STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235311	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alamo Nursing Home Inc	8290 W C Ave Kalamazoo, MI 49009

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on observation, interview, and record review the facility failed to ensure PASSAR (Preadmission Screening/Annual Resident Review) for a Level I OBRA evaluation and OBRA Level II evaluation were completed timely for 1 resident (Resident #109) of 2 residents reviewed, resulting in the potential for unmet behavioral health needs. Findings include: .Under the PASRR program, all persons seeking admission to a nursing facility who are seriously mentally ill and/or have an intellectual/developmental disability are required to be evaluated to determine whether the nursing facility is the most appropriate place for them to receive services and whether they require specialized behavioral/mental health services. https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/obraResident #109: Review of an admission Record revealed Resident #109 was a female with pertinent diagnoses which included paranoid schizophrenia, dementia, and cognitive communication deficit (progressive degenerative brain disorder resulting in difficulty with thinking and how someone uses language). Review of current Care Plan for Resident #109, revised on 6/14/25, revealed the focus, .Resident has a behavior concern r/t (related to) Psychiatric Diagnosis-Paranoid Schizophrenia. Resident may be paranoid about money and what others think of her which may cause her to intrude or interject herself on others and their privacy. with the intervention .Assist the resident to develop more appropriate methods of coping and interacting. Encourage the resident to express feelings appropriately. Anticipate and meet resident's needs, if she is unable to express them. Behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.). Follow up as indicated. Administer medication as ordered. Monitor/document for side effects and effectiveness and report any abnormals (sic) to medical staff. In an interview on 2/20/26 at 09:38 AM, Social Services Director (SSD) Y reported she did not have Resident #109's Level II evaluation which was due on 1/4/26 but the Obra evaluator was in the facility on 2/19/26 but reported she was unsure if they had seen Resident #109 for her Level II evaluation. SSD Y reported the Level I evaluations were completed yearly for each resident and when there was a change in condition.Review of Level II Evaluation letter dated 1/5/25, revealed, .2. RESULT OF THE DETERMINATION: The individual may continue to reside in a nursing facility and may choose to receive specialized mental health/developmental disabilities services. The local community mental health services agency will discuss with the individual, the individual's legal representative and the nursing facility a plan for the provision of specialized services.3. REASON FOR THE DETERMINATION: The individual's physical, mental and psychosocial needs can be adequately met in a nursing facility provided specialized services are implemented. a Level II evaluation would need to be completed by 1/4/2026. Review of electronic correspondence from Nursing Home Administrator (NHA) A on 2/20/25 at 12:01 PM, revealed, .The level one was completed on 12/5/2024. And the level two was completed on 1/5/2025. I do not have a level one for 2025.

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 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** This citation pertains to Intake: 2638850Based on observation, interview, and record review, the facility failed to implement resident comprehensive care plans for 3 (Resident #103, #109, and #112) of 13 residents reviewed for care planning implementation, resulting in a lack of service for residents to maintain their highest practicable physical, mental, and psychosocial well-being.Findings include: Resident #103: Review of an admission Record revealed Resident #103 was a male with pertinent diagnoses which included repeated falls, multiple sclerosis (a chronic autoimmune disease where the immune system attacks the protective myelin sheath of nerves in the brain and spinal cord causing communication issues, incurable), dementia, anxiety, and weakness. Review of current Care Plan for Resident #103, revised on 6/24/25, revealed the focus, .Resident has limited physical mobility r/t (related to) weakness, hx (history) of falls, infection, medication use, schizoaffective disorder, depression. with the intervention .pillow to bed to assist in defining bed boarders. Review of Care Plan dated 7/24/25, for Resident #103 revealed the focus .Resident at risk for falls r/t (related to) weakness, hx (history) of falls, infection, medication use, schizoaffective disorder, depression. with the intervention .Resident will remain free from fall related injury through the review date.will use rolled blanket for mattress boundary to right side of bed until body pillow can be obtained. During an observation on 2/19/25 at 11:23 AM, Observed Resident #103 lying in his bed, he was leaning to the right side some, head of bed was 60 degrees, and observed no pillow, blanket, or wedge on his right side to define bed boarder. During an observation on 2/20/26 at 9:15 AM, Resident #103 was observed in his room, lying in bed, he was leaning to that right side like he has been, there was no pillow, blanket, or wedge in the bed on the right side. During an observation on 2/24/26 at 9:26 AM, Resident #103 was observed lying in bed, he was leaning to the right in the bed, his right arm and shoulder were observed as off the side of the mattress, there was a blue wedge on the rolling bedside table at the foot of the bed, no pillow, no blanket or wedge was in place. Resident #109: Review of an admission Record revealed Resident #109 was a female with pertinent diagnoses which included dementia, osteoporosis (weak, brittle bones from bone density loss), and muscle sclerosis. Review of Care Plan for Resident #109 7/1/24 revealed the focus of .Resident at risk for falls r/t res has a high desire for independence with challenged balance/coordination resulting in falls. res has low safety awareness and tends to lean forward when propelling self in w/c (wheelchair). dx (diagnosis) of ms (multiple sclerosis), depression/anxiety with tx (treatment), paranoid schizophrenia, epilepsy, cognitive communication deficit and adjustment disorder. with the intervention of.NON-SLIP GRIP PAD: dycem (nonslip product for improved stability and grip) to side of bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Incident Report dated 1/1/26, revealed, .Resident was sitting on the floor in front of her bed.Resident stated, .I slide on the floor trying to get into my wheelchair.gait imbalance.Other info: Resident was attempting to transfer herself from her bed into her wheelchair without staff assistance.1/2/26: IDT (Interdisciplinary team) review of occurrence completed. Plan of care reviewed and updated to reflect intervention of dycem to side of bed. During an observation on 2/20/26 at 11:08 AM, Resident #109 was not in her room, there was no noted dycem observed on the exit (left) side of her bed, pulled back the blankets on the left side of Resident #109's bed and there was no dycem under the blankets on her sheet, or under her sheets. During an observation on 2/24/26 at 9:20 AM, no dycem was noted to the side of Resident #109's bed. In an interview on 2/20/26 at 1:01 PM, Resident #109 reported she did not know what a dycem was nor was there a dycem on her bed. During an observation and interview on 2/20/26 at 2:18 PM, Certified Nursing Assistant (CNA) LL reported there was not a dycem on Resident 109's bed and had not seen one on her bed. CNA LL reviewed the Kardex (care guide) and it showed Resident #109 required the use of a dycem to the side of her bed. In an interview and observation on 2/24/26 at 2:32 PM, Licensed Practical Nurse (LPN) K reported she was not aware of Resident #109 needing a dycem on her bed. LPN K reported an order would be needed for something like that, and new communication about the resident's care was shared during verbal report during shift change. CNA NN reported she had never heard of or seen the dycem on Resident #109's bed, she reported it was usually used under the pad on a wheelchair to prevent it from slipping. In an interview on 2/20/26 at 2:21 PM, MDS Coordinator Registered Nurse (RN) MM reviewed the Kardex and care plan and reported the dycem should have been over the top of the sheet and it was used to prevent her from sliding to the floor as Resident #109 does transfer herself and has had falls. In an interview on 2/20/26 at 12:10 PM CNA OO reported the CNAs were able to view the care plan as well as the Kardex and would review for the resident care needs. When queried if she felt the CNAs had time to review the Kardex, CNA OO reported the CNAs were in the medical record charting all the time as well as any changes to the care interventions were noted with a bullet point to indicate a new change or intervention for a resident so the CNAs would know and should know what needs the resident had. In an interview on 2/20/26 at 1:34 PM, Unit Manager (UM) W reported the CNAs were to refer to the Kardex (care guide) for caring for a resident as it tells the nursing staff how to take care of the residents. UM W reported the nurses had access to the care plan to see how the resident should be cared for. Resident #112 Review of an admission Record revealed Resident #112 was originally admitted to the facility on [DATE] with pertinent diagnoses which included type 2 diabetes mellitus (condition where the body cannot use insulin properly or doesn't make enough of it leading to high blood sugar). Review of Resident #112's Care Plan revealed, Resident has an ADL (Activities of daily living) self-care performance deficit .Date Initiated: 01/18/2026. Goal: Resident will improve current level of function in selfcare performance through the review date. Date Initiated: 01/18/2026. Interventions: Resident requires assistance with eating. Date Initiated: 02/02/2026 Review of Resident #112's Progress (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Note dated 1/31/26 revealed, Resident requires assistance with feeding. Eating only bites of her meals. Review of Resident #112's Eating task revealed that the facility had documented that Resident #112 was independent with eating meals on the following dates: 2/3/26, 2/4/26, 2/6/26, 2/7/26, and 2/11/26 and that Resident #112 required only set up assistance on 2/3/26, 2/5/26, 2/8/26, and 2/9/26. During an interview on 2/20/26 at 8:46 AM, LPN N reported that Resident #112 always ate in her room, and that she did often need assistance and queuing with eating. LPN N reported that she had noticed that Resident #112 did not eat much when she did not have assistance with eating. LPN N reported that she was unaware that Resident #112's care plan indicated that she required assistance with eating. During an interview on 2/20/26 at 12:05 PM, LPN P reported that she had noticed that Resident #112 had not been eating well. LPN P confirmed that Resident #112 always ate in her room, and that staff did not typically provide her with assistance with eating. During an interview on 2/20/26 at 10:51 AM, LPN L confirmed that she was the nurse caring for Resident #112 on 2/11/26 when she was sent to the hospital for hypoglycemia. LPN L reported that Resident #112 ate meals in her room, she did not require assistance with eating, and she had eaten her meals in her room on 2/11/26. During an interview on 2/20/26 at 11:47 AM, CNA H reported that Resident #112 always ate in her room, and that she did not require assistance with eating. CNA H reported she had noticed that Resident #112 did not always eat well, and it seemed like she needed assistance with eating. During an interview on 2/24/26 at 9:54 AM, CNA AA reported that she was caring for Resident #112 that day. CNA AA confirmed that Resident #112 had eaten breakfast by herself in her room that morning. During an observation on 2/24/26 at 11:57 AM, Resident #112 was observed sitting in her room in her wheelchair with her tray table in front of her. Resident #112 had chicken, rice, and vegetables on her plate. Resident #112 was attempting to bring food to her mouth and struggled to scoop food onto the fork to bring to her mouth. Resident #112 attempted to cut her chicken breast and was unable to. It was noted that there was not staff in her room to assist her with eating.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2661176, 2728846, 2638850. Based on observation, interview, and record review, the facility failed to provide appropriate Activities of Daily Living (ADL) care for 5 (Resident #101,#103,#110, #113, and #114) of 7 residents reviewed) reviewed for ADL care, resulting in the potential for avoidable negative physical and psychosocial outcomes for resident's who are dependent on staff for assistance. Findings include: Resident #101 Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE] with pertinent diagnoses which included need for assistance with personal care and muscle weakness. Review of Resident #101's Care Plan revealed, Resident has an ADL (Activities of daily living) self-care performance deficit .Date Initiated: 06/16/2025. Goal: Resident will improve current level of function in mobility, strength through the review date. Resident will be able to: assist with self-care. Date Initiated: 06/16/2025. Interventions: . BATHING/SHOWERING: The resident is totally dependent on 2 staff to provide bath and or shower 2 times a week and as necessary. Date Initiated: 08/03/2025 . Review of Resident #101's Hospital Records dated 11/2/25 revealed, HPI (History of Present Illness): (Resident #101) is . male past medical history of TBI (traumatic brain injury) in 2023 . and recent admission . for community-acquired and sepsis . Was reportedly soaked in urine, right eye crusted shut, and crusted around the mouth . During an interview on 2/18/26 at 11:25 AM, Family Member (FM) PP reported Resident #101 required total assistance from staff with all care. FM PP reported she frequently visited Resident #101 for 3 or more hours at a time, and every time she visited Resident #101, she never witnessed staff assist Resident #101 with care. FM PP reported Resident #101 was often observed as disheveled during her visits, with peeling skin, soiled briefs, wearing double briefs, and with salvia down his mouth and face. FM PP' reported Resident #101 was supposed to get two showers or bed baths a week, and that he was often missing showers. FM PP reported she felt like Resident #101 was often ignored because he was nonverbal and unable to ask for assistance. FM PP reported she would practically beg the staff to provide basic care to Resident #101 ever time she was at the facility. FM PP reported she frequently voiced her concerns that Resident #101 was not receiving adequate care to the nurses, Unit Manager (UM), Director of Nursing (DON), and Social Worker (SW), but she felt that the facility staff did not take her concerns seriously, and Resident #101's care did not improve. This writer requested Resident #101's Shower Sheets from 12/19/25-2/19/25. The facility provided 7 shower sheets from 12/19/25- 2/19/25. It was noted that Resident #101 should have had 14 showers/bed baths or documented refusals for the requested time frame. During an interview on 2/19/26 at 11:01 AM, Licensed Practical Nurse (LPN) Q reported that the facility's certified nursing assistants (CNA's) were supposed to provide a shower sheet to the nurse every time they completed a bed bath or shower, or let the nurse know that the resident refused, so that the nurse could reapproach the resident. LPN Q confirmed that when the facility was short staffed, they were not able to complete showers for residents. During an interview on 2/19/26 at 11:13 AM, LPN N reported that when the facility was short (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staffed, the staff struggled to complete all care for residents, and that residents had been missing showers and bed baths. During an interview on 2/19/26 at 2:07 PM, LPN M reported that residents at the facility were often missing showers at the facility. LPN M reported that the facility had a shower aide, but she was often getting pulled from that position to assist on the floor, and when that happened, residents would miss their showers. LPN M reported that she was aware that FM PP had voiced concerns about Resident #101 not getting adequate ADL care. During an interview on 2/20/26 at 10:51 AM, LPN L reported that staffing at the facility had been a struggle, and that residents were often missing showers because the shower aide would get pulled to work the floor. LPN L reported when the shower aide was pulled to work the floor, the aides were supposed to complete resident showers, but that was not always happening. During an interview on 2/20/26 at 11:47 AM, CNA H reported that staffing was hit and miss and that it was very common for the aides to have to skip ADL care such as showers and bed baths because they did not have enough time to complete them. During an interview on 2/20/26 at 12:05 PM, LPN P reported that she cared for Resident #101 often, and she was aware that FM PP had voiced concerns about Resident #101 missing ADL care often. LPN P reported that FM PP concerns about Resident #101 missing ADL care were valid, because she had often observed Resident #101 as disheveled. LPN P reported that the aides were often documenting refused or not available under resident shower tasks because they were not able to get to them. During an interview on 2/19/25 at 12:15 PM, Unit Manger (UM) W reported that she was aware that FM PP had voiced concerns about Resident #101's ADL care. UM W reported that CNA's were supposed to complete a shower sheet and turn it into the nurse to review after every bed bath or shower, or they should document a refusal. UM W reported that she was responsible for reviewing the shower sheets and ensuring that residents were receiving their showers as scheduled. When this writer queried about Resident #101's missing shower sheets, UM W reported that the staff were not great at ensuring that they were completed, and the facility had been working on trying to come up with a better process to ensure showers were being completed. When this writer queried about Resident #101's hospital record dated 11/2/25 which noted that Resident was admitted to the hospital soaked in urine, with his eyes crusted shut, UM W reported that she was aware of that incident, and that it was very embarrassing and upsetting to the facility, but that he could have urinated on himself in the ambulance to the hospital. UM W reported that she had not done any follow-up regarding ADL care for Resident #101 after the incident on 11/2/25. During an interview on 2/24/26 at 10:03 AM, Director of Nursing (DON) B' reported she was not aware that FM PP had concerns about Resident #101 getting ADL care at the facility. DON B reported Unit Managers at the facility were supposed to be reviewing shower sheets and resident care tasks every day and following up on any missed documentation/care. Resident #103: Review of an admission Record revealed Resident #103 was a male with pertinent diagnoses which included repeated falls, multiple sclerosis (a chronic autoimmune disease where the immune system attacks the protective myelin sheath of nerves in the brain and spinal cord causing communication issues, incurable), dementia, anxiety, and weakness. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of current Care Plan for Resident #103, revised on 4/18/25, revealed the focus, .Resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) weakness, infection (right knee and UTI (urinary tract infection)). with the intervention .BATHING/SHOWERING: The resident requires set up assistance for UB (upper body) and mod (moderate) assistance for LB (lower body) by 1 staff with bathing/showering twice weekly and as necessary. Review of Task-Shower for the last 30 days for Resident #103 revealed, on 1/21/26 (Wed) it was documented a shower was given. Review of Skin Observation Shower Sheet for Resident #103 dated 1/21/26 revealed, Resident #103 had refused a shower. Review of Progress Notes for Resident #103 revealed, no progress note entered which documented Resident #103's 1/21/26 shower refusal. Review of Skin Observation Shower Sheet for Resident #103 dated 2/6/26 (Fri), revealed, Resident #103 had refused his shower. Review of Progress Notes for Resident #103 dated 2/6/26 revealed, no progress note entered which documented Resident #103's 2/6/26 shower refusal. Review of Shower Schedule for Resident #103 revealed he was scheduled to receive his showers on Wednesdays and Sunday evenings. Resident #103 should have received a shower on 1/18/26, 1/25/26, 1/28/26, 2/1/26, 2/4/26, 2/8/26, 2/11/26, 2/15/26, and 2/18/26, which created 9 opportunities for showers to be provided for the last 30 days. Review of Skin Observation Shower Sheet dated 2/26/26, revealed Resident #103 had refused his shower. This writer received the shower sheets for Resident #103 on 2/19/26. Resident #113: Review of an admission Record revealed Resident #113 was a male with pertinent diagnoses which included chronic pain syndrome, depression, muscle weakness, unsteadiness on feet, and wheelchair dependence. Review of Care Plan for Resident #113, revised on 6/30/24, revealed the focus, .Resident has an ADL self-care performance deficit r/t (related to) impaired mobility, chronic pain, and muscle weakness. Dx (diagnosis) includes: dystonia (neurological movement disorder characterized by involuntary often painful sustained muscle contractions causing repetitive twisting movements, or abnormal posture), generalized muscle weakness, h/o (history of) TBI (traumatic brain injury), w/c (wheelchair) dependence.h/o nervous system disorders, arthritis, .adjustment disorder w/ (with) mixed anxiety & depressed mood, major depressive disorder, COPD (chronic obstructive pulmonary disease). with the intervention .Showering/Bathing per schedule or as needed. Prefers to be bathed twice per week. BATHING/SHOWERING: The resident requires Extensive assist with scheduled & PRN (as needed) showers. In an interview on 2/20/25 at 9:21 AM, Resident #113 reported he does not get a shower every week and would at times he would get a shower every other week. Resident #113 reported that when the shower aide takes a day off on his shower day, he doesn't get a shower that day. Resident #113 reported he wanted a shower at least once a week as he had long hair and only wanted it washed in the shower (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not during a bed bath. Review of Shower Schedule for Resident #113, revealed, he was scheduled to receive his showers on Tuesday and Saturday days. Review of Resident #113's Documentation Survey Report for November 2025, revealed, Resident #113 had his hair washed on 11/18/25, received a shower on 11/4/25, 11/11/25, 11/18/25 and 11/25/25, refused a shower on 11/8/25. Review of Resident #113's Skin Observation Shower Sheet dated 11/11/25 revealed, Resident #113 refused the shower due to not feeling well. Resident #113 should have received a shower on 11/4/25, 11/8/25, 11/11/25, 11/15/25, 11/18/25, 11/22/25, 11/25/25 11/29/25 which created 8 opportunities for a shower. Review of Resident #113's Documentation Survey Report for December 2025, revealed Resident #113 received a bed bath on 12/6/25, 12/13/25, 12/20/25, and 12/30/25. Received one shower on 12/23/25 with his hair washed. Resident #113 should have received a shower on 12/2/25, 12/6/25, 12/9/25, 12/13/25, 12/16/25, 12/20/25, 12/23/25, 12/27/25, 12/30/25 which created 9 opportunities for a shower. Review of Resident #113's Documentation Survey Report for January 2026 revealed, Resident #113 received a shower on 1/13/26, 1/20/26, and 1/27/26 (hair washed this day). Refused on 1/6/26, 1/17/26, and 1/23/26 noted in the report. No noted bed baths during this time. No documentation in the medical record to indicate Resident #113 refused his showers on 1/6/26, 1/17/26, and 1/23/26. Resident #113 should have received a shower on 1/3/26, 1/6/26, 1/10/26, 1/13/26, 1/17/26, 1/20/26, 1/24/26, 1/27/26, 1/31/26, which created 9 opportunities for a shower. Review of Resident #113's Documentation Survey Report for February 2026, revealed, Shower with hair washed on 2/3/26 and 2/10/26. No noted bed baths during this time. No documentation in the medical record to indicate Resident #113 refused his showers. Resident #113 should have received a shower on 2/3/26, 2/7/26, 2/10/26, 2/14/26, 2/17/26 which created 5 opportunities for a shower. Resident #114: Review of an admission Record revealed Resident #114 was a female with pertinent diagnoses which included wedge compression fracture T11-T12 (broken bone collapses and takes on a wedge shape), muscle atrophy, arthritis, and anemia (low red blood count). Review of Kardex dated 2/20/26 for Resident #114, revealed, .BATHING/SHOWERING: The resident requires setup with upper body and moderate to maximum assistance with lower body. Review of Shower Schedule for Resident #114, revealed, she was scheduled to receive his showers on Wednesday and Saturday evenings. Review of Resident #114's Task – Showers dated 2/20/26, revealed, for the previous 30 days Resident #114 received a shower on 2/4/26 and 2/11/26 and 1 refusal noted for 1/31/26. Resident #114 should have received a shower on 1/21/26, 1/24/26, 1/28/26, 1/31/26, 2/4/26, 2/7/26, 2/10/26, 2/14/26, and 2/18/26 which created 9 opportunities for a shower/bath. Review of Resident #114's progress noted revealed no documented refusal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #110: Review of an admission Record revealed Resident #110 was a female with pertinent diagnoses which included diabetes, depression, overactive bladder, and multiple sclerosis (a chronic autoimmune disease of the central nervous system where the immune system attacks the myelin sheath protecting nerves, disrupting brain to body communication). In an interview on 02/19/26 at 1:25 PM, Resident #110 reported she felt the resident to staff ratio affected resident care. Resident #110 reported she had contracture on her left hand, and at times it was hard to get staff to respond to her call for assistance for something simple like the remote especially on third shift when the staffing was less. Resident #110 reported she had concerns with staff getting her and other residents up in the morning and in bed before 10:00 PM. Resident #110 reported that if the shower aide called in, the CNAs (Certified Nursing Assistant) who worked on the floor were not completing showers for the residents whose showers were scheduled that day. Resident #110 reported the shower aide had too many showers scheduled for her during her hours scheduled and she was not able to complete them. Resident #110 had reported she requested to get her showers before dinner so she knows she would be able to receive one. Resident #110 reported some CNAs try to postpone the shower to later, but she insists the shower got done otherwise she would not get one. Resident #110 reported she had been the resident council president prior but now was an attendee and had heard these same concerns from the residents when she attended resident council. Review of Shower Schedule revealed the number of residents scheduled, .Day shift showers: Monday: 17 residents, Tuesday: 13 residents, Wednesday: 5 residents, Thursday: 10 residents, Friday: 17 residents, and Saturday: 6 residents; Evening shift showers: Monday: 8 residents, Tuesday: 10 residents, Wednesday: 6 residents, Thursday: 9 residents, Friday: 10 residents, and Saturday: 6 residents. In an interview on 2/20/26 at 12:10 PM, CNA OO reported if a resident refused a shower or bath, the staff would go back and reapproach to see if the resident would like to continue with a shower/bath. CNA OO reported if the resident continued to refuse the shower/bath the CNA would inform the nurse supervisor of the refusal, the nurse would reapproach and see if the nurse can get the resident to take a shower/bath, if not, it was documented on the shower skin sheet and signed by the nurse. CNA OO reported if the shower aide was not able to complete the resident's showers/baths, the CNA assigned to the resident would provide the resident with their shower/bath. In an interview on 2/20/26 at 1:07 PM, Shower Aide (SA) F reported she started work most mornings at 4:30 AM to get here to start the resident showers. SA F reported she got pulled a lot to work the floor and she got at the facility early as there were residents willing to take a shower early so they would have one on their shower day. SA F reported she was pulled to work the floor at least 3 times per week and that was 3 days residents were not receiving their showers. SA F reported with the shower scheduling it was impossible for her to complete the number of showers scheduled for the day. SA F reported until recently she had 20 showers scheduled to complete on Mondays. SA F reported with the scheduling of showers she was not able to keep up with showers for residents and she couldn't provide every shower scheduled that day. In an interview on 2/20/26 at 1:30 PM, Unit Manager (UM) W reported when the shower aide was pulled from showers to work in assisting residents the CNA assigned to the resident was responsible for completing the shower for the resident that day. UM W reported the Kardex indicated what days a resident was to receive a shower or bed bath. UM W reported if a resident had refused a shower/bed bath, the CNA was to attempt to complete at a different time or have someone else approach, if the resident (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was still refusing the shower/bed bath, the CNA would notify the nurse and if the resident was still refusing it was documented on the shower sheet the resident refused and the nurse would enter a progress note. UM W reported the nurse would sign the sheet and the sheets would be submitted to the unit manager to follow up on with the resident.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2728846Based on interview and record review, the facility failed to provide adequate care to prevent skin breakdown and the worsening of pressure ulcers in 1 of 3 (Resident #101) residents reviewed for pressure ulcers, resulting in the worsening of a pressure ulcer. Findings include:Resident #101Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE] with pertinent diagnoses which included need for assistance with personal care and muscle weakness. Review of Resident #101's Care Plan revealed, Resident has potential for impairment to skin integrity r/t (related to) TBI (traumatic brain injury) post MVA (motor vehicle accident. Date Initiated: 06/16/2025. Goal: Resident will maintain intact skin with no skin breaks through the next review date. Interventions: Alternating pressure mattress to bed. Check for comfort and proper inflation with care. Report any concerns. Date initiated: 12/9/25. Elevate heels off bed surface while at rest in bed as tolerated, encourage good nutrition and hydration in order to promote healthier skin, Keep skin clean and dry. Use lotion on dry skin. Do not apply on open injuries, Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration etc. to MD (Medical Doctor). Observe skin daily with care activities. Report any changes in coloration, integrity, etc. to nurse. Date initiated: 6/16/25 . Review of Resident #101's Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE] revealed that Resident #101 had a score of 12, indicating that he was High Risk for skin breakdown. Review of Resident #101's Nursing admission Screening dated 6/13/25 revealed, .Skin: Note all skin issues: (there were no skin issues documented) Notes: Skin intact. Review of Resident #101's Nursing admission Screening dated 9/16/25 revealed, .Skin: Note all skin issues: (there were no skin issues documented) Notes: Skin intact with some dryness noted. Review of Resident #101's Hospital Surgery consult dated 10/20/25 revealed, Surgery Consultation . (Resident #101) . presented to the hospital from his SNF (skilled nursing facility) for sepsis (Sepsis is a life-threatening reaction to an infection that causes your immune system to harm healthy tissues and organs) found to have a bilateral pneumonia (infection of the lungs) . Overnight he had a temperature of 100.2 therefore prompting a skin search for other possible sources of infection given his resolving pneumonia. A small sacral wound was found .general surgery was consulted for the sacral wound . From nursing and IM (internal medicine) physician, it drained purulent (pus) fluid earlier in the day with foul smelling odor . Physical Exam: Warm, mepilex (type of dressing) dressing covering sacral area, small 2 cm wound with scab over the top, no drainage or fluctuant area noted. Wound appears to have scabbed over the previous draining area .Plan: Local wound care as needed, Mepilex dressing and offloading area as much as possible. No acute surgical intervention at this time . Review of Resident #101's Nursing Re- admission Screening dated 10/27/25 revealed, . Skin: Note all skin issues: (there were no skin issues documented) Notes: dry skin noted. Noted there were no skin issues related to Resident #101's sacral skin alteration previously noted in the hospital records. Review of Resident #101's Hospital records dated 11/2/25 revealed, .Physical Exam: Skin: Lesion (Grade 1 pressure ulcer which does not appear to be acutely infected to the coccyx) present .Review of Resident #101's Nursing re-admission Screening dated 11/5/25 revealed, . Skin: Note all skin issues: (there were no skin issues related to Resident #101's sacral skin alteration previously noted in the hospital records). Left elbow: open area length 0.5 cm. Width: 0.3 cm. Notes: Dry skin to feet .Review of Resident #101's Skin Issues progress note dated 11/11/25 revealed, Skin issue #001: new skin issue: Location: right gluteus. Laterality/Orientation: Medial. Issue type: abrasion. Progress: new wound. Wound acquired in house. Signs and symptoms of infection: none. Painful: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	no. Length (cm-centimeters): 0.94. Width: 0.89. Depth: 0. Area: (cm2) 0.59. Undermining (tissue beneath the skin separates from the deeper wound bed, creating a pocket or shelf that extends under the wound edges, often making the wound larger than it appears on the surface.) No. Tunneling (narrow channel or tract extending from the surface into deeper tissue layers) No. Odor after cleaning: none. Surrounding tissue: fragile. Edema: No swelling or edema . #002: new skin issue: location: left gluteus. Laterality/Orientation: Medial. Issue type: abrasion. Progress: new wound. Wound acquired in house. Signs and symptoms of infection: none. Painful: no. Length (cm-centimeters): 6.7. Width: 2.28 Depth: 0. Area: (cm2) 11.58 Undermining (tissue beneath the skin separates from the deeper wound bed, creating a pocket or shelf that extends under the wound edges, often making the wound larger than it appears on the surface.) No. Tunneling (narrow channel or tract extending from the surface into deeper tissue layers) No. Odor after cleaning: none. Surrounding tissue: fragile. Edema: No swelling or edema .Review of Resident #101's Orders revealed, left gluteal abrasion cleanse with NS (normal saline), apply A&D ointment BID (twice a day) and leave OTA (open to air) every morning and at bedtime for wound care. Start date: 11/12/25 .Review of Resident #101's Hospital Wound Consult dated 11/17/25 revealed, . Wound Assessment: Date: 10/15/25 . Primary wound: Pressure. Present on admission: yes. Pressure injury stage: U (unstageable) . wound site assessment: Black; eschar (dead tissue); pink; dark purple. Color percent wound length (cm). 60 black eschar, 10 dark purple, 30 pink . Wound length: 7 cm, Wound width: 5 cm, Wound depth: 0.1 cm. Wound surface area: 27.49 cm^2 (centimeters squared) . Location: Right Heel. Present on admission: yes. Pressure injury stage: DTPI (Deep tissue pressure injury) .Wound site assessment: black. Wound length: 3 cm. Wound width: 5 cm. Wound depth: 0 cm. Wound surface: 11.78 cm^2 Location: Left Heel. Present on admission: yes. Pressure injury stage: cluster of two . Wound site assessment: Dark purple; black. Wound length: 3.5 cm. Wound width: 3 cm. Wound depth: 0 cm. Wound surface: 8.25 cm^2 .Recommendations for discharge: Outpatient wound clinic .Review of Resident #101's Progress note dated 11/21/25 revealed, . Skin assessment completed, no edema, dry, fragile skin noted. Multiple pressure injuries extending to coccyx extending to right and left buttock (unstageable), left heel, right elbow and left elbow Review of Resident #101's Progress note dated 11/21/25 revealed, Resident wound measures: Left heel: 2cm x1.125 cm, Right elbow: 3.5 cm x3cm, L (left) elbow: 5cmx1cm, Coccyx-7.5 cm x 9cm .Review of Resident #101's Progress note dated 11/21/25 revealed, . Okay to initiate treatments to coccyx (right and left buttock), left heel, right elbow, and left elbow .Review of Resident #101's Orders revealed, cleanse coccyx unstageable with wound wash, pat dry, apply nickel thick Santyl (wound treatment cream) to wound bed, cover with dry dressing, change daily and as needed one time a day for pressure injury. Start date: 11/22/25 . cleanse left elbow with wound wash, pat dry, apply dry dressing change daily one time a day for wound care. Start date: 11/22/25 .cleanse right elbow open area with wound wash, pat dry, apply dry dressing change daily one time a dayfor wound care. start date: 11/22/25 . betadine (topical antiseptic) BID (twice daily) to left heel wound #1 two times a day for wound care. Start date: 11/26/25 .betadine to left heel wound #2 BID two times a day for wound care. Start date: 11/26/25 .Review of Resident #101's Progress Note dated 11/25/25 revealed, (Wound Care Nurse Practitioner (WCNP) HH) in to assess resident right and left gluteal abrasions . 1. Coccyx pressure ulcer unstageable mechanically debrided (dead tissue removed) with 40% slough and 60% eschar with moderate amount of serosanguineous (thin, watery, pale pink to light red fluid that commonly drains from wounds) drainage. 8.6x9.x2 UTD. (unable to determine). Peri wound fragile. area declined while in hospital. 2. Left elbow stage 2 pressure injury 1.0x1.0x SF (superficial) 100% superficial with scant amount of serosanguineous drainage . 3. left medial heel DTI (deep tissue injury) 100% (sic) 1.2x0.8xUTD with no drainage .Review (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	of Resident #101's Progress Note dated 12/9/25 revealed, left and right wound abrasion have combined into one coccyx wound .Review of Resident #101's Progress Notes dated 12/17/25 revealed, WCNP HH into (sic) assess resident. Left elbow stage 2 and right elbow area resolved. Coccyx wound unstageable community acquired PI (pressure injury) 7.6 x 7.5xUTD (unable to determine) post debridement (dead tissue removal). 10% granulation (newly formed connective tissue that develops on the surface of a wound during the healing process) tissue, 90 % slough (soft, yellowish or white dead tissue that impedes healing and requires removal for proper recovery) with moderate amount of serosanguineous drainage, positive for odor, peri-wound fragile declined. Left medial heel 1.0 x0.7xUTD DTI (deep tissue injury) 100% (sic) with no drainage. area calloused and stable. Left heel DTI now stage 3 1.0x0.4x0.1 100 % superficial improved . Review of Resident #101's January Treatment Administration Record (TAR) revealed, cleanse coccyx with dakins solution, pack with calcium alginate and cover with largesacral dressing every shift every shift for treatment. Noted that there were 9 treatments with missing documentation (not documented as completed or refused). During an interview at on 2/18/25 at 11:25 AM, Family Member (FM) PP reported Resident #101 did not have any skin issues when he was admitted to facility in June 2025. FM PP reported that Resident #101 required total assistance from staff with all care, and that he was not able to reposition himself. FM PP reported she frequently visited Resident #101 for 3 or more hours at a time, and every time she visited Resident #101, she never witnessed staff assist Resident #101 with repositioning or any other care. FM PP reported that she frequently voiced her concerns that Resident #101 was not receiving adequate care to the nurses, Unit Manager (UM), Director of Nursing (DON), and Social Worker (SW), but she felt that the facility staff did not take her concerns seriously. During an interview on 2/19/25 at 11:13 AM, Licensed Practical Nurse (LPN) N reported she had cared for Resident #101 frequently and confirmed that Resident #101 was dependent on staff for all care. LPN N reported Resident #101 had been in and out of the hospital due to several medical conditions while he was at the facility, and every time he was readmitted , the admitting nurse was responsible for completing an admission assessment which included a total skin assessment to ensure that the facility was aware of any new conditions that may have developed when Resident #101 was in the hospital. LPN N reported Resident #101 was always compliant with treatments, and he did not refuse care. LPN N reported she had provided treatment to Resident #101's coccyx wound before, but she could not recall the date. LPN N recalled that she had noted that Resident #101's coccyx wound was open and draining during a recent treatment that she had completed, but she thought that it was an old wound and she did not notify the provider regarding this. During an interview on 2/19/25 at 12:15 PM, Unit Manager (UM) W reported she was responsible for overseeing the care of Resident #101. UM W reported that Resident #101 had been in and out of the hospital several times, and that the facility had been monitoring his sacral area after they found abrasions on the area in November, and that when Resident #101 returned from the hospital on November 21, 2025, he had an unstageable pressure ulcer. UM W reported that the facility had WCNP P had assessed Resident #101's wounds on 11/12/25 and noted that Resident #101's coccyx wound was a stage 3, and that the facility then initiated treatments. When this writer queried as to why Resident #101's nursing re-admission assessment on 10/27/25 and 11/5/25 did not indicate that Resident #101 had a pressure ulcer on his coccyx, UM W reported that the nurse must have missed documenting this. UM W reported the facility staff were supposed to complete skin checks twice a week during showers, and that nurses were also supposed to complete weekly skin assessments. When this writer queried about Resident #101's missing shower sheets (sheets that aides document skin checks on during bath care) and weekly skin assessments, UM W confirmed that Resident #101 had missing skin assessments and shower sheets. UM W was unable to (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	report how many weekly skin assessments Resident #101 had missed. UM W reported she was responsible for ensuring that the staff had completed skin assessments and shower sheets, and that she had been having ongoing issues with staff completing those tasks timely. UM W reported that she was not aware that Resident #101 had missing wound care treatments in his treatment administration record. UM W confirmed that the facility did not identify and begin treatment on Resident #101's coccyx wound until 11/12/25. UM W was unable to provide any documentation that the facility had assessed Resident #101's coccyx area prior to 11/11/25 when this writer queried for more documentation to verify that staff were assessing and monitoring Resident #101's sacral area for skin breakdown. UM W reported that she felt like the hospital was at fault for Resident #101's pressure ulcer development, and that the facility had just failed to accurately document their assessments and treatments. During an interview on 2/19/25 at 2:07 PM, LPN M reported that she frequently cared for Resident #101. LPN M confirmed that Resident #101 was dependent on staff for all care. LPN M confirmed that nurses were responsible for completing the weekly skin assessments for residents, and that the aides were responsible for completing skin checks during showers and letting the nurse know if they saw any new skin issues for the nurse to assess. LPN M reported that the aides were often not able to complete showers/baths for residents, and so they were not completing shower sheets twice a week as they were supposed to. LPN M reported that she knew that Resident #101 had been missing showers and skin assessments because she had been approached by his family a few times to ask when he had last had a shower and she would look and note that staff had documented not available or refused when he was available and did not refuse care. LPN M reported that it was common for staff at the facility to skip care and treatments at the facility because they were often short staffed and unable to get to it. During an interview on 2/20/26 at 12:05 PM, LPN P reported that she was familiar with Resident #101 and cared for him frequently. LPN P confirmed that Resident #101 was not getting showers or skin checks regularly. LPN P reported that the facility often did not have the staff to provide care and treatments, so it was common for residents to miss them. LPN P reported that Resident #101 was not getting checked on and repositioned every 2 hours as he required because the facility did not have the staff to provide care. LPN P reported that she had voiced her concerns about residents missing treatments and care to facility management, but she did not feel like they had done anything to address the care concerns. During an interview on 2/24/26 at 10:03 AM, Director of Nursing (DON) B reported that she was aware that Resident #101's family had concerns with his care at the facility. DON B reported Unit Managers were expected to review the residents on their units daily to ensure that all treatments and assessments were completed, and if not, they were expected to follow up with the nursing staff. DON B confirmed that Resident #101 was admitted to the facility without any skin conditions. DON B reported that she did not think that Resident #101's wounds developed at the facility, and she reported she would look into that and let me know if she had any further evidence or documentation to provide. DON B did not provide any further documents prior to survey exit. During a follow up interview on 2/24/26 at 2:15 PM, UM W reported that she did not feel that Resident #101 developed a pressure ulcer at the facility. UM W showed this writer the skin assessments which were completed by the facility on 11/12/25. This writer again confirmed that the facility first identified the wounds on Resident #101's coccyx and elbows on 11/12/25. UM W was unaware of the wound care treatment note dated 10/27/25 from the hospital which indicated that Resident #101 had a wound on his coccyx at that time. Review of the facility's Pressure ulcer policy dated 7/11/2018 revealed, Policy: It is the policy of this facility that 1. A resident who enters the facility without a pressure ulcer does not develop pressure ulcers unless the individual's clinical condition or other factors demonstrate that a developed (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	pressure ulcer was unavoidable; and 2. A resident having pressure ulcers receives necessary treatment and services to promote healing, prevent infection, and prevent new, unavoidable sores from developing .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2745481Based on interview and record review, the facility failed to assess the need for an indwelling catheter for 1 (Resident #108) of 5 residents reviewed for incontinence care resulting in pain, frustration, and a delay in the removal of a foley catheter (medical device that helps urine drain from your bladder). Findings include:Review of an admission Record revealed Resident #108 was originally admitted to the facility on [DATE] with pertinent diagnoses which included essential hypertension (high blood pressure). Review of Resident #108's Urology After Visit Summary dated 6/25/25 revealed, . Scheduling instructions: OK to remove foley catheter; if unable to void after 6 hours or experiencing a post void residual of greater than 250 please replace catheter and call for follow up .Review of Resident #108's Progress Note dated 6/25/25 revealed, pt (patient) was seen at (Local Urology office) today for his follow up appointment from his recent procedure. ureteral stent (thin, flexible tube inserted into the ureter to keep it open, allowing urine to flow from the kidneys to the bladder, especially in cases of blockage) removed. New catheter was placed . Review of Resident #108's Progress Note dated 8/9/25 revealed, . Resident verbalized to this nurse that he is wondering if about a follow up appointment with urologist or surgeon from his last surgery. This nurse verbalizes will try to find out if resident needs appointment with urologist or surgeon. This nurse will leave written communication with Unit Manager and will let resident know if and when appointment will be .Review of Resident #108's Progress Note dated 8/19/25 revealed, Phone call attempted to (local urology office) to schedule resident in an appointment, without success, message left for return call .Review of Resident #108's Progress Note dated 8/20/25 revealed, Phone call with (local urology office) to request appointment for resident per his request to see if his catheter can be removed. (local urology doctor) nurse advised that resident has the appointment scheduled for 11/4/25 for testing .Review of Resident #108's Progress Note dated 9/29/25 revealed, Resident c/o (complained of) to this nurse that he experienced leaking around his foley catheter on and off during the previous weekend. This nurse assessed resident catheter and noted that it was leaking, and his bed was wet with what appeared to be urine. Old foley removed, and new catheter placed per protocol. This nurse experienced resistance during insertion. This nurse pulled the foley back and noted a dime sized blood clot at the end of the catheter. This catheter was disposed and a new catheter was utilized to place a new foley catheter. Resident stated that feels much better. I think that could have been blocking my urine. Resident had a small amount of blood noted in the catheter collection bag .Review of Resident #108's Progress Note dated 10/1/25 revealed, pt stated his catheter was leaking from insertion site. I flushed with 10 cubic centimeters) (cu saline, and it began leaking from the insertion site. I checked the level of the balloon, and it was at 10cc. I repositioned and refilled balloon and this time there was no leaking .Review of Resident #108's Progress Note dated 10/6/25 revealed, pt states that his catheter was leaking again. I deflated the balloon and repositioned and reflated. I then flushed the line. All saline solution leaked through the insertion site. I then removed the catheter and attempted 3 times to replace. Catheter would not go into the position due to resistance. I then brought on another nurse to attempt to insert his catheter in the correct position with no success either. Pt is able to urinate without catheter inserted. Will use brief and monitor output and possible retention. Pt agrees to this plan as well as Physician Assistant (PA) JJ. Review of Resident #108's Encounter note dated 10/6/25 and documented by PA JJ revealed, . Patient was urinating around his foley catheter which was placed inpatient previously due to renal stone. Pt is requesting to keep foley out and has been (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	able to freely void .During an interview on 2/20/26 at 3:32 PM, Resident #108 reported that he had a foley catheter for months after his urology appointment in June 2025. Resident #108 reported that he had asked facility staff several times to assess if he still needed the catheter, and he felt that the facility did not act promptly to see if he could have the catheter removed, which was very frustrating to him. Resident #108 reported that when he had the foley catheter, it leaked often and at times was very painful for him. Resident #108 reported that when nursing staff were unable to replace his leaking catheter in October, they finally allowed him to have his catheter removed, and it was instant relief. Resident #108 reported that the longer he had the catheter in, he felt like his body was starting to reject it, and it became more and more uncomfortable. Resident #108 reported that he wished the facility would have acted sooner to his request to have the catheter removed. During an interview on 2/20/26 at 12:40 PM, Unit Manager (UM) V reported that she thought that Resident #108 had originally had a foley catheter placed due to a history of renal stones. UM V reported that Resident #108 was having a lot pain with the catheter, so he had asked for staff to remove it, and when they did, he had no issues urinating on his own and has not had further issues. UM V reported that she was not sure if Resident #108 was supposed to have a catheter after his urology appointment in June 2025. During a follow up interview on 2/24/26 at 1:20 PM, UM V reported that she was not sure if the facility was supposed to remove Resident #108's catheter after his urology appointment in June 2025. This writer reviewed Resident #108's Urology Note dated 6/25/25 with UM V and queried if she was aware of the instructions to remove the foley catheter. UM V reported that she interpreted that they did want the catheter removed, and she could not recall why the facility had not removed the catheter. UM V reported that she had not followed up with the Urology office for clarification. UM V reported that she did not know if the facility providers had assessed Resident #108 after his appointment in June 2025 to determine if he still needed the catheter or not. During an interview on 2/26/25 at 10:54 AM, Medical Director (MD) GG reported that he had not assessed Resident #108 to determine if he still needed the foley catheter after his urology appointment. MD GG reported that he did not see Resident #108 that often so he could not comment on his condition and why he had a catheter in the first place. During an interview on 2/26/26 at 1:30 PM, PA JJ reported that she thought that Resident #108 had urinary retention, and she thought that was why he had a catheter. PA JJ reported that she had not assessed Resident #108 to determine if he still needed the catheter, or if it could be removed. PA JJ asked this writer what kind of catheter Resident #108 had, and when this writer informed her that he no longer had the catheter, PA JJ reported that oh, he must have passed a voiding trial then.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure care was provided consistent with professional standards of practice for residents who received enteral nutrition (tube feeding) in 1 (Resident #107) of 2 residents reviewed for tube feeding, resulting in the potential for aspiration pneumonia.Findings include: Resident #107: Review of an admission Record revealed Resident #107 was a male with pertinent diagnoses which included stroke, malnutrition, dehydration, starvation, GERD (stomach acid flows back into the esophagus), and dysphagia (difficulty initiating a swallow, impaired control of food or liquid within the mouth). Review of current Care Plan for Resident #107, revised on 5/31/25, revealed the focus, .Resident has a swallowing problem r/t (related to) Coughing or choking during meals or swallowing med, difficulty with thin liquids. with the intervention .Diet to be followed as prescribed. Review of current Care Plan for Resident #107, revised on 10/16/25, revealed the focus, . Resident has nutritional problem or potential nutritional problem r/t malnutrition, FTT (failure to thrive), using enteral feedings via PEG [delivers liquid nutrients directly into the stomach via tubes for those residents with the inability to swallow/chew.potential risks include aspiration (breathing of food, liquid, or saliva into the airway/lungs often causing coughing, choking, wet voice or pneumonia)] to meet nutritional needs, dysphagia, aphasia (language disorder caused by brain damage that impairs speaking, understanding), anemia. with the intervention .TF (tube feeding) as ordered, NPO (nothing by mouth).During an observation and interview on 2/19/26 at 11:10 AM, Resident #107 was observed in his room reclined in his Broda chair (a specialized wheelchair to assist with positioning) requesting water. Certified Nursing Assistant (CNA) Z was observed to open a mouth swab package which had a sponge on the end. CNA Z proceeded to grab a Styrofoam cup of water on the nightstand, dip the sponged tipped mouth care swab in the cup of water and inserted into Resident #107's mouth without allowing excess water to run out, or applied pressure to the sponge to remove excess water. CNA Z proceeded to do this approximately 7 times, while Resident #107 sucked the water out of the sponge. Registered Nurse (RN) R reported Resident #107's tube feeding was beeping, and he needed to check the tubing as it was giving an error. RN R reported Resident #107 was able to accept thickened liquids. Resident #107 observed attempting to place the call light in his hand in his mouth requiring redirection by CNA Z who informed him it was not the swab she was using for the water. CNA Z reported Resident #107 had asked for water a few times this morning since 7:00 AM and other times throughout the morning as she had entered the room for other care activities. CNA Z reported she had given him water (using the sponge tipped mouth swab) anytime he had asked for it this morning. In an observation and interview on 2/19/26 at 11:30 AM, CNA G reported Resident #107 was on a fluid restriction and he was always asking for water. CNA G reported he received water via his feeding tube and he was NPO. CNA G reported to keep moisture in Resident #107's mouth, the staff used the lemon mouth swabs (premoistened disposable oral applicators). Resident #107 was observed calling out for water. CNA G reported it was tough as he can't have anything by mouth. At 11:39 AM, Observed Resident #107 was calling out for water. In an interview on 2/20/25 at 1:13 PM, Shower Aide F reported the lemon swabs for Resident #107 were used in place of water for him as he was NPO. CNA F reported she had observed the water cup in his room on (2/19/26) and assumed the nurse was using the water for his flushes for his tube feeding. Review of Electronic communication received on 2/20/26 at 2:01 PM, Nursing Home Administrator (NHA) A reported .There is no order for mouth swabs. Oral care is a standard of care. During an observation on 2/24/26 at 9:26 AM, Resident #107 was observed lying in his bed, supine, head of bed was 35 degrees, observed half of a gallon jug of distilled water on the nightstand dated (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/23/26. Over his bed on a shelf was another unopened gallon of distilled water. Review of Progress Note for Resident #107, dated 2/23/26 at 00:00 AM, revealed, .History Of Present Illness: Patient is assessed today after a full cup of water was at bedside. Patient is NPO (nothing by mouth) with PEG in place. Per nursing staff, patient had this water at bedside for oral care.Review of General Progress Note for Resident #107, dated 2/24/2026 at 09:16 AM, revealed, .Observed doing (sic) med (medication) pass brown colored emesis on resident gown and linen. Further assessment done bowel sounds auscultated heard hypoactive sounds in all 4 quads (quadrants), Abdomen soft nondistended. At this time resident abdominal binder observed in place, no grimacing observed when palpated, Doctor notified received order to stat (urgent) x-ray r/o (rule out) obstruction, Hold tube feeding until results are available. Resident in bed HOB (head of bed) elevated at 35-45 degrees vitals assessed. Reported to Unit manager POC (plan of care) continue in progress. Review of Speech Evaluation for Resident #107, dated 7/3/25, revealed, .Assessment: Swallow function diagnosis: Moderate oral dysphagia (significant difficulty initiating a swallow, impaired control of food or liquid within the mouth, increased risk of aspiration); Clinical signs/symptoms of pharyngeal dysphagia (difficulty initiating a swallow and moving food from the mouth to the esophagus, characterized by coughing, choking, food sticking in the throat, and nasal regurgitation).Swallow function comment: (Resident #107) presents with moderate oral and clinical s/s (signs/symptoms) of pharyngeal dysphagia in the setting of prolonged intubation (6/27-7/2) with hx (history) of CVA {cerebrovascular accident (stroke)}and chronic dysphagia. PEG tube recently placed due to failure to thrive.At this time, recommend maintain NPO status using PEG tube for all nutrition/hydration and meds.Diet and Swallowing Recommendations: Recommended food texture: NPO.Recommended liquid texture: NPO.In an interview on 2/20/26 at 1:35 PM, Unit Manager (UM) W reported Resident #107 should not have received water as he was not swallowing and it would cause him to aspirate. UM W reported when Resident #107 was asking for water, the lemon swabs were to be used to create the sensation of water in his mouth due to the increased saliva. UM W reviewed Resident #107's Kardex (care guide) which revealed oral (care), routine in AM and HS (prior to bed). UM W reported the Kardex was unclear as his oral, routine and another resident's oral routine would be different, and it needed clarification. After review of Resident #107's care plan, UM W reported he had an intervention for .Oral Care Routine: (AM, PC (after meals), HS): brush teeth. UM W reported Resident #107 would not have his teeth brushed due to not being able to swallow or rinse his mouth out and could result in aspiration.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2748436 and 2728846. Based on interview and record review the facility failed to ensure 2 residents (Resident #112 and Resident #101) were free from significant medication errors when (a) medications were administered outside physician prescribed parameters (b) medications were not administered as ordered without provider notification resulting in Resident #112 being hospitalized for hypoglycemia (low blood sugar) and Resident #101 missing multiple doses of seizure medication, having a seizure and subsequent change in condition resulting in hospitalization. Findings include: Findings include: Resident #112 Review of an admission Record revealed Resident #112 was originally admitted to the facility on [DATE] with pertinent diagnoses which included type 2 diabetes mellitus (condition where the body cannot use insulin properly or doesn't make enough of it leading to high blood sugar). Review of Resident #112's Care Plan revealed, Resident has risk for fluctuations in blood sugar and complications r/t (related to) diagnosis of DM (diabetes mellitus). Date Initiated: 01/18/2026. Goal: Resident will have no complications related to fluctuations in blood sugar through the review date. Date Initiated: 01/18/2026. Interventions: Administer medication(s) as ordered by doctor. Refer to physician orders or eMAR (Medication Administration Record) for current. Monitor/document for side effects and effectiveness. Adjust as directed by physician, diet as ordered. offer substitutes for foods not eaten, dietary consult for nutritional regimen and ongoing monitoring, Discuss mealtimes, portion sizes, dietary restrictions, snacks allowed in daily nutritional plan, compliance with nutritional regimen, Follow facility protocol for acute s/sx (signs and symptoms) of hypoglycemia. Report to Physician and adjust plan of care as directed, Monitor/document/report PRN (as needed) compliance with diet and document any problems, Obtain fingerstick glucose as ordered and prn. Report abnormal or changes in pattern to Physician for review and adjustment of plan of care as directed. Date initiated: 1/18/26 . Review of Resident #112's Progress Note dated 1/31/26 revealed, Resident requires assistance with feeding. Eating only bites of her meals. Review of Resident #112's Progress Note dated 2/5/26 revealed, resident blood sugar before dinner was 399 (typical target blood sugar levels are 80-130 mg/dL before meals and under 180 two hours after eating.) On call provider notified. verbal order to change insulin glargine (long-acting insulin) 5 units BID (Twice daily) to 10 units at bedtime. New sliding scale (a method of adjusting insulin doses based on current blood sugar levels to help manage glucose) added as order to give 7 units (of insulin) with meals . Review of Resident #112's Progress Note dated 2/7/26 and documented by Licensed Practical Nurse (LPN) P revealed, entered resident room to assess evening blood sugar. upon entering room, resident was found to be non-responsive to verbal stimuli/fingerstick blood glucose measured 27 (critically low level) administered glucagon (hormone produced by the pancreas that raises blood sugar) per protocol. Rechecked in 15 minutes: 46. Provided oral gel glucose and orange juice, subsequent blood glucose increased to 76. Resident became awake, alert, and talking. Offered and fed dessert from dinner. resident remained stable with improved responsiveness. Review of Resident #112's Progress Note dated 2/11/26 and documented by LPN L revealed, CNA (Certified Nursing Assistant) reported to this nurse that resident was hot and didn't want any blankets on around 1515 (3:15 PM). At 1525 (3:25 PM) this nurse went in to check on resident. Resident was diaphoretic (sweating) and unresponsive. CBG (current blood glucose) was 29 (critically low). This nurse ran and got two glucagon injections and administered them. 2 other floor nurses and both Unit Managers came into resident room to assist. NP (Nurse Practitioner) also on site. 1540 (3:40 PM) Resident continues to be diaphoretic and unresponsive. 3 more glucagon injections given, and NP gave resident a tube of glucose gel orally. at 1600 (4:00 PM) CBG was 52 and resident began to respond to her (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	name but was still disoriented. resident drank 240cc of orange juice and immediately vomited it up. 1615 (4:15 pm) CBG was 55. At this time, resident was sent to (local hospital) for evaluation . Review of Resident #112's Hospital Records dated 2/11/26 revealed, Chief complaint: Hypoglycemia .comes in with hypoglycemia observed at (facility). Patient was found to be with a glucose of 26, patient received 5 doses of glucagon and unknown amount of oral glucose her blood glucose had improved to 87 by the time EMS (Emergency Medical Services) arrived on scene . Patient takes 10 units long-acting insulin at night with 2 units scheduled with meals, patient had been receiving both doses of insulin during her stay at the nursing home, at this point hypoglycemia could be due to iatrogenic (illness caused by medical examination or treatment)insulin dosing error or accurate insulin dosing in a patient who is not eating due to decreased appetite. Other potential causes include infection or systemic disease causing a drop in blood glucose . Review of Resident #112's Orders revealed, Insulin Glargine (long acting insulin) . Inject 10 unit subcutaneously at bedtime for Diabetes. Start date: 2/5/26 .Fingerstick Blood Sugar. call MD (Medical Doctor) if less than 70 or greater than 350. before meals for Diabetes . Insulin Lispro (short acting insulin) .Inject 7 unit subcutaneously with meals for diabetes. Start date: 2/5/26 . Insulin Lispro Injection Solution (Insulin Lispro) Inject as per sliding scale: if 150 - 200 = 2; 201 - 250 = 4; 251 - 349 = 6; 350 - 400 = 7; 401 - 450 = 8 Notify MD/PA, subcutaneously before meals for diabetes. Start date: 2/5/26 Noted that Resident #112's insulin orders did not reflect what was documented in Resident #112's hospital records. Review of Resident #112's Medication Administration Record (MAR) revealed, Insulin Lispro Injection Solution (Insulin Lispro) Inject 7 unit subcutaneously with meals for diabetes at 8:00 AM. Noted that LPN L had documented that she had administered 7 units of insulin to Resident #112 at 10:32 AM. It was noted that Resident #112 had a documented blood glucose reading of 140 at 10:32 AM. Review of Resident #112's MAR revealed, Insulin Lispro Injection Solution (Insulin Lispro) Inject 7 unit subcutaneously with meals for diabetes at 12:00 PM .Insulin Lispro Injection Solution (Insulin Lispro) Inject as per sliding scale: if 150 - 200 = 2; 201 - 250 = 4; 251 - 349 = 6; 350 - 400 = 7; 401 - 450 = 8 Notify MD/PA subcutaneously before meals for diabetes at 11:30 AM. Noted that LPN L had documented that she had administered 7 units of insulin to Resident #112 in addition to 2 units per sliding scale for a blood glucose of 177 at 1:05 PM. Review of Resident #112's Eating task revealed that on 2/11/26, facility staff had documented that Resident #112 had eaten her lunch independently, and her meal intake was between 51-70% for breakfast and lunch. Noted that the facility did not document if Resident #112 ate independently for breakfast. During an interview on 2/20/26 at 8:46 AM, LPN N reported that Resident #112 always at in her room, and that she did often need assistance and queuing with eating. LPN N reported that she had noticed that Resident #112 did not eat much when she did not have assistance with eating. During an interview on 2/20/26 at 12:05 PM, LPN P reported that she had cared for Resident #112 on 2/5/26 when Resident #112 had experienced her first episode of hypoglycemia. LPN P reported that she had found Resident #112 in the afternoon in her room and she seemed out of it, so she checked her blood glucose and found that Resident #112's blood glucose was critically low, so she administered glucagon and continued to monitor Resident #112 throughout the remainder of her shift, and Resident #112 remained stable. LPN P reported she thought that she had notified the provider, but she could not recall. LPN P reported that she would have documented if she notified the provider in her progress note if she did. LPN B reported Resident #112 had not been eating well, and the facility had recently increased her insulin orders. Noted that LPN P did not indicate in her progress note if she had notified the provider of Resident #112's hypoglycemic episode. During an interview on 2/20/26 at 10:51 AM, LPN L confirmed that she was the nurse caring for Resident #112 on 2/11/26 when (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	she was sent to the hospital for hypoglycemia. LPN L reported she had been notified by a CNA that Resident #112 was feeling hot, so she went to check on Resident #112 and when she entered her room, she found Resident #112 lying in her bed, and that she was very sweaty and out of it. LPN L reported that when she checked her blood glucose and it was critically low at 29. LPN L reported she ran to grab glucagon and with the assistance of two Unit Managers and Physician Assistant (PA) JJ, the facility was able to administer a total of 5 glucagon injections to help increase Resident #112's blood sugar. LPN L reported that after 45 minutes, Resident #112's blood glucose had increased to 57, and the facility sent Resident #112 to the hospital for evaluation and treatment. LPN L reported she was aware that Resident #112 had a previous episode of hypoglycemia the previous week. During a follow up interview on 2/20/26 at 3:40 PM, LPN L reported that she had been running behind on 2/11/26 and she was late to administer medications that day. LPN L confirmed that she did administer Resident #112's insulin at 10:32 AM, and that it was well after she had breakfast, and that she did not know if Resident #112 had already eaten lunch or not when she administered her afternoon dose of insulin. LPN L confirmed that she had not paid attention to if Resident #112 had ate at all for breakfast or lunch, and that she did not know how much she had eaten. LPN L reported that she had not realized that she had administered Resident #112's morning and afternoon doses of insulin 2.5 hours apart. LPN L was unable to answer if Resident #112's short acting insulin (lispro) should have been administered so close together. LPN L did confirm that she should have checked Resident #112's blood glucose prior to eating, and she should have monitored how much food Resident #112 had eaten. During an interview on 2/20/26 at 11:00 AM, Unit Manager (UM) U confirmed that Resident #112's insulin orders were changed on 2/5/26, and Resident #112's short and long-acting insulin orders were increased. UM U reviewed Resident #112's record with this writer and confirmed that Resident #112's had not been assessed by a provider after her first episode of hypoglycemia on 2/7/6, and that Resident #112's insulin orders had also not been reviewed to determine if they should be adjusted after 2/7/26. UM U confirmed that nursing staff were supposed to notify the provider when a blood glucose is out of parameters, and for any change in condition. During an interview on 2/24/26 at 10:00 AM, Director of Nursing (DON) B reported she was aware of Resident #112's hypoglycemic episode on 2/11/26. DON B reported that she had investigated the situation, but that she was not aware that LPN L had administered Resident #112's short acting insulin 2.5 hours apart. DON B reported that nurses were supposed to administer medications within 1 hour of the scheduled administration time. DON B confirmed that Resident #112 received her morning and lunch dose of insulin late, as it was ordered to be given at 8:00 AM and 11:30 AM. DON B reported that nurses were supposed to assess a resident's blood glucose prior to eating, and that the nurses assess that the Resident is eating appropriately. When this writer queried as to if DON B would be concerned that LPN L administered Resident #112's short acting insulin within 2.5 hours of the first dose without knowing how much the resident had eaten, DON B reported that she would need to look into it more. During an interview on 2/24/26 at 10:54 AM, Medical Director (MD) GG reported that he had not been made aware of Resident #112's hypoglycemic episode on 2/7/26, and that the facility providers had not assessed and reviewed Resident #112's insulin orders. MD GG reported that he was unaware that Resident #112 had received her short acting insulin orders 2.5 hours apart, but that he would be concerned about the insulin being administered so close together as that would increase Resident #112's risk of hypoglycemia. MD GG reported that insulin lispro was supposed to be administered with meals, and monitoring of food intake was needed to ensure that residents receive the correct amount of insulin based on their blood glucose levels, and how much they eat. During an interview on 2/24/26 at 1:30 PM, Physician Assistant (PA) JJ reported she was at the facility (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	when Resident #112 had her second episode of hypoglycemia. PA JJ reported Resident #112 was diaphoretic and disoriented. PA JJ reported that she would be concerned about a resident experiencing an episode of hypoglycemia if they received lispro 2.5 hours apart. PA JJ reported it was important for nurses to know when and how much a resident was eating with insulin administration to ensure that they are receiving an adequate amount of insulin, and that nurses were supposed to follow the physician orders of administering insulin with meals for that reason. During an interview on 2/24/26 at 2:00 PM, Pharmacist KK reported that it was critical for insulin to be administered with meals and per the physician orders. Pharmacist KK confirmed that if a resident received insulin lispro 2.5 hours apart without knowledge of how much a resident had eaten, there would be a potential concern for hypoglycemia. Resident #101 Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE] with pertinent diagnoses which included need for assistance with personal care and epilepsy (brain condition that causes recurrent seizures). Review of Resident #101's Care Plan revealed, The resident has a seizure disorder r/t (related to) head injury dx (diagnosis) of epilepsy. Date Initiated: 07/21/2025. Goal: The resident will be free from injury from seizure activity through the review date. Date Initiated: 07/21/2025. Interventions: Give medications as ordered. Monitor/document for effectiveness and side effects. Date Initiated: 07/21/2025. Review of Resident #101's July 2025 MAR revealed, Orders: Keppra (anti-epileptic drug) Oral Tablet 500 MG (Levetiracetam). Give 2 tablet by mouth two times a day for seizures. Noted that on 7/20/25, it was documented that Resident #101 did not receive the 8:00 AM dose. Review of Resident #101's July 2025 MAR revealed, Orders: Keppra Oral Tablet 750 MG (Levetiracetam) Give 1 tablet by mouth two times a day for seizures. Noted that it was documented that Resident #101 did not receive the 8:00 AM dose. Review of Resident #101's July 2025 MAR revealed, Orders: Valproic Acid (anti-epileptic drug) Oral Solution 250 MG/5ML (Valproate Sodium). Give 10 ml by mouth three times [NAME] for seizures. Noted that it was documented that Resident #101 did not receive this medication on 7/19/25 at 8:00 AM, 1:00 PM, and on 7/20/25 and the 8:00 AM and 1:00 PM on 7/20/25 and 1:00 PM on 7/21/25. Review of Resident #101's Progress Note dated 7/19/25 at 11:46 AM, revealed, patient refused morning medications. Nurse reapproached patient at breakfast and sat with him for 20 minutes, but patient still refused medications. Patient's guardian approached nurse asking about morning medications, at this time, nurse was trying to send out another patient out on a medical emergency. The patient's guardian was asking if he received his medications and asked if we could reapproach give the medications (sic). Nurse reapproached the patient and he took 50% of his meds. Patient's guardian seemed pleased with the amount of medication that he took. Review of Resident #101's Progress Note dated 7/19/25 at 3:22 PM revealed, Patient's sister called asking nurse if the patient ate lunch, after he refused his morning medications. The sister noticed that the patient had not been responding normally stating, I visited with him yesterday and we were laughing together. He was acting normal yesterday. But today he struggled to keep his eyes open and was not responding like he usually does. I would be okay with him being sent out today (to the hospital) in case of seizure. Physician notified of patient's current symptoms and vital signs. Physician ordered patient to be sent out due to DPOA's (durable power of attorney) request. EMS called. Review of Resident #101's Progress Note dated 7/20/25 at 6:55 AM revealed, Resident returned from (local hospital) at approximately 5:00 AM this AM .new order received to increase Keppra to 1000 mg po (by mouth) twice daily. Review of Resident #101's Progress Note dated 7/20/25 at 6:21 PM revealed, Resident noted to be lethargic today and refused all meals, refused medications at time as well. Review of Resident #101's Physician Note dated 7/21/25 revealed, . Patient is assessed today for refusing medications and meals. Patient also noted to have a fever of 101 which improved with (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Tylenol . Review of Resident #101's Progress Note dated 7/21/25 revealed, Resident had seizure activity while getting ready to eat dinner. Resident's eyes rolled back and foaming at the mouth. resident returned to bed, laying on the left side. Provider notified and told to administer Ativan (medication used to treat seizure activity) and continue to monitor . Review of Resident #101's Progress Note dated 7/25/25 at 11:23 AM revealed, CNA notified nurse of resident being unable to swallow foods and medication the past couple of days, resident did not swallow his medication this morning and appeared to have dysphagia (difficulty swallowing), resident was not given his valproic acid for this reason . Review of Resident #101's Progress Note dated 7/25/25 at 2:15 PM revealed, Resident unable to swallow food and liquid the past couple of days. Dr was notified and ordered resident to send out to ED (Emergency Department) . Review of Resident #101's Hospital Notes dated 7/25/25 revealed, Chief Complaint: .male with history of TBI (traumatic brain injury), epilepsy, and nonverbal status who presents emergency department for failure to thrive patient has been dealing with significant dysphagia for quite some time but over the last 24 to 48 hours has been unable to take his medicines or have any significant oral intake due to dysphagia. (Family) is at bedside and states she was told by nursing staff at his rehab facility that when they give him his oral antiepileptic medication today they just drooled out of the side of his mouth and he was unable to swallow them. (Family Member) states the patient is otherwise at his baseline and as far as she is aware the patient has had no fevers, vomiting, difficulty breathing. His last seizure was a few days ago which she believes was also due to inability to take his oral medications .Summary of hospitalization: Patient was found to be in Status epilepticus (dangerous brain condition that happens when a person has seizures that last too long or happen too quickly in sequence) on 7/27 with Acute right parietal, temporal, occipital distribution ischemic infarction (stroke) on 7/27/25 . Attending update: It seems that due to dysphagia he would frequently miss doses of his antiepilepticsand therefore, is not particularly surprising that he has breakthrough seizures . During an interview on 2/18/26 at 11:25 AM, Family Member (FM) PP reported that when she had gone to visit Resident #101 on 7/19/25, she had noticed that Resident #101 had seemed more lethargic and confused and was unable to swallow his coffee. FM PP reported that she had approached Resident #101's nurse LPN Q to report her concern that he was not swallowing his coffee, and she learned that Resident #101 had not taken all of his medications that morning. FM PP reported that she had asked LPN Q to reapproach Resident #101 and try to administer his medications again, because she was very concerned about him missing his seizure medications. FM PP reported that she had called later that day to check on Resident #101 and when she was told that he was still unable to eat or take his medications, she asked that the facility to send Resident #101 to the hospital to be evaluated. FM PP reported feeling frustrated with LPN Q because she did not seem to be concerned that Resident #101 was unable to eat or take his medications appropriately. During an interview on 2/19/26 at 11:01 AM, LPN Q reported that she had cared for Resident #101 on 7/19/25, and she recalled that Resident #101's family member was upset regarding his care and wanted him sent to the hospital. LPN Q reported that FM PP was concerned that Resident #101 may have had a seizure. When this writer queried LPN Q about if she had notified the provider about Resident #101 missing doses of his Keppra and Valproic acid on 7/19/25 and 7/20/25, LPN Q reported that she could not recall any details of that date, and she did not know if she had notified the provider. During an interview on 2/19/25 at 12:15 PM, Unit Manager (UM) W reported that she had been made aware that FM PP had concerns that LPN Q had not responded to her concerns about Resident #101 missing his medications and change in his condition. UM W reported that after FM PP reported her concerns with LPN Q, the facility removed LPN Q from caring for Resident #101 per FM PP request, and she did not look into the concern (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	further. UM W reported that nurses were supposed to notify the provider anytime a resident missed a medication. UM W' reviewed Resident #101's July 2025 MAR with this writer and confirmed that Resident #101 had missed multiple doses of anti-epileptic medication, and she could not verify that nursing staff had notified the provider. UM W confirmed that the facility provider did not assess Resident #101 until 7/21/25 when he had a seizure at the facility. During an interview on 2/19/26 at 2:07 PM, LPN M reported that she had been approached by a CNA E that Resident #101 had been having issues swallowing and taking his medications for days, and that staff were not doing anything about it. LPN M reported that she went to assess Resident #101 and noted that he was unable to swallow medications/liquids, so she notified the provider and Resident #101 was sent to the hospital. LPN M reported that nurses were supposed to notify the provider anytime a resident missed medications. During an interview on 2/24/26 at 10:03 AM, Director of Nursing (DON) B reported that nurses were expected to notify the provider any time a resident missed a medication. DON B reviewed Resident #101's MAR with this writer and confirmed that Resident #101 had missed doses of his keppra and valporic acid, and that she could not find a note indicating that the provider had been notified. DON B reported that she also expected nurses to notify the provider anytime a resident had a change in condition. DON B reported the facility Unit Managers were supposed to review Resident's treatment records and notes every day to ensure that all changes in condition and missed treatments/medications were identified. DON B reported she was unaware that Resident #101 had missed multiple doses of keppra and valporric acid. During an interview on 2/24/26 at 1:30 PM, PA JJ reported that Resident #101 was admitted to the facility with a history of seizures. PA JJ' reported that nurses were supposed to notify the provider anytime a resident missed medications, so that the provider could assess the resident. PA JJ reviewed her notifications and reported that she did not have any notification on 7/19, 7/20, 7/21, 7/22, 7/23 or 7/24 regarding Resident #101 missing his medications due to issues swallowing. PA JJ reported that if nursing staff had notified the facility provider, they should have documented that, and she also did not see documentation from nursing staff noting a notification to the provider. PA JJ confirmed that she would be concerned that Resident #101 could have seizures and complications from seizures if he missed doses of his medication. Review of the facility's Medication Administration policy dated 7/11/18 revealed, Policy: It is the policy of this facility that medications shall be administered as prescribed by the attending physician. Procedures . 2. Medications must be administered in accordance with the written orders of the ordering/prescribing physician. NOTE: If a dose seems excessive considering the resident's age and condition, or a drug order seems to be unrelated to the resident's current diagnosis or condition, the nurse should contact the physician .7. Medications should be administered in accordance to meet the needs of the resident. Facilities that follow standard med pass models, medications may not be set up in advance and must be administered within one (1) hour before or after their prescribed time. NOTE: Before and/or after meal orders must be administered as ordered. Facilities that follow a resident centered med pass model, refer to specific facility administration times . 12. Should a drug be withheld, refused, or given other than the scheduled time, the nurse must enter an explanatory note. NOTE: The Director of Nursing and attending Physician must be notified when two (2) doses of a medication are refused or withheld .Review of the facility's Change in Condition policy dated 7/11/28 revealed, Policy: It is the policy of this facility that all changes in resident condition will be communicated to the physician. Procedure: . Acute Medical Change: 1. Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. The licensed nurse in charge will notify the physician .3. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Licensed nurse will notify, consistent with the resident's authority, the resident's representative of the change of condition and what steps have been taken. 4. All nursing actions will be documented in the licensed progress notes as soon as possible after resident needs have been met .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2728846, 2661176, and 2638850. Based on interview and record review, the facility failed to maintain accurate medical records for 3 residents out of a total of 13 residents (Resident #101, #103 and #112) reviewed for complete and accurate medical record documentation, resulting in the potential for staff and providers mismanaging care for residents. Findings include:Resident #101 Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE] with pertinent diagnoses which included need for assistance with personal care and muscle weakness. Review of Resident #101's January 2026 Treatment Administration Record (TAR) revealed, left inner knee, ruptured blister, cleanse with NS (normal saline), pat dry, applysmall piece of xeroform and cover with dry border gauze everyday shift for wound care. Noted that there was missing documentation to indicate if the treatment had been completed or refused on the following dates: 1/25/26. Review of Resident #101's January 2026 Treatment Administration Record (TAR) revealed, skin tear to right forearm skin flap in place, 4 steri-strips applied.monitor for s/s (signs and symptoms) of infection daily and allow strips to fall off naturally every day shift for wound care. Noted that there was missing documentation to indicate if the treatment had been completed or refused on the following dates: 1/22/26 and 1/25/26. Review of Resident #101's January 2026 Treatment Administration Record (TAR) revealed, Bilateral pressure relieving boots to be worn at times except when receiving care. every shift. Noted that there was missing documentation to indicate if the treatment had been completed or refused on the following dates: 1/10/26. Review of Resident #101's January 2026 Treatment Administration Record (TAR) revealed, Catheter care has been provided every shift for management routine. Noted that there was missing documentation to indicate if the treatment had been completed or refused on the following dates: 1/10/26. Review of Resident #101's January 2026 Treatment Administration Record (TAR) revealed, Check placement of G-tube (medical device inserted through the abdomen directly into the stomach to deliver nutrition, fluids, and medication when oral intake is unsafe or insufficient): verify has not moved from permanent mark on the tube/measurements have not changed > (greater than)1 inch. If any concerns with placement, notify medical provider immediately. every shift for proper placement monitoring. Noted that there was missing documentation to indicate if the treatment had been completed or refused on the following dates: 1/10/26. Review of Resident #101's January 2026 Treatment Administration Record (TAR) revealed, cleanse coccyx with dakins (wound care)solution, pack with calciumalginate (wound care medication) and cover with large sacral dressing every shift for treatment. Noted that there was missing documentation to indicate if the treatment had been completed or refused on the following dates: 1/17/26, 1/20/26, 1/22/26, 1/25/26, and 1/29/26. Resident #112 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an admission Record revealed Resident #112 was originally admitted to the facility on [DATE] with pertinent diagnoses which included type 2 diabetes mellitus (condition where the body cannot use insulin properly or doesn't make enough of it leading to high blood sugar). Review of Resident #112's February 2026 TAR revealed, Assess pulse oximetry (oxygenation level). in the morning related to PNEUMONIA. Noted that there was missing documentation to indicate if the treatment had been completed or refused on the following dates: 2/4/26. Review of Resident #112's February 2026 TAR revealed, Right medial gluteal community acquired stage 3 now unstageable, cleanse with NS, pat dry, apply hydrogelto wound bed only, and cover with border gauze daily everyday shift for wound care. Noted that there was missing documentation to indicate if the treatment had been completed or refused on the following dates: 2/4/26, 2/5/26, and 2/7/26. Review of Resident #112's February 2026 TAR revealed, To community acquired unstageable DTI (deep tissue injury) to left heel: apply betadine in the morning. Noted that there was missing documentation to indicate if the treatment had been completed or refused on the following dates: 2/4/26 and 2/7/26. Review of Resident #112's February 2026 TAR revealed, Check oxygen concentrator. Initials indicate proper function and flow rate. every shift for patient monitoring. Noted that there was missing documentation to indicate if the treatment had been completed or refused on the following dates: 2/4/26. During an interview on 2/24/26 at 10:03 AM, Director of Nursing (DON) B' reported Unit Managers at the facility were supposed to be reviewing shower sheets and resident care tasks every day and following up on any missed documentation/care. DON B reported that she expected nurses to document any time a treatment was missed with an explanation of why in a progress note. Review of the facility's Charting and Documentation policy dated 7/11/18 revealed, POLICY: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Procedure: .7. Documentation of procedures and treatments will include care-specific details, including a. The date and time the procedure/treatment was provided, b. The name and title of the individual(s) who provided the care c. The assessment data and/or any unusual findings obtained during the procedure/treatments. d. How the resident tolerated the procedure/treatment, e. Whether the resident refused the procedure/treatment; f. Notification of family, physician or other staff, if indicated, and g. The signature and title of the individual documenting . Resident #103: Review of an admission Record revealed Resident #103 was a male with pertinent diagnoses which included repeated falls, multiple sclerosis (a chronic autoimmune disease where the immune system attacks the protective myelin sheath of nerves in the brain and spinal cord causing communication issues, incurable), dementia, anxiety, and weakness. Review of Resident #103's medical record revealed no weekly skin assessments were completed for Resident #103 during the weeks of: 11/3/25, 11/24/25, 12/8/25, 12/15/25, 12/22/25, and 12/29/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/20/26 at 9:30 AM, Registered Nurse (RN) T reported she was PRN (as needed) and she believed skin assessments were conducted weekly and the nurses do those to find any changes in resident skin conditions. RN T reported the assessments were completed to ensure the facility would catch any skin changes in the resident's skin condition before it would become an bigger issue. In an interview on 2/20/26 at 09:45 AM Licensed Practical Nurse (LPN) L reported UADs (assessments) would come up in the medical record for every resident to be completed. LPN L reported the certified nursing assistant (CNA) would report to the nurses any changes in a resident's skin, the nurse would go and assess to determine what the skin issue was, and would complete a skin assessment at that time. In an interview on 2/20/26 at 1:43 PM Unit Manager (UM) W reported skin assessments were completed weekly to find any concerns with the resident's skin before it would get bad. UM W reported the UAD would appear on the screen for the nurse to complete. UM W reported the UAD could be skipped and would be assigned to the next nurse to complete, and the assessment would need to be completed within 24 hours otherwise it would disappear from the alert. UM W reported most skin assessments were done on the day shift and if the resident refused to complete a skin assessment, the nurse would document in the medical record the refusal by the resident.