STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235535	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Nursing Centre	415 Friant Street Grand Haven, MI 49417

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP), resulting in the potential for increased risk of respiratory infection among all residents in the facility. Findings include:On 02/09/2026 at 2:30PM, during interview with Maintenance Supervisor (MS) T it was found that MS T had not participated in a Water Management Team meeting, a policy review or a risk assessment during employment at facility. MS T has been with the facility since October 2025. Review of the maintenance department's Water Management Plan Binder indicates there is no documentation for minutes from a Water Management Team meeting, policy review or risk assessment occurring within the past twelve months.

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

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

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain general cleanliness and repair of premises and equipment. This resulted in an increased potential for contamination and a possible decrease in satisfaction of living for residents. Findings Include:On 02/09/2026 at 11:46AM, food debris observed on base of a lift, stored in [NAME] hallway. Food debris consisted of food ground into the mat sitting in indented area of base and loose food particles. During facility walkthrough on 02/09/2026 at 2:00PM, with Maintenance Supervisor (MS) T, food debris was observed on matting at base of equipment. It appears this is the same food debris seen in the morning. MS T stated general cleaning of equipment was a responsibility for the hall's resident care staff, but housekeeping would clean the equipment if equipment could not be cleaned with the cleaning wipes provided for the equipment. On 02/09/2026 at 12:57PM, observed baseboard heater cover was not installed in room [ROOM NUMBER], leaving approximately 3 ft of the heaters metal fins exposed and accessible to residents. Residents' bed is partially blocking the remaining portion of the baseboard heater which also does not have a cover. Interview with MS T regarding the baseboard cover and work orders revealed they were aware of the issue and had made multiple repairs to baseboard heater, however the repairs had been short term as the cover would not remain on. MS T indicated they were considering vacating room during repairs as they may be extensive in nature. On 02/09/2026 at 1:55PM, observed in shared bathroom for rooms [ROOM NUMBERS], cobwebs and dust accumulated on vent cover. On 02/09/2026 at 2:05PM, observed in shower room, dust accumulation on vent cover. MS T was asked, at time of observation, who was responsible for cleaning of the ceilings and vents in the facility, MS T stated it was the responsibility of housekeeping personnel. On 02/09/2026 at 2:25PM, observed on East hallway, the wall covering under hallway mini-split unit was bubbling and peeling away from wall allowing exposure of the wall surface behind it. On 02/09/2026 at 3:00PM, cobwebs were observed on ceiling over the dry storage area in the kitchen. Spoke to Dietary [NAME] (DC) U about observed cobwebs, DC U indicated they were unaware of the cobwebs prior to our discussion. MS T indicated during interview regarding cleaning procedures housekeeping was not responsible for cleaning in the kitchen area.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #s 2655849 and 2663547.Based on interview and record review, the facility failed to ensure residents were treated with dignity and respect for 2 of 12 residents (Resident #10 and #17), and residents in attendance at the resident group meeting, reviewed for resident rights, dignity and respect.Findings: Resident #10 (R10) Review of an admission Record revealed R10 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes and hypertension Review of a Minimum Data Set (MDS) assessment for R10, with a reference date of 12/24/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated R15 was cognitively intact. Review of a Facility Incident Report received via online submission on 10/24/25 revealed, (R10) made an allegation that a staff member took a long time to assist her to the bathroom and that the staff member said, I'm not doing this and left the resident there. The resident then stated that the staff member came back to assist her to the bathroom and after that she put her in bed, then stated, Don't ring that bell again for the rest of the night. The resident alleges that this took place around 1:30 am on the 10/24/25.There was a staff member fitting that description working during that time period named (Certified Nursing Assistant [CNA] C).When asked to give more clarification the event that took place, (R10) stated: (I) needed to get up and go to the bathroom and was having a hard time getting up. Rang the call light and she (CNA C) came and she (CNA C) said, I'm not doing that because you (R10) were having a hard time getting up. She (CNA C) left and came back in a short time and took me (R10) to the bathroom. She (CNA C) told me (R10) to put the call light on when I was done, so I did. She (CNA C) put me back in bed and said, Don't push the call light for the rest of the night . Review of a Complaint/Incident Investigation Report received by the State on 10/27/25 revealed, .On 10/24/2025, (R10) pressed her call light for assistance to use the bathroom. (CNA C) came in and told her that she couldn't assist her at the moment. (CNA C) did return to get her to the bathroom and put her back into bed again. Afterwards, (CNA C) told (R10) not to press the call light again. Review of CNA C's Personnel Action Form with an effective date of 11/4/25 revealed, .Investigation completed. Resident states employee told her not to push her call light the rest of the night. Employee says untrue. Resident alert + oriented. No reason to not believe resident.Termination of employment. During a confidential group meeting with 8 residents in attendance on 02/11/2026 at 10:30 AM until 02/11/2026 at 11:37 AM, the residents were queried on the staff attitudes and their right to be treated with dignity and respect. The residents unanimously agreed that the agency staff did not perform their work duties as they should reporting that they would often stand at the (nurses) station and talk, get real loud and goof around, don't know their a** from a hole in the ground, don't follow protocol at the facility. One resident reported that upon answering their call light an agency staff member impolitely stated, your lights on, what do you want. Another resident reported they would shut off their call light and would not return. They unanimously agreed that on nights with primarily agency staff, there were extensive call light wait times (up to an hour) and medications were administered (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	later than their preferred time. The residents in the group meeting unanimously reported that the agency staff members were overall rude and disrespectful and need to be trained. Further discussion revealed dissatisfaction with the environment and the sound level. 5 of the 8 residents reported that at night the facility staff members were not careful about doors shutting and would allow them to slam which was terrifying at night. Review of the facility policy Resident Rights last reviewed 01/2025 revealed, It is the policy of this facility to ensure residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Resident #17 (R17) Review of an Face Sheet revealed R17 admitted to the facility on [DATE] with pertinent diagnoses which included acute respiratory failure, chronic kidney disease, type II diabetes mellitus, morbid obesity, chronic obstructive pulmonary disease, difficulty in walking, and need for assistance with personal care. Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R17, with a reference date of 12/02/2025 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15, out of a total possible score of 15, which indicated R17 was cognitively intact. Review of a current (Activities of Daily Living) ADL Care Plan intervention for R17, initiated 06/14/2023, revealed R17 required the assistance of two staff to go to the bathroom. Further review of ADL Care Plan indicated: to keep R17 clean and dry as possible and to minimize skin exposure to moisture. In an interview on 02/09/2026 at 11:11 AM, R17 reported she had been incontinent of bowel the previous night after waiting for her call light to be answered. R17 reported when staff answered her call light the Certified Nursing Assistant (CNA) stated you stink. R17 reported when the staff treat her like that she feels like I don't mean anything.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to formulate and complete advanced directives in a timely manner for 4 of 17 residents (R2, R4, R6, and R24) reviewed for advanced directives. Findings include: R2 A review of R2's Face Sheet, dated 2/11/26, revealed R2 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple diagnoses that included a compression fracture of the third thoracic vertebra, depression, and generalized muscle weakness. A review of R2's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 1/28/26, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15 which revealed R2 was cognitively intact. A review of R2's Electronic Medical Record (EMR), dated 1/13/26 to 2/9/26, failed to reveal if R2 had been offered to formulate an advanced directive and/or complete an advanced directive (i.e., there was not any completed advanced directive documentation in R2's EMR. A review of R2's Electronic Medical Record (EMR), dated 1/13/26 to 2/9/26, failed to reveal if R2 had been offered to formulate an advanced directive and/or had completed an advanced directive. A review of R2's undated Informed Health Care Decisions form in their admission Packet revealed the facility failed to determine if R2 wished to prepare an advanced directive during the admission process and/or what R2's wishes regarding medical treatment was as it applied to an advanced directive (the form was blank). During an interview on 02/10/2026 at 3:00 PM, a copy of R2's Advanced Directives was requested from the Director of Nursing (DON). On 02/10/2026 at 04:23 PM, R2's Advanced Directives was requested from the DON a second time and also from the Nursing Home Administrator (first request). A further review of R2's EMR on 2/11/26 revealed a Medical Treatment Decisions of Resident form, dated and signed 2/10/26 (almost a month after R2 had been admitted to the facility), that indicated R2 wished to formulate an advanced directive and that she wished to have treatments such as cardiopulmonary resuscitation and other treatments (e.g., artificial nutrition, antibiotics, hospitalization, and artificial hydration) as needed During an interview on 02/11/2026 at 08:40 AM, the DON verbally verified that she could not locate R2's advanced directives in her medical record. She stated the facility completed an advanced directives form (Medical Treatment Decisions of Resident form) for R2 yesterday when she could not locate a completed form. Resident #4 (R4) Review of a Face Sheet revealed R4 admitted to the facility on [DATE] with pertinent diagnoses which included congestive heart failure, chronic kidney disease, type II diabetes mellitus, and (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	weakness. Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R4, with a reference date of 12-19-2025 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15, out of a total possible score of 15, which indicated R4 was cognitively intact. Review of R4's Do Not Resuscitate Order and Medical Treatment Decisions of Residents dated 10-09-2024 indicated that R4 had requested that in the event her heart stopped beating that no person shall attempt to resuscitate R4. Review of R4's Physician Order dated 03-04-2025 revealed R4's code status as a Full Code, meaning R4 would receive full resuscitation in the event her heart stopped beating. In an interview on 02-10-2026 at 2:00 PM, Social Services (SS) A stated she was unsure how R4's resuscitation was changed to a full resuscitation. SS A revealed that R4 should be documented as do not resuscitate per R4's Medical Treatment Decisions of Residents form dated 10-9-2024. Resident #6 (R6) Review of a Face Sheet revealed R6 admitted to the facility on [DATE] with pertinent diagnoses which included end stage renal disease with dependence on renal dialysis, acute kidney failure, and congestive heart failure. Review of a MDS assessment for R6, with a reference date of 12-22-2025 revealed a BIMS score of 15, out of a total possible score of 15, which indicated R6 was cognitively intact. Review of R6's Do Not Resuscitate Order dated 05-01-2025 indicated that R6 had requested that in the event his heart stopped beating that no person shall attempt to resuscitate R6. Further review of the document revealed there was only one witness signature (form requires two witnesses) and no physician signature (required to activate a do not resuscitate order). In an interview on 2-11-26 at 7:47 AM with SS A revealed that she removed the Do Not Resuscitate Order dated 05-01-2025 from the electronic medical record (EMR) because it wasn't right. SS A stated that the document should have had two witnesses and a physician signature. Resident #24 (R24) Review of a Face Sheet revealed R24 admitted to the facility on [DATE] with pertinent diagnoses which included acute pancreatitis, respiratory failure, and chronic obstructive pulmonary disease. Review of an MDS assessment for R24, with a reference date of 01-21-2026 revealed score of 13, out of a total possible score of 15, which indicated R24 was cognitively intact. Review of Electronic Medical Record (EMR) indicated that R24 was a Full Code. Further review of the EMR revealed there was not a Do Not Resuscitate Order and there was not a Medical Treatment Decisions of Residents that indicated R24's decision for code status. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 2-11-2026 at 10:03 AM SS A revealed that R24 had a Medical Treatment Decisions of Residents dated 10-18-2025 that was not uploaded into the EMR. Medical Treatment Decisions of Residents was signed by R24 and was marked NO for cardiopulmonary resuscitation. When asked why R24's EMR was marked full code SS A stated she would correct R24's EMR. Review of facility/procedure Advanced Directive Planning, indicated that Advance Directive planning discussions are available with each resident.upon admission to the facility.care planning conferences will include the resident's preference for Advance Directive planning

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the provider was immediately notified of a change in resident medical condition for 4 of 12 residents (Resident #8, #10, #30, and #5), reviewed for notification of change.Findings:Resident #8 (R8)Review of an admission Record revealed R8 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: asthma and epilepsy.Review of the provider Concerns/Communication log with an entry dated 1/30/26 which revealed, (R8) Concern: saturations (oxygen level) for day shift were in the 50's.Team Action/Date: Oxygen was 50!!Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Pulse oximetry (SpO2) Normal: SpO2 ˆ95% (greater than or equal to 95%).Review of R8's Nursing Progress Note dated 02/03/2026 at 03:19 PM revealed, (nurse practitioner) in to see (R8) today per note in providers' book that O2 sat on 1/31/26 was in the 50s.Review of R8's provider Progress Note dated 02/03/2026 at 06:17 PM revealed, Nursing notes oxygen sat on 1/30 was in the 50's. No VS charted for 1/30, no call to provider, no nursing note. Confirming a delay in physician notification of an acute change of condition.Review of R8's O2 Saturation log revealed an oxygen assessment was documented on 1/27/26 and then again on 2/3/26. There was no reassessment of R8's oxygen saturation documented.Resident #10 (R10)Review of an admission Record revealed R10 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes and hypertension (high blood pressure).Review of R10's Nursing Progress Note dated 01/02/2026 at 02:55 PM revealed, resident found to have manual BP of 70/42 with associated s/s (signs and symptoms) of lightheadedness and dizziness while standing. (nurse practitioner) informed (and) verbal instructions received to administer 1000ml (milliliters) of 0.9 NS (normal saline) IV (intravenous fluids) 250ml/hr (milliliters and hour) now recheck BP (blood pressure) during and after infusion There was no documentation in the blood pressure log of vital signs during the infusion. There were no blood pressure assessment(s) documented in the blood pressure log on 1/2/26.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Hypotension is present when the systolic BP falls to 90 mm Hg or below.Review of R10's Nursing Progress Note dated 01/05/2026 at 5:04 PM revealed, At 1600 (4:00 PM): (R10) with manual 80/60 BP (blood pressure) with associated headache and fatigue.Review of the provider Concerns/Communication log with an entry dated 1/5/26 revealed (R10) hypotn (hypotension) 80s/60s manual-tx'd (treated) PO (oral) fluids 1600-2000 (4:00 PM through 8:00 PM)-planned to tx (treat) IVF (with intravenous fluids) if symp. (symptomatic)/ (or) SBP < 100 (systolic blood pressure less than 100) at 2000 (8:00 PM) 1/5.Review of R10's Blood Pressure log revealed that on 1/6/26 at 4:00 AM a blood pressure on 90/60 (SBP less than 100).Review of R10's Nursing Progress Note dated 01/06/2026 at 5:26AM revealed, Manual BP (blood pressure) checks completed at 2115 (9:15 PM), 0000 (midnight) and 0400 (4:00 AM). Resident continues to complain of fatigue and headache. Indicating R10 had a blood pressure of less than 100 systolically (top number) and continued to be symptomatic of low blood pressure, and the provider was not notified for further direction on treatment and or monitoring.R10's blood pressure was not reassessed until 1/6/26 at 5:20 PM. R10's Blood Pressure log revealed a blood pressure of 88/51. Indicating blood pressure assessments were not completed to ensure R10 was not in a hypotensive crisis.Review of R10's provider Progress Note dated 01/06/2026 at 2:32 PM revealed, .Nursing reports hypotension w/ (with) SBP (systolic blood pressure) in the 70's. Pt (patient) asymptomatic. Average BP runs in the 80-100 systolic. Medications reviewed, fluids encouraged.May consider Midodrine (medication to increase blood pressure) if she becomes symptomatic.Review of R10's Order Summary dated 07/01/2025 revealed, Vital Signs Weekly to be assessed on 1/6/26, 1/13/26, 1/20/26, and 1/27/26.Review of R10's Blood Pressure log revealed that on 1/6/26 at 5:20 PM a blood pressure of 88/51 was obtained. There was no blood pressure (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessment again until 1/20/26 at 5:47 PM.Review of R10's January Medication/Treatment Administration Record revealed the entry for vital signs on 1/13/26 utilized the vital signs obtained on 1/6/26 despite the known symptomatic hypotensive incidents R10 experienced.Resident #30 (R30)Review of an admission Record revealed R30 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: down syndrome and anxiety disorder.Review of the provider Concerns/Communication log with an entry dated 1/14/26 revealed, (R3) Extra dose ativan 1/12 + 1/13.Review of R30's Order Summary and January Medication Administration Record revealed the following:Ativan (lorazepam) tablet; 0.5 mg; Amount to Administer: 1 tab; oral Every 4 Hours - PRN (as needed). dated 01/12/2026 and discontinued 01/16/2026.There was no documentation that the as needed Ativan was administered between 01/12/2026 and 01/16/2026.lorazepam (Ativan) tablet; 0.5 mg; Amount to Administer: 0.5mg; oral Three Times a Day dated 12/19/25 and discontinued 1/16/26.All 3 doses of the Ativan 0.5 mg were administered on 1/12/26 and 1/13/26.On 1/14/26 the morning dose was not administered Due to Condition.On 1/14/26 the afternoon dose was not administered due to lethargy.Ativan (lorazepam).tablet; 0.5 mg; Amount to Administer: 1 tab; oral Three Times a Day. Dated 1/12/26 and discontinued 1/13/26On 1/12/26 the evening dose of Ativan 0.5 mg was administered (along with the previous order for a total of 1mg of ativan and not 0.5 mg)On 1/13/26 the morning dose was not administered by Licensed Practical Nurse (LPN) D due to Duplicate order. There was no documentation that LPN D notified the provider or the Director of Nursing (DON) of the duplicate order.LPN D did not place the order on hold and on 1/13/26 the afternoon dose of Ativan 0.5 mg was administered (along with the previous order for a total of 1mg of ativan and not 0.5 mg).Review of R30's Blood Pressure log revealed that on 1/13/26 at 6:57 AM a blood pressure result of 73/45 (an excessive amount of Ativan can result in low blood pressures). There was no documentation that the provider was notified of the hypotension and change from R30's baseline blood pressures.Review of R30's Incident Report with an event date of 1/13/26 revealed, Duplicate order was entered for Ativan for 2 days. Resident received a double dose of Ativan on 01/12/26 and 01/13/2026. Duplicate order entered. Resident received 2 extra doses of Ativan, once on 1/12 and once on 1/13.Review of R30's Nursing Progress Note dated 1/15/2026 at 02:45PM revealed, Nurse on the floor notified this nurse of a duplicate order for Ativan in resident's chart. This nurse reviewed medications and found that resident did have a duplicate order of Ativan since 1/12/26. In reviewing residents medication administration record, it was found that resident had received 2 extra doses of Ativan 0.5mg, once on 1/12/26 and once on 1/13/25 due to the duplicate order. Resident was assessed and no negative outcomes were observed by this nurse. Vitals were stable. Resident was at baseline. Provider, guardian and hospice was notified. Order was corrected.Resident #5 (R5)Review of an admission Record revealed R5 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: Type 1 Diabetes.Review of R5's Order Summary dated 11/8/25 revealed, Notify physician for blood glucose readings less than 70 mg/dL or greater than 400 mg/dLReview of R5's January and February Blood Sugar log and Electronic Medical Record revealed:On 01/13/2026 at 11:26 AM R5's blood sugar was 500. There was no documentation that the provider was notified.On 01/15/2026 at 12:13 PM R5's blood sugar was High (greater than 600). There was no documentation that the provider was notified.On 01/19/2026 at 05:09 PM and 05:14 PM R5's blood sugar was High. There was no documentation that the provider was notified.On 01/20/2026 at 03:32 PM R5's blood sugar was High. There was no documentation that the provider was notified.On 01/27/2026 at 12:03 PM R5's blood sugar was High. There was no documentation that the provider was notified.On 01/29/2026 at 12:00 PM R5's blood sugar was 519. There was no documentation that the provider was notified.On 02/04/2026 at 12:56 PM R5's blood sugar was 447. There was no documentation that the provider was notified.On 02/06/2026 at 11:20 AM R5's blood sugar was 504. There was no documentation that the provider was notified.On 02/06/2026 at 04:31 PM R5's blood sugar was High. There was no documentation that the provider was notified.On 02/06/2026 at 06:13 PM R5's blood sugar was 511. There was no documentation that (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Nursing Centre	415 Friant Street Grand Haven, MI 49417

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the provider was notified.On 02/07/2026 at 07:43 PM R5's blood sugar: 539. There was no documentation that the provider was notified.On 02/09/2026 at 11:49 AM R5's blood sugar was 456. There was no documentation that the provider was notified.During an interview on 02/12/2026 at 9:11 AM, the Director of Nursing and Regional Nurse (RN) E confirmed the nurse did not follow nursing standards of practice or facility policy regarding the notification of change for R8. The DON and RN E reported that LPN D should have immediately notified them of the duplicate order to ensure the subsequent double dose was not administered confirming the afternoon ativan medication error was preventable. The DON and RN E reported the licensed nurses should immediately report and change in resident condition and critical results directly to the provider and reported they would be completing education for all licensed nurses on what was appropriate to document in the provider communication log and what requires an immediate call to the provider. Additionally, they would be educating licensed nurses on appropriate timeframes for notification to the providers.Review of the facility policy, Notification of Change last reviewed 01/2025 revealed, The Residents physician and responsible party must be notified when an event involving the resident occurs or when the resident experiences a change in condition.Some physicians may require different notification parameters for conditions such as blood glucose or other conditions.The Licensed nurse will use professional judgement any time that in their opinion the resident requires immediate medical attention.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Vital Signs Acceptable Ranges for Adults-Temperature range Average temperature range: 36 to 38 C (96.8 to 100.4 F)Average oral/tympanic: 37 C (98.6 F)Average rectal: 37.5 C (99.5 F)Axillary: 36.5 C (97.7 F)Pulse 60 to 100 beats/min, strong and regularPulse oximetry (SpO2) Normal: SpO2 ˆ95%Respirations 12 to 20 breaths/min, deep and regularBlood pressure Systolic <120 mm Hg Diastolic <80 mm Hg.[NAME] RN, MSN, PhD, FAAN, [NAME] A.; [NAME] RN, MSN, EdD, FAAN, [NAME] G.; Stockert RN, BSN, MS, PhD, [NAME] A.; Hall RN, BSN, MS, PhD, CNE, [NAME]. Fundamentals of Nursing - E-Book . Elsevier. Kindle Edition.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Hypotension is present when the systolic BP falls to 90 mm Hg or below. [NAME] RN, MSN, PhD, FAAN, [NAME] A.; [NAME] RN, MSN, EdD, FAAN, [NAME] G.; Stockert RN, BSN, MS, PhD, [NAME] A.; Hall RN, BSN, MS, PhD, CNE, [NAME]. Fundamentals of Nursing - E-Book . Elsevier. Kindle Edition.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Blood glucose level is above or below target range. Continue to monitor patient. Check for any medication orders for deviations in glucose level. Notify health care provider. Administer insulin or carbohydrate source as ordered, depending on glucose level. [NAME] RN, MSN, PhD, FAAN, [NAME] A.; [NAME] RN, MSN, EdD, FAAN, [NAME] G.; Stockert RN, BSN, MS, PhD, [NAME] A.; Hall RN, BSN, MS, PhD, CNE, [NAME]. Fundamentals of Nursing - E-Book . Elsevier. Kindle Edition.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Maintaining normoglycemia or a glucose level of less than 180 mg/dL and reducing blood glucose variability are recommended as an evidence-based practice for safe and effective patient management ([NAME], 2020). [NAME] RN, MSN, PhD, FAAN, [NAME] A.; [NAME] RN, MSN, EdD, FAAN, [NAME] G.; Stockert RN, BSN, MS, PhD, [NAME] A.; Hall RN, BSN, MS, PhD, CNE, [NAME]. Fundamentals of Nursing - E-Book . Elsevier. Kindle Edition.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to 1.) ensure medications and treatments were administered/completed following the physician order for 6 residents (Resident #21, #18, #6, #31, #17, and #5) out of 12 residents reviewed for nursing professional standards of practice.Findings:Resident #17 (R17) Review of a Face Sheet revealed R17 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: Type 1 Diabetes. Review of R17's Physicians Orders revealed an active order for insulin aspart U-100, before meals at 9:15AM, 12:15PM, and 5:00PM. During a medication administration observation on 02-10-2026 at 8:04 AM, Licensed Practical Nurse (LPN) B was observed preparing to administer insulin Aspart to R17. LPN B attached a new pen needle to the insulin pen, dialed the ordered insulin amount and administered the insulin to R17. LPN B did not dial a priming dose or expel insulin into the needle to ensure patency of the needle. In an Interview on 02-10-2026 at 8:10 AM, LPN B stated she did not know she had to prime the insulin needle prior to administration. LPN B stated she administers her own insulin and has never primed the insulin needle. LPN B revealed she was going to check facility policy. Resident #5 (R5) Review of a Face Sheet revealed R5 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: Type 1 Diabetes. Review of R5's Physicians Orders revealed an active order for Insulin Lispro 100 units per milliliter; 4 units to be given twice a day at 8:00 AM and 5:00 PM per insulin pen. Hold for blood sugar less than 120. Further review of R5's Physicians Orders revealed an active order for Lantus Solostar U-100 Insulin 15 units to be given once a morning per insulin pen. During a medication administration observation on 02-10-2026 at 8:14 AM and before checking facility policy, LPN B was observed preparing to administer insulin Lispro and insulin Lantus to R5. LPN B attached a new pen needle to the insulin pen for Insulin Lispro and Insulin Lantus, dialed the ordered insulin amounts and administered the insulin to R5. LPN B did not dial a priming dose or expel insulin into either of the needles to ensure patency of the needle. In an interview on 2-10-2026 at 10:00 AM with Regional Nurse (RN) E revealed standard of practice is to prime an insulin pen needle prior to dialing the ordered amount of insulin during an administration. Review of facility policy/procedure Injection Technique, Insulin pens should be primed prior to administering medications. Resident #21 (R21) Review of an admission Record revealed R21 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: Chronic Diastolic Heart Failure. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R21's Order Summary dated 10/2/25 revealed, daily weight once a morning. Review of R21's January and February Weight Summary revealed a weight was not obtained on 1/1/26, 1/4/26, 1/7/26, 1/13/26, 1/19/26, 1/21/26, 1/22/26, 2/2/26, or 2/4/26, Review of R21's January and February Medication/Treatment Administration Record revealed: On 1/1/26 the entry was left blank. On 1/4/26 the entry was left blank. On 1/7/26 the weight from the previous day was reentered. On 1/13/26 the weight from the previous day was reentered. On 1/19/26 the entry was left blank. On 1/21/26 Other was documented but there was no corresponding progress note. On 1/22/26 the entry was left blank. On 2/2/26 the weight from the previous day was reentered. On 2/4/26 the weight from the previous day was reentered. Review of R21's Electronic Health Record revealed no documentation for a rationale for not obtaining R21's weights on the above dates. Resident #18 (R18) Review of an admission Record revealed R18 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: Type 2 diabetes mellitus. Review of R18's Order Summary dated 8/26/25 revealed, Humalog KwikPen Insulin (insulin lispro) insulin pen; 100 unit/mL; amt: 8 units; subcutaneous Special Instructions: Hold if BS (blood sugar) less than 110.Three Times A Day. To be completed at 08:00 AM, 12:00 PM, and 05:00 PM Review of R18's Blood Sugar log revealed: On 1/9/26 no lunch blood sugar assessment (assessed at 4:25 AM and again at 4:13 PM.) On 1/16/26 no dinner assessment. (assessed at 1:00 PM and again at 7:43 PM.) On 1/22/26 no dinner assessment. (assessed at 1:00 PM and again at 7:18 PM.) On 1/29/26 no lunch assessment (assessed at 4:30 AM and again at 4:38 PM.) On 2/4/26 no dinner assessment (assessed at 12:44 PM again on 2/5/26.) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R18's January and February Medication Administration Record revealed: On 1/9/26 R18's lunchtime Humalog was administered despite no documented blood sugar assessment. On 1/12/26 R18's Humalog was held for BG (blood glucose) 121 Resident not eating much for lunch. (Held when blood sugar within parameters without an order from the provider). On 1/14/26 at 4:26 AM R18's blood sugar was 98 and the breakfast Humalog was administered. On 1/15/26 at 11:18 PM R18's blood sugar was 96 and the lunchtime Humalog was administered. On 1/16/26 R18's dinnertime Humalog was administered despite no documented blood sugar assessment. On 1/20/26 at 4:38 AM R18's blood sugar was 79 and the breakfast Humalog was administered. On 1/22/26 R18's dinnertime Humalog was administered despite no documented blood sugar assessment. On 1/24/26 at 4:37 AM R18's blood sugar was 97 and the breakfast Humalog was administered. On 1/27/26 at 5:02 AM R18's blood sugar was 96 and the breakfast Humalog was administered. On 1/29/26 R18's lunchtime Humalog was administered despite no documented blood sugar assessment. On 2/3/26 at 4:06 AM R18's blood sugar was 96 and the breakfast Humalog was administered. On 2/4/26 R18's dinnertime Humalog was administered despite no documented blood sugar assessment. Resident #6 (R6) Review of an admission Record revealed R6 was an [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: Hypertensive heart and chronic kidney disease with heart failure. Review of R6's Order Summary dated 9/5/25 revealed, metoprolol tartrate tablet; 25 mg; amt: 1; oral Special Instructions: hold for systolic blood pressure less than 100 or HR (heart rate) less than 60 Once A Day on Sun, Mon, Wed, Fri. Review of R6's December Medication Administration Record revealed: On 12/31/25 R6's metoprolol was held despite heart rate and blood pressure within acceptable range BP 101/79 and heart rate 61). Review of R6's Blood Pressure log and Heart Rate log revealed: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/18/26 there was no blood pressure or pulse assessment. On 1/19/26 there was no blood pressure or pulse assessment. Review of R6's January and February Medication Administration Record revealed: On 1/18/26 the blood pressure and pulse assessment obtained on 1/16/26 was utilized and the metoprolol was administered. On 1/19/26 R6 was not administered the metoprolol for drug/item unavailable. There was no corresponding progress note to indicate the provider or management were notified. Resident #31 (R31) Review of an admission Record revealed R31 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: hypertension and atrial fibrillation. Review of R31's Order Summary dated 1/20/26 revealed, metoprolol succinate tablet extended release 24 hr; 25 mg; amt: one; oral Special Instructions: HOLD for SBP (systolic blood pressure) < (less than) 110 and/or HR (heart rate) <60. Twice A Day To be administered in the morning and in the evening. Review of R31's Heart Rate and log revealed: On 1/21/26 there was no morning heart rate assessment. On 1/22/26 there was no morning assessment. On 1/23/26 there was no morning or evening assessment. On 1/24/26 there was no morning or evening assessment. On 1/25/26 there was no morning assessment. On 1/26/26 there was no morning assessment. On 1/29/26 at 9:09 AM R31's pulse was 53. On 1/29/26 at 11:12 PM R31's pulse was 56. Review of R31's Blood Pressure log revealed: On 1/21/26 there was no morning assessment. On 1/25/26 R31's evening blood pressure was 108/68. On 1/26/26 R31's evening blood pressure was 100/68. On 1/29/26 R31's evening blood pressure was 107/53. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R31's January Medication Administration Record revealed R31's metoprolol was administered on 1/21/26, 1/22/26, 1/23/26, 1/24/26, 1/25/26, 1/26/26, and 1/29/26 despite the lack of assessments or blood pressure and/or heart rates out of parameters. During an interview on 2/11/26 at 2:08 PM, The Director of Nursing (DON) confirmed the above medication administration errors and the lack of daily weights and reported that moving forward it would be required to input the vital signs into the electronic medication administration record to ensure assessments were completed. Additionally, all licensed nurses would receive education on administering medication following the providers ordered parameters. Review of the facility policy, General Dose Preparation and Medication Administration last revised 1/1/13 revealed, .4. Prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following.If necessary, obtain vital signs. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, (Nurses) are also responsible for documenting any preassessment data required with certain medications such as a blood pressure measurement for antihypertensive medications or laboratory values, as in the case of warfarin, before giving the medication. After administering a medication, immediately document which medication was given on a patient's MAR per agency policy to verify that it was given as ordered. Inaccurate documentation, such as failing to document giving a medication or documenting an incorrect dose, leads to errors in subsequent decisions about patient care. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (pp. 643-644). Elsevier Health Sciences. Kindle Edition.

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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** Based on observation, interview and record review, the facility failed to ensure assistance with Activities for Daily Living (ADL) care was consistently provided for 2 of 12 residents (Resident #17 and #18) and residents in attendance at the resident group meeting, reviewed for ADL care.Findings:Resident #17 (R17) Review of a Face Sheet revealed R17 originally admitted to the facility on [DATE] with pertinent diagnoses which included acute respiratory failure, chronic kidney disease, type II diabetes mellitus, morbid obesity, chronic obstructive pulmonary disease, difficulty in walking, and need for assistance with personal care. Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R17, with a reference date of 12/02/2025 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15, out of a total possible score of 15, which indicated R17 was cognitively intact. Review of a current (Activities of Daily Living) ADL Care Plan intervention for R17, initiated 06/14/2023, indicated: to keep R17 clean and dry as possible and to minimize skin exposure to moisture. In an interview on 02/09/2026 at 11:11 AM, R17 reported she had not received a shower in approximately two weeks. R17 stated the shower that was scheduled (2/5/26) they (staff) told R17 there was not enough time for her to shower. R17 indicated she liked getting showers and it made her feel clean. R17 reported no bed baths had been substituted for showers during the last 2 weeks. In an interview and record review on 02/10/2026 at 1:21 PM, Director of Nursing (DON) revealed Shower Sheets that R17 had received a shower on 01/05/26 and 02/04/26. R17 received two showers within a 5-week span. DON revealed a document Point of Care History for R17 indicating possible received showers. DON was unsure if this documentation was an actual shower or bed bath due to staff signing out twice a day or not at all and no signatures documented on R17's actual shower days. Resident #18 (R18) Review of an Face Sheet revealed R18 admitted to the facility on [DATE] with pertinent diagnoses parkinsonism, bipolar disorder, anxiety disorder, and need for assistance with personal care. Review of a MDS assessment for R18, with a reference date of 01/01/2026 revealed a BIMS score of 15, out of a total possible score of 15, which indicated R18 was cognitively intact. Review of the current Pressure Ulcer Care Plan intervention for R18, initiated 07/09/2021, indicated: to keep R18 clean and dry as possible and to minimize skin exposure to moisture. In an interview on 02/09/2026 at 11:50 AM, R18 stated that she is supposed to get two showers a week and usually only gets one. R18 reported it makes her feel grubby. R18 stated there was a basin in the bathroom that is used some days to wash up, but it doesn't help with washing her hair. R18 reported the last shower she received was on Tuesday (2/3/26). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and record review on 02/10/2026 at 1:21 PM, DON revealed Shower Sheets that R18 had received a shower on 1/9/2026, 1/24/2026, and 2/6/2026. DON revealed a document Point of Care History for R18 indicating possible received shower on 1/27/26. R18 had received 4 showers in a 5-week span. DON reported the expectation for resident showers would be two showers a week or resident preference. Review of facility/procedure Resident Rights, revealed residents have the right to a dignified existence. During a confidential group meeting with 8 residents in attendance on 02/11/2026 at 10:30 AM until 02/11/2026 at 11:37 AM, the residents were queried on the frequency they received showers. 6 of 8 residents reported that when there were agency aides working then we get skipped for showers further reporting that it wasn't because the agency staff are so busy it was because they (agency staff) were good for skipping things. The residents reported that they frequently observed agency staff sitting at the front desk (nurses' station) BS'ing. One resident stated, we are on a (shower) list, and it should be followed with another resident stating they didn't feel that we should have to beg to get a shower.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2741552Based on interview and record review, the facility failed to 1.) ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, and 2.) ensure that controlled pain medications were administered following provider orders and the residents' goals and preferences for 4 of 12 residents (Resident #24, R6, R1, and R20) and residents in attendance at the resident group meeting, reviewed for pain management.Findings:Resident #24 (R24)Review of an admission Record revealed R24 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: acute and chronic respiratory failure with hypoxia, spinal stenosis, low back pain, and asthma.Review of a Minimum Data Set (MDS) assessment for R24, with a reference date of 1/21/26 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated R24 was cognitively intact. Review of R24's Order Summary dated 12/4/25 revealed, hydromorphone (dilaudid) tablet; 2 mg; Amount to Administer: 2mg; oral Every 6 Hours Take with methocarbamol. AND methocarbamol (muscle relaxer) tablet; 750 mg; Amount to Administer: 750mg; oral Four Times A Day Take with hydromorphone.During an interview on 02/11/2026 at 11:40 AM, R24 reported that a few weeks prior she had not received her scheduled pain medication when an agency nurse was working. R24 confirmed the nurse was Licensed Practical Nurse (LPN) F. R24 stated, Supposedly he came in at midnight and at 6AM to give me my medicine. He did not! R24 reported LPN F brought medications to her room (around 9:30 PM) but her dilaudid was missing. When she confronted LPN F about the missing dilaudid, he kept saying it was in there (in the medication cup). LPN F did not go through and identify each medication he provided in the medication cup with R24 to refute the allegation. R24 stated, I know my pills. I know what they look like and I know if they're there. R24 reported that she had filed a complaint with the Director of Nursing (DON) after speaking with Registered Nurse (RN) G about not receiving her scheduled midnight or 6:30 AM pain medication and the agency nurse was terminated.Review of the Social Services Note dated 01/15/2026 at 4:20 PM revealed, Social Work met with (R24) for a supportive visit, specifically regarding concerns reported on 1/15/2026. Inquiry was made as to what occurred that prompted her concerns. (R24) reports that the nurse last night did not provide her with her prescribed pain medication or muscle relaxer. She reports the nurse gave her other medications, but her pain medication and muscle relaxer were not included. She states, I hate to second guess what the nurse gives me, but I know what I am taking and what my medications look like. She further stated, I can't have my pain medication and muscle relaxer until 11:00pm and the nurse was in between 9:30pm-9:45pm, that is too early. (R24) reports the only effect from the reported concern was that she is experiencing increased pain. Indicating her dilaudid ordered for pain control had not been administered.Review of the Social Services Note dated 01/16/2026 revealed, Social Work met with (R24) for a supportive visit, specifically regarding concerns reported on 1/15/2026.She reports she still has lingering pain, from not getting her meds the night prior, but she said, it will be better once it builds up in my system again.Review of a Facility Incident Report received via online submission on 1/15/26 revealed, Resident reported to the DON that she (R24) strongly believes that she did not receive her pain medication last night or this morning form (sic) (LPN F). It is reported in the medication administration record that the medication was given at 0000 on 1/15/26 and at 0600 on 1/15/26 and proof of use sheets coincide with medication being given. There was no discrepancy in medication count. Resident states that she did not receive her pain medication at those times.Audit of other residents receiving pain medications and no discrepancies identified.A statement written by (DON) stated: At 3:28pm on January 15th, 2026, (R24) came into my office stating, I need to talk to you. Something's been on my mind all day. (R24) explained how she strongly believes she did not receive her pain medication (Dilaudid) last night or this morning from (LPN F) (agency LPN). DON informed (R24) that (LPN F) had charted that he gave her Dilaudid at (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(midnight) on 1/15/26 and (6:00AM on 1/15/26. (R24) shook her head no and said, THAT DID NOT HAPPEN. I know what my Dilaudid looks like. He was last in my room around 9:30pm last night and I never saw him again. She explained how she shook the med cup around after he gave her meds at 9:30pm and stated, There was no medicine in there, when referring to her Dilaudid.The dictated statement from (R24) stated: At 945pm last night, he (LPN F) brought me medicine. He told me my pain pill and muscle relaxer were and (in) it. I looked and no matter what I did, I could not find them. And I did look to the bottom of it looking for the little pill because the pain pill, it's very small and I couldn't see it, so I shook it around, looked in the top, shook it around some more, looked in the bottom: there was nothing there. He (LPN F) told me he was giving me my 12am pain medication and muscle relaxer because he didn't want to have to wake me up to give it to me, which is very unusual. And then he said he gave me my medicine at 6:00 this morning. There was no medicine in there. He never came in and I think I was reading between 4:00 and 6:00 this morning and I mean I was reading pretty early. But yeah. I just don't know what he did with my medication, but I know I wasn't given them. I'm worried he took them for himself. I know what my meds look like. And those weren't it.A statement by (RN G) who was the off-going nurse at the time of the alleged incident. She stated that she was nervous following him and that he was not a good communicator, possibly a language barrier. Truly I think he is a sloppy nurse. He told me that morning conflicting times when he locked his (med cart) keys in the med room. Once it was 1:00, then 3:30 am. He did tell me he prepped all his narcs. He did want everyone to know that. I think that he has poor practices. If you are thinking he's diverting, I don't think he is, I don't ever see any signs. He tried to leave that morning without counting, he signed out before I got him to count with me.A statement from (Regional Clinical Nurse [RCN] H) who spoke with (LPN F) the morning in question prior to his departure. The writer (RCN H) arrived at the facility on January 15, 2026, at 7:00 AM to conduct an in-service training for nurses regarding controlled substance policies, including record-keeping, shift to shift counts, and verification procedures for items such as fentanyl patches. Upon arrival, (RNC H) noticed confusion at the medication cart. (RNC H) approached two nurses identified as (LPN F and RN G) regarding the required controlled substance count. (LPN F) stated he had already completed and signed off on the count, while (RN G) indicated she had not participated and that he needed to complete the count with her before leaving, in accordance with policy. (RNC H) expressed concern that (LPN F) appeared not to understand or follow the policy, as he insisted he already completed the count but did not perform it with another nurse as required. (RNC H) instructed (LPN F) to complete an additional medication count, in which he did so. Also, (RNC H) also observed that (LPN F) did not complete the medication refrigerator count as required and admitted to not doing so, but ultimately completed the medication count as required and instructed.On January 15, 2026, (LPN F) notified the Director of Nursing at 4:53 AM that he had accidentally locked the narcotic and med-cart keys inside the medication room, preventing access to controlled medication. Access was restored at 6:40 AM when incoming nurse (RN G) obtained spare keys. After arriving around 6:45 AM, the DON spoke with (LPN F) who explained he mistakenly locked the keys in the med room while receiving an early morning medication delivery. As a result, some narcotics were not administered until 7:00 AM, after the narcotic box was opened and a proper nurse-to-nurse narcotic count was completed. After his shift, (LPN F) called the DON at 8:58 AM and made several unsolicited statements about medication administration, including giving medications overnight and that morning without proper documentation. He appeared distressed, repeatedly using profanity and speaking nervously. When asked for clarification he avoided the question. (LPN F) called again at 9:10 AM, but the DON informed him she was in a meeting. Later that day, at 6:12 PM, (LPN F) texted the DON asking for help correcting what he said (staffing agency) believed was a no-call/no-show for 1/14/2026. He made additional attempts to call the DON that evening and again the following morning (January 16) at 8:41 AM, but she did not answer. At 12:02 PM on January 16, (LPN F) arrived at the facility in person with several bottles that appeared to contain home medications. He attempted to discuss the prior events, but the DON and (RNC H) instructed him that (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	he was not permitted on the property. He was escorted out and seen leaving at 12:03 PM.Conclusion Based on the information obtained, the investigation into the alleged incident involving (R24) and (LPN F) has yielded inconclusive results. (R24) alleges that she did not receive her pain medications on the night of 1/15/26 but an in-depth narcotic reconciliation of facility narcotic records showed that there was no diversion or missing medications.(LPN F) denies any diversion and states that he gave the medications to the resident. Given the lack of corroborating evidence and the conflicting accounts, the investigation cannot definitively substantiate a drug diversion. (The statements above were dated and signed by the referenced nurses).Although it was reported in the medication administration record that the medication was given at 0000 on 1/15/26 and at 0600 on 1/15/26 and proof of use sheets coincide with medication being given, LPN F reported to both the oncoming nurse (RN G) and the DON that he did not have access to the narcotic key during the 6:00 AM dilaudid administration. Additionally, he reported to RN G that he had prepped all his narcs (narcotics). Indicating LPN F removed 2 doses of R24's dilaudid and documented the administration on her Controlled Substance Proof of Use form at the beginning of his shift and not at the actual time the dilaudid was dispensed (for R24 and all other residents that were to receive controlled drugs throughout the entirety of his shift). Prepping R24's dilaudid would account for the correct count (number of remaining dilaudid tablets) on R24's Controlled Substance Proof of Use form. Prepping/presetting controlled drugs can lead to medication errors (wrong resident, wrong dose, wrong time, wrong medication), count discrepancies, and/or missed doses.LPN F confessed to the DON that he did not properly document medications that he administered throughout his shift and that narcotics were administered late (when he obtained access to the narcotic keys). He openly admitted to RNC H that he did not complete or follow the required controlled substance count procedures and RNC H expressed concerns of LPN F's inability to understand or follow controlled drug policies. LPN F was described as a sloppy nurse with poor (nursing) practices by a colleague. Resident Group MeetingDuring a confidential group meeting with 8 residents in attendance on 02/11/2026 at 10:30 AM until 02/11/2026 at 11:37 AM, the residents were queried about medication administration. 1 resident reported (with 5 other residents in agreement) that medications were not always administered and that staff were always confrontational if the concern was addressed. 1 resident reported that pain medications that are scheduled are passed late and as needed pain medications are not promptly administered when requested (greater than an hour).3 residents reported that they have not received pain medications in the past which they reported to management. 1 resident reported because they did not receive their as needed pain medication timely, they had to receive therapy services unmedicated, further reporting how difficult it was to participate in therapy when experiencing pain. The resident reported that he had had a problem with a male nurse they brought in not administering pain medication on time and sometimes not at all (3 other residents reported the same concerns with the male nurse). The residents reported resolution of the concerns with that nurse as he was no longer working at the facility.Resident #6 (R6)Review of an admission Record revealed R6 was an [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: Hypertensive heart and chronic kidney disease with heart failure.Review of R6's Order Summary dated 9/225 revealed, hydrocodone-acetaminophen (Norco)- tablet; 7.5-325 mg; amt 1 tab Three Times A Day. To be administered between 07:00 AM-11:00 AM, 01:00 PM-02:30 PM, and 07:00 PM-11:00 PM. Review of R6's Controlled Substance Proof of Use form revealed that on 2/6/26 the afternoon dose (1:00 PM-2:30 PM) was not dispensed. (Indicating the medication was not removed from the blister pack for administration).Review of R6's Medication Administration Record revealed that on 2/6/26 the afternoon dose of Norco was not administered (area left blank).Review of R6's Electronic Medical Record revealed no documentation for the withholding of the Norco.Resident #1 (R1)Review of an admission Record revealed R1 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: lumbar inflammatory spondylopathy (inflammatory disease that typically causes lower back pain and stiffness).Review of R1's Order (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Summary dated 6/20/25 revealed, hydrocodone-acetaminophen (Norco) tablet; 10-325 mg; amt: 1 tab; oral Three Times A Day. To be administered between 07:00 AM-11:00 AM, 01:00 PM-02:30 PM, and 07:00 PM-11:00 PM.Review of R1's Controlled Substance Proof of Use form revealed that on 2/8/26 R1's morning dose of Norco was not dispensed.Review of R1's Medication Administration Record revealed that on 2/8/26 all 3 doses of R1's Norco was documented as administered.Review of R1's Electronic Medical Record revealed no documentation for the withholding of the Norco.Resident #20 (R20)Review of an admission Record revealed R20 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: neuropathy.Review of R20's Order Summary dated 1/23/26 revealed, pregabalin (Lyrica-used for nerve pain) capsule; 50 mg; amt: one capsule; oral Three Times A Day. To be administered between 07:00 AM-11:00 AM, 01:00 PM-02:30 PM, and 07:00 PM-11:00 PM.Review of R20's Controlled Substance Proof of Use form revealed that on 2/6/26 the afternoon dose of lyrica was not administered.Review of R20's Medication Administration Record revealed that on 2/6/26 R20's afternoon dose of Lyrica was not administered (area left blank).Review of R20's Electronic Medical Record revealed no documentation for the withholding of the Lyrica.Review of the facility policy, General Dose Preparation and Medication Administration last revised 1/1/13 revealed, .Facility staff should only prepare medications for one resident at a time.Review of the facility policy Controlled Substances Standards of Practice last reviewed 01/2025 revealed, Policy: In order to accurately account for all control substances through the process of ordering, receiving, storage, administration and destruction, the following procedures have been provided.Distribution and Record Keeping in FacilityNurses removing controlled substance from the narcotic storage require documentation on the Proof-of-Use Sheet the amount removed using a full last name signature. Nurse documentation of inventory balance on Proof-of Use sheet MUST be made as soon as the controlled substance is removed from the package/cart. Avoid waiting until the end of med pass or end of shift.Once the nurse completes the administration, then the nurse is to document on the MAR paper record or E-Mar electronic record. If PRN medication is administered, additional documentation regarding reason, result, time and initials are required. Note: If documentation is not provided on MAR or E-Mar, medication will be considered not given. MAR or E-Mar is record of administration NOT the proof-of-use sheet.Both on-going and off-going Nurses will count the number of containers and narcotic Proof-of-Use sheets to ensure accuracy reconciliation and provide signatures on the Narcotic Page and Card Count sheet.Both on-going and off-going nurses reconcile the Narcotic EDK and Narcotic Refrigerator EDK by checking and signing that the tag numbers on the boxes to ensure accuracy of safekeeping. Counts will occur with each change in ownership of narcotic keys, at shift change and change in assigned.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Never document that you have given a medication until you have actually given it. Document the name of the medication, the dose, the time of administration, and the route on the MAR. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 644). Elsevier Health Sciences. Kindle Edition.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the physician failed to address pharmacy recommendations, the facility failed to implement physician approved pharmacy recommendations, and/or the facility failed to implement physician approved pharmacy recommendations timely for 4 of 5 residents (R2, R3, R12, and R24) reviewed for monthly pharmacy medication regimen reviews. Findings include: R2 A review of R2's Face Sheet, dated 2/11/26, revealed R2 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple diagnoses that included a post-traumatic stress disorder (PTSD), depression, and anxiety. A review of R2's Consultation Report, dated 1/22/26, revealed the pharmacist recommended that the physician either discontinue the as needed (prn) alprazolam (a medication for anxiety) or add a stop date not to exceed 14 days from the time it was initiated. The physician signed on 1/27/26 that they accepted the recommendation. A review of R2's Physician Order Report, dated 1/11/26 to 2/11/26, failed to reveal that the physician discontinued and/or added a stop date for R2's as needed alprazolam. A review of R2's Medication Administration Record, dated 1/11/26 to 2/11/26, revealed R2 had been receiving alprazolam as needed from 1/22/26 (the day after the order was initiated) to 2/11/26 (21 days after the order was initiated and 15 days after the physician accepted the recommendation) and there was no stop date listed. R3 A review of R3's Face Sheet, dated 2/11/26, revealed R3 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R3's Face Sheet revealed they had multiple diagnoses that included depression, psychotic disorder with delusions, insomnia, and anxiety. A review of R3's Consultation Report, dated 4/3/25, revealed the pharmacist recommended that the physician add a stop date for as needed lorazepam (a medication for anxiety and insomnia) that was no more than 14 days from initiation. However, the report was not signed and/or acknowledged by the physician and/or designee (except for a handwritten note without name or initials of the writer at the bottom of the form, dated 2/11/26, that indicated it was reviewed, no stop date was implemented, and the medication was discontinued on 1/6/26 and re-ordered with a stop date of 1/19/26). A review of R3's Consultation Report, dated 10/8/25, revealed the pharmacist recommended that the physician add a stop date for as needed lorazepam that was no more than 14 days from initiation (a repeat recommendation from 4/3/25) or discontinue the as needed lorazepam. The physician accepted the recommendation on 1/15/26 and noted to add a stop date. A review of R3's Physician Order Report for January 2026 revealed that R3 had consecutively written physicians orders (3/27/25 to 1/6/26 and 1/6/26 to 1/19/26) for Ativan (lorazepam) to be (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered every eight (8) hours as needed. A review of R3's Medication Administration Record, dated 4/1/25 to 1/31/26, revealed R3 had received Ativan (lorazepam) as needed three times in April 2025, twice in May 2025, once in July 2025, once in August 2025, four times in September 2025, once in October 2025, once in November 2025, and twice in December 2025 before the original pharmacy recommendation on 4/3/25 was addressed and a stop date was initiated. A review of the facility's Medication Regimen Review policy and procedure, dated 11/28/26, revealed, 6. The pharmacist will address copies of residents' MRRs to the Director of Nursing and/or the attending physician and to the Medical Director. Facility staff should ensure that the attending physician, Medical Director, and Director of Nursing are provided with copies of the MRRs. 7. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR and the Director of Nursing to act upon the recommendations contained in the MRR. 7.1 For those issues that require Physician/Prescriber intervention, Facility should encourage Physician/Prescriber to either accept and act upon the recommendations contained within the MRR, or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected. 7.2 The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. 7.2.1 If the attending physician has decided to make no change in the medication, the attending physician should document the rationale in the residents' health record. 8. Facility should alert the Medical Director when MRRs are not addressed by the attending physician in a timely manner. 11. The attending physician should address the consultant pharmacist's recommendation no later than their next scheduled visit to the facility to assess the resident, either 30 or 60 days per applicable regulation. Resident #12 (R12) Review of an Face Sheet revealed R12 admitted to the facility on [DATE] with pertinent diagnoses which included type II diabetes mellitus, hypertension, chronic respiratory failure, and weakness. Review of a Pharmacist Monthly Medication Review for R12 revealed irregularities were noted in September 2025, October 2025, November 2025, and December 2025. A request was made to the Director of Nursing (DON) on 2/11/2026 at 9:29 AM to produce the four pharmacy reported medication irregularities and recommendations for R12. In an interview on 2/11/2026 at 2:45 PM, Regional Nurse (RN) E and DON revealed that September 2025, October 2025, and December 2025 Pharmacy medication reports for R12 could not be located. Resident #24 (R24) Review of an Face Sheet revealed R24 admitted to the facility on [DATE] with pertinent diagnoses which included depression, insomnia, and chronic respiratory failure. Review of a Pharmacist Monthly Medication Review for R24 revealed irregularities were noted in October 2025 and December 2025. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A request was made to the DON on 2/11/2026 at 9:29 AM to produce the two pharmacy reported medication irregularities and recommendations for R24. Review of Irregularity Reports for R24 on 2/11/26 at 12:29 PM, document titled Consultation Report dated 10/15/2025 with recommendation to reduce Amitriptyline (used to treat depression) to 25 milligrams daily with the end goal of discontinuation. Further recommendations documented on 12/22/25 were again to taper Amitriptyline to 25 mg daily for 5 days and discontinue related to a fall. Both recommendations were not reviewed or signed. Review of R24's Physicians Orders on 2/11/26 at 1:00 PM revealed an active order for Amitriptyline 50 milligrams daily. In an interview on 2/11/26 at 1:15 PM, the DON revealed that the completed pharmacy consult reports for R24 were still trying to be located. The DON stated that pharmacy consult recommendations should be completed within 30 days. Review of facility policy/procedure Medication Regimen Review, revealed facility should independently review each resident's medication regimen directly from the resident's medical chart and with Interdisciplinary Care Team members. for those issues that require Physician/Prescriber intervention, facility should encourage Physician/Prescriber to either accept and act upon the recommendations contained within the recommendation or reject all or some of the recommendations contained in the recommendation and provide an explanation as to why the recommendation was rejected. The attending physician should address the consultant pharmacist's recommendation no later than their next scheduled visit to the facility to assess the resident, either 30 or 60 days.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were administered in accordance with physician orders without errors for 2 (R17 and R5) of the 7 residents observed during the medication administration task. This resulted in a facility medication error rate of 10.34% (3 errors out of 29 opportunities).Findings include:Resident #17 (R17 Review of a Face Sheet revealed R17 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: Type 1 Diabetes. Review of R17's Physicians Orders revealed an active order for insulin aspart U-100, before meals at 9:15AM, 12:15PM, and 5:00PM.During a medication administration observation on 02-10-2026 at 8:04 AM, Licensed Practical Nurse (LPN) B was observed preparing to administer insulin Aspart to R17. LPN B attached a new pen needle to the insulin pen, dialed the ordered insulin amount and administered the insulin to R17. LPN B did not dial a priming dose or expel insulin into the needle to ensure patency of the needle. In an Interview on 02-10-2026 at 8:10 AM, LPN B stated she did not know she had to prime the insulin needle prior to administration. LPN B stated she administers her own insulin and has never primed the insulin needle. LPN B revealed she was going to check facility policy. Resident #5 (R5)Review of a Face Sheet revealed R5 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: Type 1 Diabetes.Review of R5's Physicians Orders revealed an active order for Insulin Lispro 100 units per milliliter; 4 units to be given twice a day at 8:00 AM and 5:00 PM per insulin pen. Hold for blood sugar less than 120. Further review of R5's Physicians Orders revealed an active order for Lantus Solostar U-100 Insulin 15 units to be given once a morning per insulin pen.During a medication administration observation on 02-10-2026 at 8:14 AM and before checking facility policy, LPN B was observed preparing to administer insulin Lispro and insulin Lantus to R5. LPN B attached a new pen needle to the insulin pen for Insulin Lispro and Insulin Lantus, dialed the ordered insulin amounts and administered the insulin to R5. LPN B did not dial a priming dose or expel insulin into the either of the needles to ensure patency of the needle. In an interview on 2-10-2026 at 10:00 AM with Regional Nurse (RN) E revealed standard of practice is to prime an insulin pen needle prior to dialing the ordered amount of insulin during an administration. Review of facility policy/procedure Injection Technique, Insulin pens should be primed prior to administering medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure there were no expired medications and ensure opened medications were dated in one of one medication cart and in one of one medication storage room. Findings include: During an observation on 2/10/2026 at 7:00 AM, the following were noted in the medication room: (a) an opened Tuberculin Purified Protein Derivative vial (used for skin testing to detect if a person has been infected with Mycobacterium tuberculosis or TB) vial was observed in the refrigerator opened and undated (Per Physician Desk Reference (PDR) recommend vial should be discarded 30 days after opened) and (b) four bottles of Famotidine 20mg (milligram) tablets with 300 tablets in each bottle that expired January 2026. During an observation on 2/10/2026 at 7:15 AM, the following were noted in the medication cart: (a) an opened Albuterol inhaler with 196 puffs remaining with no date indicating the date it was opened (Per PDR recommend inhaler should be discarded 90 days after opened), (b) Gas Relief 125 mg bottle with expiration date of 1/2026, and (c) an opened Wixela inhub inhaler with 39 puffs remaining with no date indicating the date it was opened (Per PDR recommend inhaler discarded 30 days from opened foil package).In an interview on 2/10/2026 at 7:15 AM, LPN B stated the expired meds should not be in the medication storage room and available for resident use.Review of facility policy/procedure General Dose Preparation and Medication Administration, Facility should.check the expiration date on the medication.facility staff should enter the date opened on the label of medications with shortened expiration dates.Review of facility policy/procedure House Stock Policy, facility should ensure that house stock medications are stored in the original manufacturer's container.the medication name, strength, expiration date, and lot number should be clearly visible.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview and record review, the facility failed to maintain best practices for storage of foods brought to residents by family and other visitors. Findings include: On 02/09/2026 at 10:32AM, at time of interview Dietary Supervisor (DS) S states they do not have the key to the refrigerator and freezer; and DS S left to the nurse's station to obtain the key to open the doors of refrigerator and freezer. DS S, noted dietary staff is not responsible for dating food or discarding food from the residents' refrigerator. Observed the following items, in the resident's refrigerator, without a date of when food was received and placed in refrigerator: cream-based soup with room number only on container, opened jar of Tostitos cheese dip, oatmeal in kitchen dishware. Record review of the facility's policy, Foods Brought in to Resident Education Material, #5 Cooked food items will be labeled with the resident's name and date of delivery. If the food items need refrigeration/freezing, the items will be placed in a resident designated refrigerator/freezer.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to properly assess one resident (R9) out of twelve reviewed for self-administration of medications.Findings include:Review of a Face Sheet revealed R9 admitted to the facility on [DATE] with pertinent diagnosis which include type II diabetes mellitus, major depressive disorder, anxiety disorder, and cognitive communication deficit. In an observation on 2/10/2026 at 8:42 AM R9 was observed to have a bottle of Flonase nasal spray (24-hour nasal spray that treats allergy symptoms) at the bedside. Licensed Practical Nurse (LPN) B asked R9 if she had already administered the medication and R9 answered that she was unsure why the Flonase nasal spray was at bedside. LPN B administered the Flonase nasal spray as physician ordered and placed the Flonase into the medication cart.Review of a Physician Order dated 03/05/2025 Flonase Allergy Relief (fluticasone propionate) spray, 50 micrograms one spray each nostril every morning. Further review of physician order revealed that R9 had no diagnosis for use of Flonase.In an interview on 2/10/2026 at 8:45 AM LPN B stated the Flonase nasal spray for R9 should have been in the medication cart and not at bedside. LPN B was unsure how long the Flonase nasal spray was at R9's bedside. In an interview on 2/10/2026 at 11:00 AM Director of Nursing (DON) reported after reviewing R9's electronic medical record, R9 did not have a self-administration assessment completed to self-administer the Flonase nasal spray at bedside. Review of facility policy Self-Administration revealed residents may not exercise the right to self-administer medications until the interdisciplinary team (IDT) has determined if the resident is safe to self-administer medications and which medications may be self-administered. a care plan will be initiated for residents who can safely self-administer medications. a physician's order will be obtained for residents who can safely self-administer medications. medications will be stored in a secured location, in resident room in a locked area or with the medication cart until dispensed to the resident for self-administration.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a resident with written notice of the facility's bed hold policy upon transfer to the hospital for 1 of 2 residents (R27) reviewed for hospital transfers. Findings include: A review of R27's Face Sheet, dated 2/12/26, revealed R27 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple diagnoses that included obstruction of the bile duct and weakness, A review of R27's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 1/9/26, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15 which revealed R27 was cognitively intact.A review of an Interdisciplinary Team note, dated 1/24/26 for 1/19/26, revealed R27 had been transferred to the hospital emergency room on 1/18/26 for evaluation and treatment of excessive purulent drainage (thick, milky, or opaque fluid often having a foul odor that signifies an active infection) from R27's biliary drain (a thin tube that is inserted through the skin into the liver and that drains fluid into a bag). In addition, the Interdisciplinary Team note revealed R27 had been transferred to another hospital for treatment, management, and admission.A review of R27's electronic medical record, dated 1/6/26 to 2/12/26, failed to reveal that the facility had provided R27 with written notice of their bed hold policy when she was transferred to the hospital emergency room on 1/18/26.During an interview on 02/12/26 at 10:20 AM, the Director of Nursing (DON) was informed that the surveyor could not locate the written notice of the facility's bed hold policy that R27 should have received prior to, or soon after, her transfer on 1/18/26 to the hospital emergency room. The DON stated she would look and see if it was in a stack of unfiled paperwork in her office. A copy of the written notification was requested from the DON, if she could locate it. During a second interview on 02/12/26 at 10:30 AM, the DON stated the facility did not give R27written notification of the facility's bed hold policy when she went to the emergency room on 1/18/26. She stated they only gave her the bed hold policy when she was admitted to the facility. A review of the facility's Bed Hold policy and procedure, reviewed 01/25, revealed the bed hold policy will be provided to the resident or the resident's representative at the time of admission and again with any emergency transfer from the community. 1. The facility Social Worker or designee will provide a copy of the bed hold policy to the resident and/or the resident representative at the time of admission and again prior to a transfer due to hospitalization or therapeutic leave. 2. The facility shall provide the bed hold policy acknowledgement to the resident or the resident representative with any resident initiated therapeutic leave or transfer to alternative healthcare community including a hospital admission. This acknowledgement will provide information to the resident and/or resident representative that explains the duration, the reserved bed payment policy and also facility permitting return of the resident to the next available bed.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete Preadmission Screening and Resident Review (PASARR) Level 1 Screenings timely for 2 of 2 residents reviewed (R2 and R12). Findings include:R12 Review of a Face Sheet revealed R12 admitted to the facility on [DATE] with pertinent diagnosis which include schizoaffective disorder, bipolar type, and type II diabetes. Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R12, with a reference date of 12/22/2025 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 04, out of a total possible score of 15, which indicated R12 had severe cognitive impairment. Further review of the MDS revealed R12 had received an antipsychotic and an antidepressant within the 7-day assessment period. Review of the electronic medical record revealed a PASARR Level 1 Screening dated 09/22/2025 marked hospital exemption discharge which meant that R12 was certified by a physician to admit to a long-term clinical facility after a hospital stay, required nursing facility service, and was likely to require less than 30 days of nursing service. Upon further review there was no completion of a new PASARR Level 1 screening after the 30-day exemption was passed the 30 days which would have initiated a level II evaluation with mental health services for R12. In an interview on 2/10/2026 at 2:42 PM with Social Services (SS) A reported she missed the 30-day exempt Level 1 PASARR screening review for R12. (SS) A reported the expectation would be to follow procedure for the PASARR process. Review of facility policy Pre-Admission-admission Process, Revised 10/2017 revealed Social Services will ensure that the referring party obtains a Level 2 PASARR screening, when indicated. A review of R2's Face Sheet, dated 2/11/26, revealed R2 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple diagnoses that included a post-traumatic stress disorder (PTSD), depression, anorexia nervosa- binge eating/purging type, and a personal history of other mental and behavioral disorders. A review of R2's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 1/28/26, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15 which revealed R2 was cognitively intact. A review of R2's electronic medical record (EMR), dated 1/13/26 to 2/9/26, failed to reveal if R2 had a Preadmission Screening and Resident Review (PASARR) Level 1 Screening (a screening that evaluates all applicants for serious mental illness and/or intellectual disability in order to ensure that they receive the appropriate care and services that they require) performed prior to admission. A review of R2's admission Packet Audit, undated, failed to indicate if facility staff had ensured that a PASARR Level 1 screening was completed prior to R2 being admitted to the facility (the Check Off and Initial boxes for this task/item were blank). During an interview on 02/10/2026 at 3:00 PM, the Director of Nursing (DON) was notified that a copy (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of R2's PASARR Level 1 screening could not be located in their medical record. The DON stated she would look and see if she could locate it within a stack of documents that were in her office that had not been scanned into residents' medical records. A copy of R2's PASARR Level 1 screening was requested from the DON, if one could be located. On 2/10/2026 at 4:48 PM, the facility provided an undated and unsigned copy of a PASARR Level 1 screening for R2. In addition, the PASARR Level 1 screening did not even have the name (typed or printed) or the title of the individual who allegedly completed the form. The PASARR Level 1 screening revealed R2 had current mental illness diagnoses and was being treated for mental illness. A second review of R2's EMR, dated 1/13/26 to 2/11/26, revealed the facility loaded R2's PASARR into the medical record on 2/10/26. During an interview on 02/11/2026 at 11:10 AM, Social Services (SS) A stated R2 did not have a PASARR Level 1 screening completed prior to her admission. SS A stated R2 came from an out of state hospital and they had requested that the facility do the PASARR Level 1 screening when R2 arrived. SS A further stated that R2's PASARR Level 1 screening had been completed on 2/10/26 by a Registered Nurse (RN) and presented the form to the surveyor with the RN's name typed on it (no signature) and the date the PASARR Level 1 screening was completed. SS A also confirmed that the PASARR Level 1 screening form that was in R2's EMR at the time of this conversation lacked the date and time the form was completed, typed/printed name and title of the individual who completed the form, and the signature of the individual who completed the form. A review of R2's PASARR Level 1 screening form that SS A presented to the surveyor confirmed that the form was completed by an RN and that the form had been completed on 2/10/26 at 3:39 PM (28 days after R2 was admitted to the facility and approximately 30 minutes after the form was requested from the DON). It also revealed that R2's PASARR Level 1 screening was unsigned by the person who completed the form. A review of the State Operations Manual, dated 08/08/24, revealed, The PASARR process requires that all applicants to Medicaid-certified nursing facilities be screened for possible serious mental disorders, intellectual disabilities and related conditions. This initial screening is referred to as Level I Identification of individuals with MD (Mental Disorder) or ID (Intellectual Disability) (483.128) and is completed prior to admission to a nursing facility. The purpose of the Level I pre-admission screening is to identify individuals who have or may have MD/ID or a related condition, who would then require PASARR Level II evaluation and determination prior to admission to the facility.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the facility policy for pressure injury/wound management for 3 of 12 residents (Resident #21, #17, and #6) reviewed for alterations in skin integrity.Findings:Resident #21 (R21)Review of an admission Record revealed R21 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: Chronic Diastolic Heart Failure.Review of R21's Order Summary dated 10/2/25 until 1/19/26 revealed, Skin Assessment Weekly.Review of R21's weekly Skin Body Assessment dated 12/18/25 revealed, LLE (left lower extremity) ulcer known finding treatment in place .There were no weekly Skin Body Assessment completed on 12/25/25 or on 1/1/26.Review of R21's Skin Body Assessment dated 1/8/26 revealed, .some excoriation on buttocks bilateral cream applied house stock barrier cream on open areas on buttock noted.Review of R21's Electronic Health Record revealed no documentation that the Director of Nursing, the provider, or the emergency contact were notified of the alteration in her skin integrity. R21's Care Plan was not updated to reflect the excoriation with implementation of new interventions to prevent the worsening of breakdown/injury. There were no new treatment orders implemented (house stock barrier cream on open areas as documented in the skin assessment.)Review of R21's Skin Body Assessment dated 1/14/26 revealed no follow up regarding the excoriation identified on 1/8/26.Review of R21's Interdisciplinary Progress Note 1/19/26 revealed, Weekly IDT (interdisciplinary team) Review of Wounds: (R21's) right medial lower leg wound has healed. Care plans/orders dc'd (discontinued) and resolved as of 1/16.Review of R21's Care Plan-Evaluation Notes dated 1/19/26 revealed, .Stable at this time with no new skin breakdown issues.Review of R21's Order Summary dated 1/19/26 revealed Skin Assessment Weekly-Sunday 1st shift. There was no weekly Skin Body Assessment documented for 1/19/26.There was no weekly Skin Body Assessment completed on 1/21/26.Review of R21's Skin Body Assessment dated 1/27/26 revealed, Sacrum/Coccyx - skin tears. (R) and (L) intergluteal cleft.Review of R21's Nursing Progress Note dated 1/27/26 [Recorded as Late Entry on 01/29/2026 02:37 PM] revealed, Moisture-associated skin tears found to RIGHT & LEFT intergluteal cleft. Wound NP (nurse practitioner) to eval at the bedside, January 30th.Orders/care plan initiated. Wounds added to Wound Manager.Review or R21's Order Summary revealed no treatment was initiated for the MASD/skin breakdown from the identification of the wound on 1/27/26.Review of R21's Medication/Treatment Administration Record revealed no documentation of treatments ordered or completed for R21 from 1/27/26-1/29/26.Review of R21's Nursing Progress Note dated 1/30/26 revealed, Wound Rounds: Skin tears to R/L intergluteal cleft correctly identified as MASD (moisture associated skin damage) to sacrum R/L (right/left) by (name omitted) NP during Wound Rounds; DON updated verbiage in Wound Manager. MASD R/L wounds evaluated at the bedside with (name omitted), NP. Initial evals for both areas. Measurements updated. Assessment attached in Wound Manager. Careplan/orders verified. Treatment for both sites: Cleanse with normal saline/wound cleanser. Apply hydrocolloid dressing MWF (Monday, Wednesday, and Friday) and as needed.Review of R21's Order Summary dated 1/30/26 revealed, Sacrum wound cleanse with NS (normal saline)/wound cleanser - apply hydrocolloid dressing. MWF (Monday, Wednesday, and Friday) and as needed.Review of R21's Nursing Progress Note dated 2/6/26 revealed, Wound Rounds w/ (with) NP: MASD to R/L sacrum assessed at bedside; MASD to R sacrum is improving; care plan/orders reviewed; measurements updated. MASD to L sacrum has healed as of 2/6/26.Review of R21's skin integrity Care Plan revealed, Problem Start Date: 01/27/2026 Category: *Skin Integrity-With active MASD to LEFT sacrum; had MASD to RIGHT sacrum--healed as of 2/6/26. Indicating a discrepancy in the healing of the wounds.Review of R21's Treatment Administration Record and Order Summary revealed the treatment for R21's sacrum wound was ongoing since the initial order on 1/30/26. There was no modification of the order with the change/resolution of the wound on 2/6/26 as of survey exit (2/12/26.)During an (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 02/12/2026 at 9:11 AM, the Director of Nursing reported that she initiated treatment for R21 upon identification of the breakdown on 1/27/26 but confirmed it was not ordered in the Medication/Treatment Administration Record until 1/30/26 following the wound consultant's assessment.Review of the facility policy Pressure Injury Prevention and Care last revised 01/2025 revealed, Purpose: To promote and facilitate pressure injury prevention and implement appropriate interventions and treatment of pressure injuries to promote and facilitate resolution of pressure injuries.Procedure: 1. Nurses will complete the Skin Body Assessment Observation upon admission/readmission, then weekly and as needed.5. Interventions will be implemented, and care planned to prevent pressure injury development or to promote pressure injury resolution.6. Pressure injuries will be assessed and documented upon admission, readmission, upon discovery, and weekly thereafter. Assessment may include the size, location, category/stage, odor (if any), drainage (if any), peri-wound condition, wound edges, undermining, tunneling, exudate, pain, and current treatment order. 7. Physicians and responsible parties will be notified of pressure injury upon identification and with change in status of pressure injury.9. Potential/suggested procedure with pressure injury identification: A. Notify the physician/provider and the resident's responsible party B. Initiate treatment in accordance with facility protocols, standing orders, or physician orders C. Document the appearance of the pressure injury (eg: size, location, appearance, odor (if any), drainage (if any), condition of peri-wound, wound edges, stage, etc.) D. Implement pressure-relieving or pressure-reducing interventions as appropriate E. Notify the Director of Nursing F. Update the resident care plan to address the area of pressure injury, and approaches initiated.

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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** Based on interview and record review, the facility failed to maintain complete medical records for 3 of 12 sample residents (R2, R3, and R27). Findings include: R2 A review of R2's Face Sheet, dated 2/11/26, revealed R2 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple diagnoses that included a post-traumatic stress disorder (PTSD), depression, and anxiety. A review of R2's electronic medical record (EMR), dated 1/13/26 to 2/9/26, failed to reveal any advanced directive documentation that would indicate if R2 had been offered to formulate an advanced directive and/or complete an advanced directive. A second review of R2's EMR, dated 1/13/26 to 2/9/26, failed to reveal if R2 had a Preadmission Screening and Resident Review (PASARR) Level 1 Screening (a screening that evaluates all applicants for serious mental illness and/or intellectual disability in order to ensure that they receive the appropriate care and services that they require) performed prior to admission. During an interview on 02/10/2026 at 3:00 PM, the Director of Nursing (DON) was notified that the surveyor could not locate any documentation in R2's EMR that would indicate the facility addressed advanced directives with R2. The DON stated she would look in the file folders and boxes in her office to see if the facility had addressed advanced directives when R2 was admitted . A copy of R2's advanced directives documentation was requested from the DON, if any could be located. During the same interview on 02/10/2026 at 3:00 PM, the DON was notified that a copy of R2's PASARR Level 1 screening could not be located in their medical record. The DON stated she would look and see if she could locate it within a stack of documents that were in her office that had not been scanned into residents' medical records. She stated the facility has had some issues with getting resident documents scanned into the residents medical records. A copy of R2's PASARR Level 1 screening was requested from the DON, if one could be located. On 2/10/2026 at 4:48 PM, the facility provided an undated and unsigned copy of a PASARR Level 1 screening for R2. In addition, the PASARR Level 1 screening did not even have the name (typed or printed) or the title of the individual who allegedly completed the form. The PASARR Level 1 screening revealed R2 had current mental illness diagnoses and was being treated for mental illness. A second review of R2's EMR, dated 1/13/26 to 2/11/26, revealed the facility loaded R2's PASARR into the medical record on 2/10/26.During a second interview on 02/11/2026 at 08:40 AM, the DON verbally verified that she could not locate R2's advanced directives in her medical record. She stated the facility completed an advanced directives form (Medical Treatment Decisions of Resident form) for R2 yesterday (2/10/26) when she could not locate a completed form. During an interview on 02/11/2026 at 11:10 AM, Social Services (SS) A presented a PASARR Level 1 screening form to the surveyor that indicated the form had been completed by a Registered Nurse (RN) on 2/10/26 at 3:39 PM (28 days after R2 was admitted to the facility and approximately 30 minutes after the form was requested from the DON) with the name of the RN typed in. However, the RN had failed to sign the form. In addition, SS A confirmed that the PASARR Level 1 screening form that was in R2's EMR at the time of this conversation lacked the date and time the form was completed, typed/printed name and title of the individual who completed the form, and the signature of the individual who completed the form. R3 A review of R3's Face Sheet, dated 2/11/26, revealed R3 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R3's Face Sheet revealed they had multiple diagnoses that included depression, psychotic disorder with delusions, insomnia, and anxiety. A review of R3's Pharmacist Drug Regimen Review forms, dated 12/4/24 to 2/10/26, revealed that the pharmacist had noted that a report was made for noted irregularities and/or recommendations on 3/13/25, 4/3/25, 10/13/25, 11/5/25 and 12/8/25. In addition, the Pharmacist Drug Regimen Review form for 5/19/25 did not indicate if R3's medications were reviewed on that visit (the bubbles for No Recommendations or Please take the following action directed below were not checked and the area for inputting (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	actions was blank. A review of R3's electronic medical record (EMR), dated 1/13/26 to 2/10/26, failed to reveal any pharmacy Consultation Reports for 3/13/25, 4/3/25, 5/19/25, 10/13/25, 11/5/25, and/or 12/8/25 that would indicate what irregularities and/or recommendations were made by the pharmacist. During an interview on 2/11/26 at 11:00 AM, the DON confirmed that R3's pharmacy Consultation Reports for 3/13/25, 4/3/25, 5/19/25, 10/13/25, 11/5/25, and/or 12/8/25 were in boxes/file folders in her office and had not been scanned into R3's medical record. A review of the facility's Medication Regimen Review policy and procedure, dated 11/28/16, revealed, 12. Facility should maintain readily available copies of MRRs on file in Facility as part of the resident's permanent health record. R27A review of R27's Face Sheet, dated 2/12/26, revealed R27 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple diagnoses that included obstruction of the bile duct and weakness, A review of an Interdisciplinary Team note, dated 1/24/26 for 1/19/26, revealed R27 had been transferred to the hospital emergency room on 1/18/26 for evaluation and treatment of excessive purulent drainage (thick, milky, or opaque fluid often having a foul odor that signifies an active infection) from R27's biliary drain (a thin tube that is inserted through the skin into the liver and that drains fluid into a bag). In addition, the Interdisciplinary Team note revealed R27 had been transferred to another hospital for treatment, management, and admission. A review of R27's electronic medical record (EMR), dated 1/6/26 to 2/12/26, failed to reveal that the facility had provided R27 with written notice of their bed hold policy when she was transferred to the hospital emergency room on 1/18/26. In addition, R27's EMR failed to reveal if the facility had provided written notice of their bed hold policy at any time after her admission. During an interview on 02/12/26 at 10:20 AM, the Director of Nursing (DON) was informed that the surveyor could not locate the written notice of the facility's bed hold policy that R27 should have received on admission and prior to, or soon after, her transfer on 1/18/26 to the hospital emergency room. The DON stated she would look and see if it was in a stack of unfiled paperwork in her office. A copy of the written notifications were requested from the DON, if she could locate them. During a second interview on 02/12/26 at 10:30 AM, the DON stated the facility did not give R27 written notification of the facility's bed hold policy when she went to the emergency room on 1/18/26. She stated they only gave her the bed hold policy when she was admitted to the facility. The DON was able to provide a copy of the bed hold policy that R27 was presented with on 1/6/26 and verified that it was not scanned into R27's medical record but had been in a box/file folder in her office. A review of the facility's Bed Hold policy and procedure, reviewed 01/25, revealed, 1. The facility Social Worker or designee will provide a copy of the bed hold policy to the resident and/or the resident representative at the time of admission and again prior to a transfer due to hospitalization or therapeutic leave. The signed copies will be maintained in the resident's financial or personal file. Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice. Documentation of nurses' work is critical as well for effective communication with each other and with other disciplines. It is how nurses create a record of their services for use by payors, the legal system, government agencies, accrediting bodies, researchers, and other groups and individuals directly or indirectly involved with health care. It also provides a basis for demonstrating and understanding nursing's contributions both to patient care outcomes and to the viability and effectiveness of the organizations that provide and support quality patient care. Timely documentation of the following types of information should be made and maintained in a patient's EHR to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care- Assessments. Communications with other health care professionals regarding the patient; Communication with and education of the patient, family, and the patient's designated support person and other third parties. Order acknowledgement, implementation, and management. Patient documentation frequently is used by professionals who are not directly involved with the patient's care. If patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not familiar with the patient's care to use the documentation. (ANA's (American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www.nursingworld.org, retrieved on 7/27/25).