident #75, revealed, the focus, .Resident is at Nutritional / Hydration risk r/t (related to) admitted with hx (history) of chronic lymphedema (swelling from lymph fluid buildup, caused by damaged lymph nodes, leading to heaviness, tightness, and limited movement) RLE (Right Lower Extremity), high blood pressure, deep vein thrombosis (a serious condition where a blood clot forms in a deep vein), diabetes, stage 4 kidney disease, rheumatoid arthritis (a chronic autoimmune disease where the immune system attacks joint linings, causing pain, swelling, and stiffness and can lead to systemic issues affecting the heart lungs and eyes) Diuretic therapy in place . with the intervention .Offer available substitutes if resident has problems with the food that is served .Honor food preferences within acceptable dietary limits for resident's quality of life concerns .Offer substitutes if consumes less than 50% of meal . Review of Lunch Dining Slip indicated Resident #75's preferences were to not receive pineapples, Mexican food, and sweet potatoes. In an interview on 12/15/2025 at 10:34 AM, Resident #75 reported he had informed the dietary staff he did not like sweet potatoes, malt o meal, oatmeal, fish, pineapple, waffles and he was still receiving those items on his meal trays. Resident #75 reported every Friday the kitchen served fish, and he reported he does not eat the fish but does eat whatever else was on the plate. Resident #75 reported during the care conferences the staff asked different questions, and he had reported to the registered dietician and shared with them his preferences and it doesn't change, Resident #75 reported he still gets items he had told them he doesn't like on his meal trays. During an interview on 12/16/2025 at 2:10 PM, Dietary Director (DD) G stated that he knew about some food concerns that come up here and there but I don't have any specifics items I can work with to fix. DD G said he only received 1 concern form related to food and that was in June when he first started at the facility. DD G also stated that he didn't hear anything from Resident Council about the food or receive concerns forms from the meeting. DD G reported that he has a Food Committee meeting monthly after Resident Council and at those meetings the residents typically don't give him any information to work with. When discussing that the residents at resident council stated, the food is horrible and they don't get what they order, DD G mentioned that he would need more details from the residents to fix their concerns.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to complete accurate assessments for 1 of 16 residents (R#75) reviewed for assessments, resulting in an inaccurate reflection of the resident's status and the potential for impaired medical, functional, and psychosocial problems due to unidentified needs. Findings include: Resident #75: Review of a Face Sheet revealed Resident #75 was a male with pertinent diagnoses which included diabetes, gout (a painful inflammatory arthritis from uric acid crystals in joints), kidney disease stage 4 (severe loss of kidney function, the kidneys only filter 15-29% if waste), chronic lymphedema (swelling from lymph fluid buildup, caused by damaged lymph nodes, leading to heaviness, tightness, and limited movement) RLE (Right Lower Extremity), high blood pressure, deep vein thrombosis (a serious condition where a blood clot forms in a deep vein), diabetes, rheumatoid arthritis (a chronic autoimmune disease where the immune system attacks joint linings, causing pain, swelling, and stiffness and can lead to systemic issues affecting the heart lungs and eyes). Review of the medical record revealed, Resident #75 had been originally admitted to the facility 7/25/2024 which would not qualify the resident as a new admission to the facility despite not appearing on the MDS data submitted by the facility prior to the survey start date. Review of Minimum Data Set (MDS) Assessments for Resident #75 revealed, Resident #75 had discharged from the facility with the expectation to return on 10/31/25 and the assessment was rejected by Centers for Medicare and Medicaid (CMS). In an interview on 12/17/2025 at 9:43 AM, MDS Nurse H reported he received a validation report which indicated the outcome of the submitted assessments. MDS Nurse H reported that the corporate MDS Nurse was capable of submitting a transfer file for the assessment as they have that capability. MDS Nurse H reported the corporate MDS Nurse had informed him of the rejection of the submission of the assessment for Resident #75 and he had forgotten to follow up on determining why and correcting it. MDS Nurse H reported he was unsure why the assessment had been rejected and proceeded to review the assessment. MDS Nurse H reported most of the information was automatically filled in for completion. MDS Nurse H reviewed the validation report for the submission, and it did show as rejected, he proceeded to open the assessment and explained the items were automatically filled in. Upon review of the report, MDS Nurse H was able to determine the cause of the rejection was the re-entry admission date kept his original admission date, and he had to physically change the date to the correct date. MDS Nurse H reported Resident #75 had managed care for insurance and the 5 Day Entry assessment was considered a place holder which indicated his re-entry date but was not required by CMS due to his insurance and therefore was not submitted but only completed. The RAI Manual revealed on page 1-7, .The RAI process has multiple regulatory requirements .and require that the assessment accurately reflects the resident's status, a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals, the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts . and on page AZ-6, .The importance of accurately completing and submitting the MDS cannot be over-emphasized. The MDS is the basis for: the development of an individualized care plan the Medicare Prospective Payment System, Medicaid reimbursement programs, quality monitoring activities, such as the quality measure reports, the data-driven survey and certification process, the quality measures used for public reporting, research and policy development and on page Z-8, .Federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete .