STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Chateau Health and Rehabilitation Center	2319 West Seventh Street Saint Paul, MN 55116

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure smoking safety interventions were identified, implemented, and monitored for 1 of 1 resident (R29) reviewed who used oxygen and smoked. The facility also failed to provide adequate supervision to ensure oxygen was not taken into the designated smoking area, which resulted in an immediate jeopardy (IJ) when R29, who had oxygen present and was observed smoking and in close proximity to others who were smoking and present in the smoking patio, which posed a serious safety risk of fire or explosion and endangering R29 and others.The IJ began on 9/15/25 at 6:46 p.m., when R29 was observed on the outdoor smoking patio with a portal oxygen tank and in close proximity to other residents smoking. The chief operation officer, administrator in training, vice president of clinical services were notified of the immediate jeopardy on 9/15/25 at 9:18 p.m. The IJ was removed on 9/16/25 at 3:30 p.m., but non-compliance remained at the lower scope and severity level of D, isolated with no actual harm but potential to cause more than minimal harm. Findings include:R29's admission Minimum Data Set (MDS) assessment dated [DATE], indicated tobacco use and oxygen therapy.R29's significant change in status MDS assessment dated [DATE], indicated R29 was admitted [DATE], cognitively intact, utilized a manual wheelchair, independent with upper body dressing, personal hygiene, transfers, diagnoses included diabetes, respiratory failure, chronic pain, no current tobacco use, no oxygen therapy.R29's care plan indicated:Revision on 6/23/25, impaired gas exchange; administer oxygen as prescribed or per standing order 2L (liter) per NC (nasal cannula) to keep sats greater than 90%.6/25/25, tobacco use and educate on risks and health effects of tobacco useRevision on 7/30/25, indicated R29 does not harm self or others, vulnerable adult due to physical limitations and traumatic life events, interventions included: if poses a potential threat to injure self or others notify provider, room smelled like smoke, cigarettes and lighter were taken, must request cigarette from nurse and smoke the entire cigarette outsideR29's medication administration record dated 9/1/25-9/30/25, indicated O2 (oxygen) via nasal cannula 2L/min every evening and night shift related to acute and chronic respiratory failure. Wean 02 off patient during the day. Keep 02 sats greater or equal to 90%.R29's Smoking and Safety assessment dated [DATE], indicated R29 used tobacco, lethargic/falls asleep easily during tasks or activities, drops ashes on self, unable to use ashtray to extinguish tobacco or marijuana, unable to smoke safely, fails to follow facility's smoking policy, seen smoking in room with oxygen.R29's Smoking and Safety assessment dated [DATE], indicated R29 used tobacco, lethargic/falls asleep easily during tasks or activities, unable to use ashtray to extinguish tobacco or marijuana, keep cigarette and lighter at the nurse station and give when out to smoke only, resident is compliant.R29's smoking observation dated 9/16/25 at 11:14 a.m., indicated R29 was a current smoker, gets up at night to smoke, able to smoke independently, smoking material kept at the nurse station, educated to wait for the nurse to deliver cigarettes, R29 verbalized understanding, R29's nursing progress notes:6/24/25 at 9:57 p.m., R29 has been smoking in his room this evening even though he has oxygen tank in his room when asked, resident stated that the smell came from outside. Meanwhile residents window is shut tight writer found a pack of (continued on next page)

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	cigarette and lighter on resident's table ashes on the floor and bed linen, cigarettes removed from resident's room and put in narcotic box resident is unable to smoke safely at this time nursing to follow through and assist.6/25/25 at 8:35 a.m., late entry for 6/24/25, writer was informed by both nurse and maintenance that there was a very strong smell of cigarettes coming from the residence room, writer then to talk to residents about the smoking policy. Resident acknowledged and stated he was not smoking and that he would not smoke in the room.6/30/25 at 9:36 a.m., late entry social service note indicated, writer was informed by a nursing assistant that resident was smoking in his room while wearing his O2. Resident eventually gave up his cigarette to the COO (chief operating officer) and other boxes of cigarettes were taken from him as this is not his first incident of smoking in his room when he was asked who gave him the cigarettes he responded I'm not telling you anything and I don't give a [explicit] who you are , resident was educated then not to smoke in his room and his response was I don't [explicit] care what you say. will have social worker meet with resident regarding behavior.6/30/25 at 12:15 p.m., social service note indicated writer was informed by staff that resident was smoking in his room writer followed up with the resident and he stated that he smoked in his room due to panic attack writer encouraged him to reach out for help during the panic attack instead of smoking. Writer also educated resident on the risks of smoking in his room with the oxygen in use smoking policy was provided resident acknowledged and said that he will not smoke in his room anymore, writer shared that if his this continues he'll be given a 30 days eviction notice which he said he is OK with and would not mind getting discharged to a homeless shelter if placement is not found, writer reached out to his mother informed her of the concern and requested their support.8/14/25 at 6:10 a.m., indicated R29 insisted to have his cigarettes given to him to keep in his room, he said he can go out now so he would not smoke in his room ever again, he kept the box of cigarettes and the lighter with him.9/15/25 at 8:35 p.m., administrator note indicated right there met with the resident to review facility smoking policy, specifically regarding the safety risk of smoking for being in the designated smoking area with oxygen in place. Resident was educated that oxygen must be removed and stored at the nurses station prior to exiting the building near the smoking area following education right to remove cigarettes and lighters from their residence room a room search was completed and additional loose tobacco and cigarette tubes were located and removed.9/16/25 at 9:16 a.m., the director of nursing progress note indicated writer met with resident to speak with him regarding the safety incident that occurred on 9/15/25, writer asked the resident if he understood the severity of the incident to which the resident stated no, I wasn't even smoking writer educated the resident on the dangers of having oxygen near open flame and explained that it included having the oxygen on or near the other smokers the resident stated he now understood and would no longer bring the oxygen to the smoking area, the resident also asked for his tobacco and tubes backEmail dated 9/15/25 at 1:18 p.m., registered nurse (RN)-C, who was known as the vice president of clinical services, provided entrance information to the surveyor and the residents who smoked included R, R4, R9, R10, R26, and R35. The list did not contain R29. RN-C sent an updated on 9/15/25 at 9:20 p.m., and added smokers R36, R39, and R43.On 9/16/25 at 8:33 p.m., RN-C indicated in an email confirmed the residents who smoked included: R9, R10, R4, R2, R26, R29, R35, R36, and R39.On 9/15/25 at 6:46 p.m., R29 was observed in the designated smoking patio seated in a wheelchair with a portable oxygen tank on the back of the chair, connected to oxygen via nasal cannula at 2 liters per minute. R29 was not actively smoking at this time, and stated his oxygen was off and then observed R29's oxygen at 2 liters and R29 used his hand to turn the knob to 0 on the oxygen tank. Three other residents (R36, R39, and one unidentified) were observed actively smoking cigarettes in close proximity (3 to 6 feet) of R29. R29 was confronted and admitted to smoking while oxygen was on, stating, I'm willing to take the risk if I blow up, and If oxygen was that flammable, the whole world would be on fire.On 9/15/25 at 6:55 p.m., R29 was seated in a wheelchair with the oxygen tank on the backside of his wheelchair and turned off and R29 was observed to smoke a cigarette. RN-C (vice president of clinical services) was walking by the inside doors of the smoking patio and confirmed (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	there was risk of oxygen use in proximity to smoking, stating poof everyone could be gone. RN-C was observed to discuss the safety concerns with R29, when R29 became upset and was observed and threw the oxygen tank to the ground. The oxygen tank was observed to be whistling under pressure.On 9/15/25 at 7:32 p.m., the administrator, who served as the chief operating officer, stated that R29 was known to keep cigarettes and a lighter in his room. The administrator acknowledged being unaware of current unsafe smoking practices involving R29 but confirmed that oxygen tanks were not supposed to be outside where smoking occurred, as things could blow up. The administrator further stated that if a resident was known to smoke in their room, cigarettes and lighters should not be in their possession or in the room.On 9/15/25 at 7:34 p.m., RN-C stated upon admission a smoking assessment was completed on all residents and expected the smoking assessment followed and stated care plans should address residents who used oxygen. RN-C stated the risk of oxygen use near smoking was things could blow up.On 9/15/25 at 7:44 p.m., licensed practical nurse (LPN)-D stated R29 kept his cigarettes and lighter on himself in his room and stated it was terrible if residents brought the oxygen tank outside when smoking. LPN-D was observed in R29's room and confirmed R29 had cigarettes, tobacco and lighters in his room. On 9/15/25 at 7:57 p.m., the administrator stated after reviewing R29's progress notes she remembered speaking with R29 previously and stated R29 was found smoking in his room previously and education was given to him at that time and stated the cigarettes and lighter were expected to be in the med cart and not in R29's room, due to the R29's previously smoking in his room. The administrator stated R29 would not be allowed to go out and smoke again until another smoking assessment was completed.On 9/15/25 at 8:37 p.m., the administrator stated that she did not search his room for other smoking materials but does know he has a bag of tobacco in his room. The administrator left to ensure all smoking materials were moved from his room.On 9/15/25 at 8:46 p.m., the administrator stated R29's room was searched and no more lighters were found but two bags of tobacco were removed from R29's room and locked and secured.On 9/19/25 at 10:25 a.m., during a telephone interview the medical director stated no residents should have oxygen present where other residents are or could be smoking as was a safety risk.The facility policy titled Smoking Policy - Residents dated 3/21/24, indicatedThis facility shall establish and maintain safe resident smoking practices.Prior to, and upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences.Smoking is only permitted in designated resident smoking areas, which are located outside of the building (2nd floor, east exit). Electronic cigarettes may be permitted outside in designated areas only. Otherwise, smoking is not allowed inside the facility under any circumstances.Oxygen use is prohibited in smoking areas.The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include: current level of tobacco consumption; method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe, etc.); desire to quit smoking, if a current smoker; and ability to smoke safely with or without supervision (per a completed Smoking Observation).A resident's ability to smoke safely will be evaluated upon admission/readmission, quarterly, upon a significant change (physical or cognitive) and as determined by the staff.Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues.The facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely. Current smoking times are from 7:00am until 9:45pm. These times are subject to change.Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a family member, visitor or volunteer worker (if available) at all times while smoking.Residents who have independent smoking privileges are permitted to keep cigarettes, e-cigarettes, pipes, tobacco, and other smoking articles in their possession. Only disposable safety lighters are permitted. All other forms of lighters, including matches, are prohibited.Residents are not permitted to give smoking articles, assist with lighting another resident's cigarette or sharing tobacco (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	or lighters to other residents.Residents without independent smoking privileges may not have or keep any smoking articles, including cigarettes, tobacco, etc., except when they are under direct supervision.This facility maintains the right to confiscate smoking articles found in violation of our smoking policies.Confiscated resident property will be itemized and ultimately returned to the resident, or his or her legal representative. When the property is returned will be determined during a meeting with the resident or representative regarding the circumstances that led to the confiscation.The IJ was removed on 9/16/25 at 3:30 p.m , when the facility developed and implemented a systemic removal plan which was verified by interview, observation, and document review. On 9/15/25, the smoking policy and procedure was reviewed by the facility leadership. On 9/15/25, signage was posted indicating no oxygen was allowed at the exit point to the designated smoking area. On 9/15/25 at 8:46 p.m., R29's room was searched and tobacco and lighters were removed from the R29's room. On 9/15/25, and 9/16/25, all current residents who smoke had a smoking assessment completed and care plans were reviewed and/or updated. No other residents who smoke utilize oxygen. On 9/16/25 at 11:14 a.m., R29 had a smoking assessment completed, which indicated R29 was able to smoke independently, and smoking material kept at the nurse station. The facility-initiated training on 9/15/25, with a mass electronic message sent to staff, along with verbal education beginning on 9/15/25. On 9/16/25, the vice president of clinical services, chief operating officer and administrator in training conducted in-service education with staff regarding oxygen use was prohibited in smoking areas. The facility plans to continue education process with on-coming staff and all staff are required to sign attesting education was received.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and document review, the facility failed to ensure metal pans were clean and dry before storing. In addition, the facility failed to monitor dish machine temperatures to ensure dishes were properly cleaned and sanitized. Further, the facility failed to ensure food temperatures were documented at the time of meal service. In addition, the facility failed to follow manufacturer's instructions for cleaning and sanitizing 2 of 2 ice machines used for resident consumption. This had the potential to affect all 42 residents who resided in the facility. Findings include:WET PANSDuring the initial kitchen tour on 9/15/25 at 11:55 a.m., with dietary aide (DA)-B, metal pans of various sizes were observed stacked upside down on top of one another on a tall wire cart. The inside surfaces of three large rectangle pans were dripping wet with water when DA-B lifted them off one another. One of the pans had clearly not been cleaned as the entire bottom of the pan resembled what it would look like if cake were scraped out of the pan. DA-B stated it was from chicken and dumplings. Three jelly roll pans on a different rack were also wet. DA-A who had been washing dishes stated he dried the pans for a minute or two then put them away on the wire racks. DA-A could not recall if he had been educated on the importance of completely drying dishes and pans before storage. MONITORING DISH MACHINE TEMPERATURESDuring the initial kitchen tour on 9/15/25 at 11:55 a.m., with DA-B, observed a paper form titled Daily Dish Machine Temperatures taped to the wall in the dish washing area. The month printed on it indicated August 2025. DA-B stated the form indicated August, but it was really for September. The last date filled in was 9/8/25 (a week ago). The wash and rinse temperatures through 9/8/25, had been documented once per day, and all temperatures had been the same (all wash temperatures were 165 degrees Fahrenheit [F]) and all rinse temperatures were 185 degrees F). The instructions on the form included: Record wash and rinse temperatures when washing dishes two times daily. Neither DA-A nor DA-B could verbalize whether or not temperatures were actually being taken and not recorded or not taken. Neither could explain why the temperatures were only being documented once a day when the sheet indicated twice a day. During an observation and interview on 9/17/25 at 10:55 a.m., with dietary manager (DM)-F, observed the Daily Dish Machine Temperatures form was no longer hanging in the dishwashing area. DM-F was not able to verify if staff had been monitoring temperatures the past two days since there was no place for staff to document it. DM-F stated she expected staff to monitor temperatures once per day and to record it. When pointed out the instructions directed staff to record wash and rinse temperatures two times daily, not just once, DM-F did not comment. During the same interview, DM-F was informed of observation of wet and dirty metal pans, and the interview with DA-A who stated he did not know pans needed to be fully dried before stacking/storing. DM-F stated DA-A had been trained by her, but she did not document the training.DOCUMENTATION OF FOOD TEMPERATURESDuring observation and interview on 9/17/25 at 11:00 a.m., observed cook (C)-A measure temperature of the food using a food thermometer. Neither during nor after, did C-A write down the temperatures obtained. DM-F who was also present, stated they did not document food temperatures, adding, I thought about it when she started working there but did not implement a process nor train staff. DM-F admitted she would not be able to verify food temperatures in the event of an outbreak of vomiting and diarrhea potentially caused by a foodborne illness or serving undercooked food. During an interview on 9/18/25 at 11:59 a.m., the administrator was informed of findings and stated she had been made aware by DM-F. Kitchen/dietary specific training records were requested for the following dietary employees:--Cook -A (hire date 5/13/25) - No documentation of orientation/training related specifically to kitchen/dietary.--DA-A (hire date 7/28/25). DA-A signed a documented titled Dietary Aide on 7/29/25, but it was a job description rather than an orientation/training record. --DA-B hire date 6/20/24) - No documentation of orientation/training related specifically to kitchen/dietary.ICE MACHINE CLEANING AND DISINFECTIONOn 9/15/25 at 11: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	55 a.m., an ice machine was observed on second floor outside the entrance to the kitchen. DA-B stated there were two ice machines in the facility used for residents when staff filled their water mugs.On 9/17/25 at 9:15 a.m., an ice machine was observed in the first-floor kitchenette. The administrator provided manufacturer instructions for the facility's two ice machines: --Ice machine in the Kitchen: Hoshizaki Low Profile Modular Crescent Cuber with revised date of 11/7/2018. Page 32 indicated the icemaker must be cleaned and sanitized at least once a year. Cleaning procedure included 32 steps. The first eight steps listed below: Dilute Hoshizaki Scale Away with warm water. Remove all ice from the evaporator and the dispenser unit/ice storage bin. Turn off power supply.Remove the front panel, then move the service switch to DRAIN position. Move the control switch to the SERVICE position. Replace front panel, turn on power supply for two minutes.Turn off power supply. Remove front panel.In bad or severe water conditions, clean the float switch assembly as described. Otherwise continue to step 9. --Ice machine in first floor kitchenette: Scotsman Ice-Maker Dispenser November 2008. Page 10 indicated the sanitation and cleaning procedure and included 19 steps. The first 12 steps listed below:This ice machine requires periodic sanitation and de-mineralization.1. Vend all ice from the machine.2. Remove top and right-side panels.3. Unplug or disconnect electrical power.4. Shut off water supply.5. Drain reservoir.6. Mix 8 ounces of Scotsman Ice Machine Scale Remover and 3 quarts of hot potable water.7. Pour the water into the reservoir.8. Wait 15 minutes for the cleaner to dissolve the minerals inside the evaporator.9. Plug in the machine or reconnect electrical power.10. As the machine operates, pour in the balance of the cleaning solution.11. Reconnect water supply, operate the machine for 15 more minutes, then switch it off.12. Repeat steps 3-11, except substitute a locally approved sanitizing solution for the cleaner. A possible sanitizing solution may be obtained by mixing 1 ounce of household bleach with 2 gallons of clean, warm water.During a telephone interview on 9/18/25 at 1:36 p.m., with the administrator, maintenance supervisor (MS)-A and language interpreter via administrator's cell phone, MS-A was asked if he followed manufacturer instructions for cleaning and disinfecting ice machines. MS-A replied, Honestly, I've never cleaned those machines. MS-A explained a company used to come in and clean them - up to 2 years ago, but no longer. MS-A stated he did only light cleaning on them. The importance of cleaning and disinfecting the ice machine according to manufacture instructions was explained (the potential for contaminated ice affecting residents, including bacteria causing legionella). The administrator stated they would address this. Facility Cleaning Dishes/Dish Machine policy dated 2023, indicated the dish machine would be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing. Prior to use, proper temperatures and/or chemical concentrations and machine function should be verified. Staff should check temperature gauges on dish machine throughout the cycle to ensure proper temperatures for sanitation. Dishes should be air dried on racks. Inspect for cleanliness and dryness and put dishes away if clean. Dishes should not be nested unless completely dry. Facility General HACCP (Hazard Analysis of Critical Control Points) Guidelines for Food Safety policy dated 2017, was not a policy but recommended training for food and nutrition staff. It included to check food temperatures and record temperatures. In addition, for dishwashing, it indicated to document dishwashing temperatures on a temperature log. Air dry dishes; do not stack immediately after washing.Facility Cleaning Ice Machine policy dated 5/22, indicated the ice machine would be cleaned and sanitized on a regular basis. Follow manufacturers cleaning and sanitizing instructions if available.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and document review, the facility failed to ensure the Quality Assurance Assessment and Performance Improvement Plan (QAPI) committee effectively sustained ongoing compliance related to repeat citations from past surveys in regards to quality of care, accuracy of assessments, activities of daily living (ADL) care provided, accidents, nutrition, tube feeding, sufficient nursing staff, food procurement, infection prevention and control and pest control, and were also identified during this survey. Additionally, the facility failed to have evidence of a Performance Improvement Project (PIP) which focused on high risk or problem-prone areas, identified thorough and appropriate data collection, analysis and evaluation of the identified concern(s) during QAPI. This had the potential to affect all 42 residents residing in the facility.Findings include: Review of the Provider History report printed 9/15/25, identified the facility had repeat deficiencies related to F641 accuracy of assessments, F684 quality of care, F689 free of accident and hazards, F692 nutrition/hydration status maintenance, F554 self-administration of medications, F677 ADL care, F812 food procurement, store/prepare/serve, F880 infection control, F656 develop/implement comprehensive care plan, F698 dialysis, F725 sufficient nursing staff, F759 free of medication error rate 5% percent or more.See F554: Based on observation, interview and document review the facility failed to ensure residents were assessed for safe self-medication administration for 4 of 4 residents (R13, R1, R14, R37) who had medications at the bedside. See F641: Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately coded for 2 of 2 residents (R14, R37) reviewed for MDS accuracy.See F656: Based on interview and document review, the facility failed to ensure the care plan included management and monitoring of an antipsychotic medication for 1 of 2 residents (R2) reviewed for antipsychotic use. See F657: Based on observation, interview and document review, the facility failed to ensure care plans were revised and updated with current health status for 3 of 4 residents (R13, R27, R4) reviewed for care planning. See F676: Based on observation, interview, and document review, the facility failed to ensure activities of daily living (ADL) assistance was provided for 1 of 1 resident (R27) reviewed for ADLs who required supervision and cueing during meals.See F677: Based on observation, interview, and document review, the facility failed to ensure activities of daily living (ADL) assistance was provided for 1 of 1 resident (R14) reviewed for ADLs and who were dependent on staff for such cares.See F684: Based on observation, interview and document review the facility failed to ensure wound care orders were implemented for 2 of 2 residents (R13, R26) who had venous ulcers (skin openings caused by weak blood circulation), failed to ensure provider-ordered leg measurements were completed and documented for 1 of 1 resident (R29) reviewed for edema management, and failed to obtain a weight upon admission and follow orders for 1 of 3 (R46) residents reviewed for hospitalization. See F689: Based on observation, interview, and record review, the facility failed to ensure smoking safety interventions were identified, implemented, and monitored for 1 of 1 resident (R29) reviewed who used oxygen and smoked. The facility also failed to provide adequate supervision to ensure oxygen was not taken into the designated smoking area, which resulted in an immediate jeopardy (IJ) when R29, who had oxygen present and was observed smoking and in close proximity to others who were smoking and present in the smoking patio, which posed a serious safety risk of fire or explosion and endangering R29 and others.See F692: Based on observation, interview, and document review, the facility failed to ensure a nutritional supplement was ordered and implemented per the dietician recommendation for 1 of 1 resident (R3) reviewed for food.See F693: Based on observation, interview and document review, the facility failed to follow physician orders to provide appropriate gastrostomy/jejunostomy (GJ Tube) tube feeding (TF) solution and to use appropriate tube to administer medication for 1 of 1 resident (R41) reviewed for tube feeding administration. See F698: Based on observation, interview, and record review, the facility failed to ensure ongoing assessment of resident's condition and monitoring (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	for complications before and after dialysis treatments and failed to ensure ongoing communication and collaboration with the dialysis facility regarding dialysis care and services for 1 of 1 resident (R4) reviewed for dialysis services.See F725: Based on observation, interview, and record review the facility failed to have sufficient staff available to provide nursing and related services to meet the residents' needs in a manner that promotes each resident's right to physical, mental, and psychosocial well-being for 10 of 10 residents reviewed for sufficient staffing (R3, R4, R5, R11, R18, R23, R29, R37, R43, R53).See F759: Based on observation, interview and document review, the facility failed to ensure a medication error rate of less than 5 percent (%). 3 medication errors occurred out of 35 opportunities resulting in an error rate of 8.57% for 2 of 5 residents (R41, R19) observed during medication administration. See F812: Based on observation, interview and document review, the facility failed to ensure metal pans were clean and dry before storing. In addition, the facility failed to monitor dish machine temperatures to ensure dishes were properly cleaned and sanitized. Further, the facility failed to ensure food temperatures were documented at the time of meal service. In addition, the facility failed to follow manufacturer's instructions for cleaning and sanitizing 2 of 2 ice machines used for resident consumption. This had the potential to affect all 42 residents who resided in the facility. See F880: Based on observation, interview, and document review the facility failed to ensure glucometer was cleaned per manufactures guideline for 1 of 1 resident (R9) observed for blood glucose testing, ensure enhanced barrier precautions (EBP) were followed for 2 of 2 residents (R26 and R41) observed for enhanced barrier precautions, ensure 1 of 1 resident (R26) had a clean water cup in place. In addition, the facility failed to ensure resident lift equipment was cleaned per manufactures guidelines, and a comprehensive Legionella prevention plan was in place. This had the potential to affect all residents who reside in the facility.See F925: Based on observation, interview and document review, the facility failed to implement an effective pest control program to eliminate mice in the building. In addition, concerns related to pest control in the facility were voiced by 4 of 4 residents (R3, R36, R10, R14). This failure had the potential to affect all 42 residents who resided in the facilityThe facility's QAPI meeting minutes dated 8/14/25, indicated significant concerns around skin assessments not being completed consistently, staffing challenges, weekly skin assessment not being completed, nurses not proactively leading certified nursing assistants (CNA) in completing assessments, plan to have PM (evening) supervisor do additional rounds on high risk meds, care plan for fall patient was not followed, staff not consistently reading/following care plans, not consistently doing antibiotic time outs, 1- new hires in July, but still significant openings, 60% of day shifts covered by agency staff, kitchen floor needs repair. Next steps indicated process to ensure consistent completion of skin assessments, retrain staff on following care plans, lacked ongoing data related to the above repeat citations.On 9/19/25 at 10:25 a.m., during a telephone interview the medical director (MD)-M stated the facility had previously been doing a multiple number of audits, and stated he was unaware what current audits were still taking place due to the change in leadership, and stated the facility was stated the facility was expected to perform audits and document areas of concern addressed during QAPI.On 9/19/25 at 1:03 p.m., the chief operating officer (COO), who was serving as administrator, and registered nurse (RN)-C, who was also the vice president of clinical services stated the QAPI committee met monthly, and the medical director completed the minutes. The COO and RN-C stated the facility QAA (Quality Assessment and Assurance) and QAPI groups met regularly with the medical director to review areas identified as needing improvement within the facility. The COO and RN-C further stated the QAPI committee was expected to perform audits and review audit findings month to month to determine problems. The COO and RN-C confirmed the facility was not currently conducting audits due to leadership turnover. The COO stated audits would still be expected to be in place to set the facility up for success, and both the COO and RN-C stated audits should continue due to ongoing concerns in multiple areas. The COO and RN-C confirmed the facility had no data or documentation related to tracking compliance with previous surveys. They further stated they could not recall what the facility's PIP was, and confirmed there was no information (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	posted regarding any active PIP.On 9/19/25 at 2:19 p.m., during a follow up interview RN-C verified there was no documentation to support a PIP was identified or performed. Facility Policy titled Quality Assurance and Performance Improvement (QAPI) Committee dated 4/25/25, indicatedPolicy StatementThis facility shall establish and maintain a Quality Assurance and Performance Improvement (QAPI) Committee that oversees the implementation of the QAPI Program.1.The Administrator shall delegate the necessary authority for the QAPI Committee to establish, maintain and oversee the QAPI program.2.The committee shall be a standing committee of the facility and shall provide reports to the Administrator and governing board (body).3.Help identify actual and potential negative outcomes relative to resident care and resolve them appropriately.4.Support the use of root cause analysis to help identify where patterns of negative outcomes point to underlying systematic problems.5.Help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality of care.6.Coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals; and7.Coordinate and facilitate communication regarding the delivery of quality resident care within and among departments and services, and between facility staff, residents, and family members.a. Establishing performance and outcome indicators for quality of care and services delivered in the facility.b Choosing and implementing tools that best capture and measure data about the chosen indicators.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure glucometer was cleaned per manufactures guideline for 1 of 1 resident (R9) observed for blood glucose testing, ensure enhanced barrier precautions (EBP) were followed for 2 of 2 residents (R26 and R41) observed for enhanced barrier precautions, ensure 1 of 1 resident (R26) had a clean water cup in place. In addition, the facility failed to ensure resident lift equipment was cleaned per manufactures guidelines, and a comprehensive Legionella prevention plan was in place. This had the potential to affect all residents who reside in the facility. Findings include: Glucometer R9's face sheet dated 5/17/25, indicated R9 had diagnoses of diabetes and left below the knee amputation. A document titled Evencare G3 Healthcare Professional Operators Manual dated 2017, directed the Evencare G3 meter should be disinfected between each resident. A list of approved products for cleaning were listed. Alcohols wipes were not included in the approved products. An observation on 9/17/25 at 8:30 a.m., licensed practical nurse (LPN)-C obtained a Evencare G3 glucometer and test strips from the medication cart and entered R9's room. LPN-C stated blood sugars were already checked on residents; however, they wanted to recheck R9's blood glucose as it was on the lower side earlier. R9 was eating breakfast. LPN-C obtained the glucose check and it was within normal range. Upon returning to the medication cart, LPN-C set the glucometer on the cart and pushed the cart down to the next room. Sanitizing wipes were not observed on the medication cart. At 8:46 a.m., LPN-C used an alcohol wipe to wipe down the glucometer and put it back in the basket located on top of the medication cart. When interviewed on 9/17/25 at 10:14 a.m., the director of nursing (DON) stated all residents should have personal glucometers int their room and nurses should be using those. DON stated she was not sure what the policy was at the facility, however felt the Sani-Wipes wipes, with the purple top should be utilized and not alcohol wipes. A facility policy for disinfecting equipment was requested however was not received. EBP/Dirty cup R26's annual MDS dated [DATE], indicated R26 was cognitively intact and had diagnoses of chronic venous hypertension and lymphedema. R26's integrated wound care provider note dated 9/11/25, indicated R26's venous wounds were deteriorating. R26's electronic medical record lacked indication R26 requited EBP. An observation and interview on 9/15/25 at 12:12 p.m., R26's room did not have signage indicating EBP were required. R26 was sitting in a chair at bedside in their room. Both legs were wrapped in kerlix wrap. R26 stated the towel was on the floor in case the wounds started leaking. R26 stated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	staff only wore gloves when completing dressing changes. R26's bedside table was in front of them and on the table was a clear mug, no cover and a straw. At the top of the mug was a dark black/brown substance around the rim and in the groove where a lid would be snapped on. R26 stated he had this water cup for a few weeks. An observation on 9/17/25 at 9:41 a.m., a clear mug, no cover and a straw. At the top of the mug was a dark black/brown substance around the rim and in the groove where a lid would be snapped on was sitting on R26's bedside table. When interviewed on 9/17/25 at 9:45 a.m., nursing assistant (NA)-A verified R26's mug was very dirty and needed to be washed. Water mugs should be changed out each morning. NA-A further stated there were “water rounds” in the morning where new mugs of water should be delivered and the ones in the room removed for washing. Furthermore, NA-A stated when attempting to do water rounds, the kitchen did not have any clean mugs and said they were all in use. An observation and interview on 9/18/25 at 11:16 a.m., the administer in training (AIT) was adding a cart of personal protective equipment (PPE) to the outside of R26's room. AIT stated R26 went to the emergency room to have the wounds tested for Methicillin-Resistant Staphylococcus Aureus (MRSA) (contagious bacteria resistant to antibiotics). AIT indicated wanted to ensure transmission-based precautions (TBP) were in place for when R26 returned. When interviewed on 9/17/25 at 10:14 a.m., the director of nursing (DON) expected staff to change water cups daily and to ensure they are clean. Furthermore, ensuring clean cups were important minimize risk of infection. When interviewed on 9/18/25 at 12:19 p.m., registered nurse (RN)-C and DON verified R26 had not been previously placed on EBP. Furthermore, RN-C stated this was a miss and with R26's venous wounds, should have been on them earlier. EBP/CLEANING LIFTS R41's face sheet received 9/19/25, identified diagnose including acute hemiplegia (one sided paralysis) following cerebral infarction (stroke) affecting right dominate side, protein calorie malnutrition, dysphagia (difficulty swallowing) following cerebral infarction and aphasia (damage to the areas of the brain responsible for language that impairs language expression and comprehension) following cerebral infarction. R41's quarterly MDS assessment dated [DATE], included R41 sometimes understands but is rarely understood and has severely impaired cognitive decision making skills. R41 had no speech. R41 received greater than 50% of nutrition through artificial means. R41 was dependent on staff for all activities of daily living. R11's quarterly MDS dated [DATE], included diagnoses of heart failure, high blood pressure, renal insufficiency, diabetes mellitus. R11 had intact cognition and required substantial to maximal assistance with transfers. R11 does not walk and used a manual wheelchair requiring substantial to maximal assistance. On observation 9/16/25 at 3:01 p.m., R41 had an enhanced barrier sign on his door. A cart with gowns, gloves, masks and hand hygiene supplies was present between his and the next room. Nursing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	assistant, NA-I entered R41's room without a gown but wore gloves. NA-K donned a gown and gloves and entered the room. R41 was in his wheelchair and NA-I and NA-K used a mechanical lift machine, to transfer R41 into his bed. R41 was then rolled side to side while peri-care was provided and brief was changed. NA-I parked the lift outside of R41's room and left the area. During interview on 9/16/25 at 3:33 p.m., NA-K stated that NA-I should have worn a gown along with gloves when providing direct resident care when residents are on enhanced barrier protections (EBP). NA-K also stated lifts should always be cleaned after use and before being parked in the hallway. During interview 9/16/25 at 3:34 p.m., licensed practical nurse (LPN)-A stated staff frequently asked her questions regarding EBP, but there was a sign on the door that clearly indicated gown and gloves when giving cares. LPN-A also stated lifts needed to be cleaned prior to parking them in the hallway. On observation and interview 9/17/25 at 8:53 a.m., NA-A and NA-M entered R41's room wearing gloves but no gowns. NA-A checked R41's brief while NA-M rolled resident side to side. NA-A completed perineal care and applied a new brief, rolling R41 side to side. NA-A and NA-M stated they should have worn gowns while providing direct care, as R41 was on EBP. On interview 9/17/25 at 9:08 a.m., NA-A and NA-M entered R11's room with a lift that had been parked in the hallway. The lift had not been cleaned prior to entering the room. R11 was transferred from his bed to his wheelchair using the lift. NA-A removed the lift from the room and parked it in the hallway and walked towards the nurse's station and then answered another call light. At 9:28 a.m., NA-A confirmed the lift was not cleaned after use and should have been prior to parking it in the hallway. NA-A went to get some sanitizing wipes from the storage room and returned and wiped down the lift. Water Management Program: Review of the facility Legionella Water Management Program dated 10/18/22, included: Identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria; a detailed description and diagram of the water system in the facility, including receiving, cold water distribution; heating, hot water distribution and waste; identification of situations that can lead to Legionella growth; specific measures used to control the introduction and/or spread of Legionella; the control limits or parameters that are acceptable and that are monitored; a system to monitor control limits and the effectiveness of control measure; a plan for when control limits are not met and or control measures are not effective and documentation of the program. On interview 9/19/25 at 9:48 a.m., the administrator provided a facility Domestic Hot Water, Free Chlorine Testing log. The testing had been completed weekly. Ranges documented ranged from 0.3 to 2.7 but did not include volume measurement or what the normal levels are. The administrator stated it is not known what the normal levels should be for free chlorine levels. The administrator confirmed the plan does not specify what is to be monitored, where to monitor and what the normal levels are for what is being tested. The administrator also stated it does not include what to do if the normal parameters are not met. The administrator also confirmed the facility does not have a diagram of the water flow in and out of the building or water distribution within the facility.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to implement an effective pest control program to eliminate mice in the building. In addition, concerns related to pest control in the facility were voiced by 4 of 4 residents (R3, R36, R10, R14). This failure had the potential to affect all 42 residents who resided in the facility.Findings include:R3's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated moderately impaired cognition. R36's quarterly MDS assessment dated [DATE], indicated intact cognition. R10's quarterly MDS assessment dated [DATE], indicated intact cognition.R14 significant change MDS assessment dated [DATE], indicated intact cognition.During an interview on 9/15/25 at 6:16 p.m., R3 stated about three weeks ago he had seen mice running in the hallway, entering his bathroom, and going under his closet door. Observations occurred while lying in bed. During an interview on 9/15/25 at 6:24 p.m., R36 stated he had seen a mouse run under his bed recently - could not recall the date. R36 stated he went to the grocery store and bought his own mouse traps. Two traps were observed in the corner of the room. During an interview on 9/15/25 at 6:28 p.m., R10 stated he had seen two mice in his room two nights ago and stated he tried to hit them with his cane, adding it was kind of a game trying to get them with his cane. R10 stated there were traps in his closet.During an interview on 9/16/25 at 8:33 a.m., R14 stated she sees mice in her room in the open area between her bed and door and didn't know where they came from -- thinks the door. R14 stated they were playful and didn't bother her. During an interview on 9/17/25 at 3:36 p.m., R14 stated in the morning the floors are all nice and clean, then throughout the day, crumbs fall on the floor, then the mice come out at night and eat the crumbs. R14 stated they should clean the floors in the evening. During an interview on 9/18/25 at 8:23 a.m., housekeeper (H)-A stated she had seen mice on 9/11/25, on the east side, on both first and second floors. When she sees mice, she tells maintenance. During an interview on 9/18/24 at 9:26 a.m., H-B had seen dead mice and mice droppings recently and wrote the sightings in the logbook and informed maintenance. Last week she found and disposed of a live mouse on a sticky trap in R51's room. Had also found a dead mouse in a linen closet. Finds mice droppings when she cleans in resident closets and when a resident moves from one room to another, finds mouse droppings in the vacated room.During an interview on 9/18/25 at 9:32 a.m., the interim administrator stated the pest control company came to the facility weekly. The company provided the facility with Pest Sighting Reports - sheets of paper where staff could document rodent sightings. When the pest control employee came to the facility, he reviewed the sighting reports and addressed them. According to the administrator, the pest control employee went around the inside of the building to check traps and bait stations, and the outside of the building to look for potential places mice were getting in, plugged the holes, set up traps and bait stations and communicated with maintenance. When the pest control employee returned the next week, he checked the previous weeks work. The administrator stated residents would occasionally report a mouse, but she had not heard anything in the past month. The administrator stated they talk to residents about containing food in their rooms. The administrator stated the concern with mice in the building was they were dirty and carried disease. Expressed concern they still had areas where mice were getting in. The administrator was informed of recent mouse sightings reported by staff and residents and stated she was unaware. The administrator was concerned staff had become desensitized to reporting sightings of mice and would need to reeducate staff. The administrator stated they might need to switch from current pest control service to a different service since they were still having problems. During a telephone interview on 9/18/25 at 11:21 a.m., pest control service employee (PCS)-Q was aware of mice in the facility. PCS-Q stated he came weekly, checked the Pest Sighting Reports, bait stations and traps. Checked the outside of the building and had not seen any new holes on the outside of the building. PCS-Q stated his supervisors were aware of the current situation with mice at the facility. PCS-Q stated in his opinion, the best (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	they could do was keep mice under control, not eliminate them entirely. At 12:32 p.m., PCS-Q was on site at the facility and was asked to explain why he did not think mice could be eliminated entirely, and PCS-Q stated mice did not seem affected by their efforts despite trying multiple kinds of traps, bait stations, and powders. Reviewed pest control agency Pest Sighting Reports from 5/29/25, to 8/30/25 (the last date there was documentation of a sighting). There were 35 documented sighting primarily between 3:00 p.m., and 3:00 a.m. Mice were sighted in resident rooms by heat registers and under beds, in hallways, by doors going into the kitchen, by the smoking patio doors, in the dining room and by nurses' stations. One report indicated a resident saw a rat in a nurse's station. Both residents and staff were seeing and reporting mice. Sightings included baby mice.During an interview on 9/19/25 at 8:50 a.m., the administrator stated the facility had a known rodent problem. Earlier in 2024, they had a pest control service that did not seem effective and therefore switched to a different one in October 2024. Unaware if previous administrator who had recently terminated employment had contacted the current pest control company to ask why they still had a rodent problem. The administrator stated it might be time to look at another service. Facility Pest Control policy with revised date of 9/6/23, indicated the purpose was to establish a pest control program contract with a professional provider. On-going measures were taken to prevent, contain and eradicate common household pests such as roaches, ants, mosquitoes, flies, mice and rats. General measures to decrease pests included elimination of cracks and crevices, proper lighting and ventilation, use of screen on windows and doors, and the use of self-closing doors. All food stored in the dietary area was kept in a designated area in securely covered containers, off the floor and away from walls. All food items kept in resident rooms were stored in covered containers, with the exception of uncut fruits such as bananas and oranges. A contract with a pest control company would be elected to assure regular inspection and application of chemical pesticides. Staff would report all sightings of pest to the maintenance and/or environmental services director for pest control intervention. All state and local regulations were followed.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 document review the facility failed to ensure residents were assessed for safe self-medication administration for 4 of 4 residents (R14, R37, R13, R1) who had medications at the bedside. Findings include: R14's face sheet received on 9/19/25, included diagnoses of chronic respiratory failure (lungs unable to adequately exchange oxygen and carbon dioxide over an extended period), high blood pressure, kidney failure and atrial fibrillation (irregular heart rate causing poor blood flow). R14's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, was understood and could understand. R14 required substantial assistance for activities of daily living (ADLs). R14's medical record did not include an assessment for self-administration of medications. R14's care plan reviewed on 9/16/25, did not include self-administration of medications. R14's provider orders reviewed on 9/16/25, lacked indication R13 was able to self-administer medications. Medication orders as follows: --Ordered 5/3/25: acetaminophen (pain reliever) 1000 mg (milligram) by mouth three times a day, aspirin (for heart health) 81 mg 1 tablet by mouth one time a day, Eliquis (blood thinner) 2.5 mg 1 tablet by mouth two times a day, gabapentin (for nerve pain) 100 mg 1 capsule by mouth one time a day, levothyroxine (for thyroid) 125 mcg (microgram) 1 tablet by mouth one time a day, ProSource liquid (protein supplement) 30 ml (milliliters) by mouth two times a day, senna-docusate (laxative) 8.6-50 mg 2 tablets by mouth two times a day, sildenafil (for pulmonary hypertension) 20 mg 1 tablet by mouth three times a day, Thera (multiple vitamin) 1 tablet by mouth one time a day. --Ordered 5/27/25: ferrous sulfate (iron) 325 mg 1 tablet by mouth one time a day. --Ordered 6/26/25: Tricor (for high cholesterol and triglycerides) 90 mg by mouth one time a day. --Ordered 8/11/25: Fosamax (for osteoporosis) 70 mg by mouth one time a day every Tuesday. During an observation on 9/16/25 at 11:20 a.m., observed R14 sitting in her wheelchair with overbed table in front of her, holding a plastic medication cup nearly filled with various pills, taking one pill at a time. A cola-colored liquid in a 30 ml medication cup was setting on the overbed table. No nursing staff were present in the room. During an interview on 9/16/25 at 12:22 p.m., licensed practical nurse (LPN)-B stated for a resident to administer their own medications, they would need a physician order, an assessment for safe self-administration and it would be care planned. LPN-B admitted she gave R14 her morning medications in a cup (listed above). LPN-B stated R14 did not like her to stand and wait for her to take them. LPN-B had not considered leaving the medication in the room as self-administration but admitted R14 should be assessed for her ability to take the medications without supervision. LPN-B looked in the electronic medical record (EMR) and verified R14 did not have an order, an assessment, nor was self-administration of medications on her care plan. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R37's face sheet received on 9/19/25, included diagnoses of obstructive sleep apnea (intermittent airflow blockage during sleep), chronic pain, pre-diabetes, allergic rhinitis (stuffy nose), and ichthyosis vulgaris (dry scaly skin) R37's quarterly MDS dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R37 was dependent upon staff for most ADLs and did not walk. R37 had an electronic self-administration of medication assessment completed on 5/8/25, and 6/15/25, but they were inconclusive. R37's care plan reviewed on 9/16/25, did not include self-administration of medications. R37's provider orders reviewed on 9/16/25, lacked indication R37 was able to self-administer medications. Physician orders dated 5/3/25, indicated R37 received pantoprazole (reduced stomach acid) delayed release 20 mg by mouth one time per day for heartburn. The provider order included being informed if heartburn or stomach problems increased. During an interview and observation on 9/15/25, at 1:10 p.m., R37 was lying in bed with overbed table next to bed. On the overbed table observed a bottle of equate brand antacid 60 chewable tablets, a bottle of Systane (relieves dry eyes) eye drops, and a bottle of Allegra (seasonal allergies) tablets. R37 stated he brought the medications from home and used the antacid tablets for heartburn, eye drops for dry eyes and Allegra for his skin. During an interview on 9/16/25 at 12:11 p.m., LPN-B stated for a resident keep medications in their room, they would need a physician order, an assessment for safe administration and it would be care planned. LPN-B stated the physician needed to be aware in case the medications would interact with prescribed medications. LPN-B was informed of the medications on R37's overbed table. LPN-B stated she had not noticed them and would remove them. LPN-B verified R37 did not have a physician order for self-administration of medications, nor did his care plan indicate self administration. Together viewed R37's electronic self-administration of medication assessments in the EMR dated 5/8/25, and 6/15/25. LPN-B stated they were not completed correctly as no medications were identified. During an interview on 9/16/25 at 12:54 p.m., the director of nursing (DON) was unaware R14 had been taking her medications without supervision and that R37 had medications in his room. The DON verified neither had a physician order for self-administration, nor was it on their care plans. The DON verified R14 did not have an assessment to determine safe self-administration of medications. The DON stated R37's assessments appeared incomplete. The DON stated it was important to assess for safe self-administration and to inform the provider in case of medication interactions. R13's significant change MDS assessment dated [DATE], indicated R13 had moderate cognitive impairment and diagnoses of chronic respiratory failure, cellulitis of the left lower extremity, and heart failure. R13's self-administration assessment dated [DATE], indicated staff were unable to determine if R13 wanted to self-administer medications and was not able to identify the expiration date of medications. R13's care plan revised 7/21/25, lacked indication R13 self-administered medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R13's provider orders reviewed as of 9/15/25, lacked indication R13 was able to self-administer medications. An observation on 9/15/25 at 12:38 p.m., R13 had refresh eye drops and a bottle of Vita Fusion gummy multivitamins on her bedside table. R13 stated she had always taken these things and was continuing to take them. When interviewed on 9/16/25 at 12:52 p.m., LPN-A stated if there are medications at resident's bedside, she removes them unless they are able to self-administer the medications. Residents who self-administer medications need a provider order and an assessment that indicates they are safe. LPN-A verified R13's refresh eye drops and multivitamins. LPN-A further stated R13 is not a candidate for self-administration and will work with the provider to add these to her medication list. LPN-A removed the medications. R1's quarterly MDS assessment dated [DATE], indicated R1 was cognitively intact and had diagnoses of Sciatica, edema, and chronic pain. R1's self-administration medication assessment dated [DATE], indicated staff were unable to determine if the resident wanted to self-administer medications. R1's care plan revised 9/9/25, lacked indication R1self-administered medications. R1's provider orders as of 9/15/25, lacked indication R1 was able to self-administer medications. An observation on 9/16/25 at 11:59 a.m., R1 was sitting in their wheelchair in her room. Different medication bottles were on R1's bedside and over the bed table. R1 stated staff know she takes them, and she was going to continue to take them. When interviewed on 9/16/25, at 12:05 p.m., LPN-B was not aware of any medications in R1's room. R1's self-administration of medication assessment was reviewed and confirmed she did not self-administer medications. LPN-B verified the following medications in R1's room: 1 bottle of Tonix brand olive leaf oil 1 bottle of Prohaps healthy hair and skin vitamins 1 bottle of Reach brain booster tablets 1 bottle of Beyond vitamin D-3 vitamins 1 bottle of immune 11x 1 bottle of [NAME] green tea extract LPN-B stated there should be a provider order indicating R1 was able to self-administer these medications, and it was also important the provider knows to ensure there are no medication interactions. Facility Self-Administration of Medications policy updated 4/27/23, indicated: residents had the right (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to self-administer medications if the interdisciplinary team had determined that it was clinically appropriate and safe for the resident to do so. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) would assess each resident's cognitive and physical abilities to determine whether self-administering medications was safe and clinically appropriate for the resident. The IDT considered the following factors when determining whether self-administration of medications is safe and appropriate for the resident: The medication was appropriate for self-administration; the resident was able to read and understand medication labels; the resident could follow directions and tell time to know when to take the medication; the resident comprehended the medication's purpose, proper dosage, timing, signs of side effects and when to report these to the staff; the resident had the physical capacity to open medication bottles, remove medications from a container and to ingest and swallow (or otherwise administer) the medication; and the resident was able to safely and securely store the medication. If it was deemed safe and appropriate for a resident to self-administer medications, it would be documented in the medical record and the care plan. The decision that a resident could safely self-administer medications was re-assessed periodically based on changes in the resident's medical and/or decision-making status. Any medications found at the bedside that were not authorized for self-administration were turned over to the nurse in charge for return to the family or responsible party.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to have sufficient staff available to provide nursing and related services to meet the residents' needs in a manner that promotes each resident's right to physical, mental, and psychosocial well-being for 10 of 10 residents reviewed for sufficient staffing (R4, R53, R11, R18, R5, R3, R29, R37, R43, R23). Findings include: RESIDENT STAFFING CONCERNS R4's part A discharge Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, setup assistance with eating, dependent for toilet use and bathing, partial assistance with upper body dressing, dependent for lower body dressing, and use of wheelchair. R53's admission MDS assessment dated [DATE], indicated intact cognition, independent with eating, extensive assistance for transfers, personal hygiene, and bed mobility, and use of wheelchair. R11's significant change MDS assessment dated [DATE], indicated intact cognition, no rejection of care, dependent with toileting hygiene and lower body dressing, substantial/maximal assistance with bathing, independent with upper body dressing, and use of wheelchair. R18's admission MDS assessment dated [DATE], indicated intact cognition, no behavioral symptoms, independent with eating, dependent for toileting hygiene, bathing, dressing, and use of wheelchair. R5's quarterly MDS assessment dated [DATE], indicated intact cognition, no rejection of care, independent with eating, dependent for toileting hygiene, substantial/maximal assistance for bathing and dressing, and use of wheelchair. During observation and interview on 9/16/25 at 8:34 a.m., R4 was in his bed with his call light on. R4 stated he wanted to get up, had asked the staff to get him up and they had turned his call light off and left. R4 further stated they would leave him in bed until 11:00 a.m., and he thought that was too long to be in bed. R4 was not able to get out of bed independently. During observation on 9/16/25 at 8:40 a.m., nursing assistant (NA)-C entered R4's room, exited at 8:40 a.m., and R4's call light was no longer on. During observation and interview on 9/16/25 at 8:55 a.m., R4 was still in bed and stated NA-C told him she can't get him up yet because she needs another person to help her, and they are too busy. During interview on 9/16/25 at 9:15 a.m., NA-C stated she knew R4 wanted to get up, but if she got him up, he would just want to go out for a cigarette and then get back in bed. NA-C further stated R4 took two people to transfer him, and they were too busy during that time of the morning so they always waited until later to get him up. During observation and interview on 9/16/25 at 9:45 a.m., R4 remained in his bed and stated staff told him they would try to get him up after their breaks. During observation on 9/17/25 at 7:25 a.m., R18's turned his call light on. At 8:05 a.m., NA-B was (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed entering his room, turning off his call light, and telling him she would help him as soon as she could. At 8:30 a.m., R18 was heard yelling “hey” into the hallway. NA-B entered the room and again stated she would be with him when able. At 9:13 a.m., NA-B and NA-E entered R18's room to provide assistance. During interview on 9/17/25 at 8:52 a.m., R18 stated he had his light on because he needed his brief changed and had been waiting a long time. R18 stated he was used to having to wait and it was no fault of the aides because they were too busy to get to everyone. During observation on 9/17/25 at 7:40 a.m., R29 turned his call light on. At 8:04 a.m., NA-B entered his room and asked if she could turn his call light off. R29 told her to leave the call light on, and NA-B stated she would return when able. At 8:40 a.m., NA-B returned to the room to assist R29 and his call light was turned off. During interview on 9/16/25 at 2:28 p.m., NA-I stated call lights should be answered in 15 minutes. NA-I stated one problem was that they have so many residents who require two staff assistance, and the staff did not have any way to communicate with each other and spent a lot of time running around looking for another staff member. During interview on 9/17/25 at 2:36 p.m., NA-C stated walkie-talkies would make a difference because she always had to try to find another aide to help her with residents who needed two staff for assistance. During interview on 9/17/25 at 10:17 a.m., NA-B stated it was hard to get everything done some morning. NA-B further stated she had to pass breakfast trays during the time the residents wanted to get up for the day, many residents required two staff assistance, and her co-worker was busy in another resident's room for almost an hour which caused R18 and R29 to have to wait because they both required assistance of two aides. During interview on 9/17/25 at 10:35 a.m., NA-E stated it was hard to answer call lights because the aides didn't have a way to communicate with each other and couldn't find each other if they were tied up in different rooms, and it took a long time to find a partner to help with residents who needed a second person to assist. During interview on 9/17/25 at 1:53 p.m., NA-D stated he thought call lights should be answered within five minutes on a good day and 15-30 minutes on a bad day. NA-D further stated it was hard to get ahold of another aide to help when needed, and especially difficult if he was in a room that required wearing a gown. During interview on 9/17/25 at 1:55 p.m., NA-B stated she would expect to answer call lights within five minutes but was unable to do that. NA-B further stated some residents took up to an hour to assist, and finding another aide to help was difficult because she had to leave the room, search for them, and they could be busy in another room. NA-B stated her shift ended at 2:00 p.m., but it was 2:01 p.m., and she was just starting a shower for a resident who missed their shower that morning because they were too busy. NA-B stated she had not started her charting yet and always worked an hour passed her shift end time to get the work done. During interview on 9/17/25 at 2:13 p.m., NA-A stated she wanted to answer call lights within five minutes, but sometimes got busy with a resident for up to 45 minutes and other residents would have (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to wait. NA-A further stated there was no way to communicate with other aides and it took a lot of time to run around and find someone. RESIDENT COUNCIL A review of facility provided Resident Council meeting minutes dated 7/23/25, and 8/27/25, indicated in section titled New Business long call light times were a concern both months. During resident council hosted by state agency and attended by ombudsman on 9/17/25 9:30 a.m., R11 and R5 stated call light times were long, sometimes up to an hour. R11 stated it could be at any time of day and depended on how many staff were working. R11 stated staff would come in and turn the light off, and then they would not come back. R11 further stated he thought the staff were told that they had to turn the call light off by the previous administrator because R11 had told staff not to turn his call light off and was told by staff that they had to turn it off. GRIEVANCES A review of facility provided grievances 8/4/25 through 8/26/25, including the following grievances: -turned call light on at 8:00 p.m., hoping to get someone to come by 9:00 p.m. Needed to be changed. No one came until between 10:30 p.m. and 11:00 p.m. Staff said he was training and had only one other person with him tonight. -resident reported call light on for over two hours, found an aide and they said they were busy and would go to that resident now. -resident reported call light on for over 20 minutes. Waited another 10 minutes with him and no one came, so went to find someone. -resident's friend reported that resident had called her and told her his urine bag needed to be emptied, and he had called for help and been waiting for hours. Resident stated he called the facility front office for assistance and [NAME] answered and informed him she was too busy to help. -resident stated service is not good and he feels ignored by staff. CALL-LIGHT LOGS A review of facility provided call light logs dated 8/16/25-9/17/25, revealed the following findings: 8/17/25-9/17/25, indicated R4's longest wait times 31 minutes, 39 minutes, 70 minutes, 141 minutes, 31 minutes, 140 minutes, 107 minutes, 62 minutes, 43 minutes, 24 minutes, 33 minutes, 43 minutes, 76 minutes, 45 minutes, 61 minutes, 50 minutes, 41 minutes, 44 minutes, 27 minutes, 97 minutes, 35 minutes, 45 minutes, 88 minutes, 45 minutes, 29 minutes, 42 minutes, 36 minutes, 29 minutes, 48 minutes, 26 minutes, 40 minutes, 27 minutes, 29 minutes, 24 minutes, 34 minutes, 44 minutes, 29 minutes, 34 minutes, 55 minutes, 102 minutes, 37 minutes. 8/16/25-9/15/25, indicated R53's longest wait times 110 minutes, 56 minutes, 26 minutes, 22 minutes, 88 minutes, 39 minutes, 65 minutes, 31 minutes, 24 minutes, 22 minutes, 27 minutes, 25 minutes, 25 minutes, 25 minutes, 24 minutes, 56 minutes, 25 minutes, 37 minutes, 39 minutes, 31 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	minutes, 26 minutes, 29 minutes. During interview on 9/18/25 at 10:42 a.m., human resources director, also known as the person who completes the schedules for the nursing department, stated he thought staffing had been getting better, staff were more prepared, and they were getting a lot of new nursing assistants. Human resources director further stated that because of the lower census, they were able to use their own staff more often, rather than agency staff. Human resources director stated he was not aware of long call light wait times for residents. During interview on 9/19/25 at 12:18 p.m., registered nurse (RN)-C stated she expected call light times to be within five to six minutes and realized call light times had gotten longer recently and had noticed the times trending up again. RN-C further stated she needed to look at acuity of residents and make some adjustments to staffing or to resident location in the building. Refer to F677. When interviewed on 9/15/25 at 1:55 p.m., R14 stated she was supposed to get a shower twice a week on Wednesday and Saturday, but she was not assisted with a shower this week. R14 stated when she asked staff they told her they didn't have time. R14 had itching in her groin area due to this. When interviewed on 9/19/25 at 9:52 a.m. R14 stated they still had not received a shower. Point of care documentation showed R14 had received a shower on 9/13/25 and refused a shower on 9/17/25. R14 stated this did not occur. RESIDENT STAFFING CONCERNS/CALL-LIGHT LOGS R3's quarterly MDS assessment dated [DATE], indicated moderately impaired cognition, no rejection of care, setup assistance for eating, and diagnosis included severe protein-calorie malnutrition. R29's significant change in status MDS assessment dated [DATE], indicated cognitively intact, utilized a manual wheelchair, independent with upper body dressing, personal hygiene, transfers, diagnoses included diabetes, respiratory failure, and chronic pain. 8/16/25-9/15/25, indicated R3's longest wait times 21 minutes, 41 minutes, 43 minutes, 59 minutes, 49 minutes, 31 minutes, 85 minutes, 50 minutes, 22 minutes, 73 minutes, 32 minutes, 29 minutes, 36 minutes, 31 minutes, 38 minutes, 80 minutes, 26 minutes, 35 minutes. 8/16/25-9/15/25, indicated R29's indicated R29's longest wait times 47 minutes, 55 minutes, 27 minutes, 30 minutes, 48 minutes, 59 minutes, 23 minutes, 267 minutes, 42 minutes, 21 minutes, 33 minutes, 45 minutes, 46 minutes, 49 minutes, 41 minutes, 27 minutes, 45 minutes, 38 minutes, 33 minutes, 25 minutes, 28 minutes, 39 minutes, 53 minutes, 39 minutes, 60 minutes, 72 minutes, 47 minutes, 24 minutes, 183 minutes, 53 minutes, 163 minutes, 50 minutes, 33 minutes, 34 minutes, 26 minutes, 25 minutes, 24 minutes, 188 minutes, 36 minutes, 30 minutes, 61 minutes, 63 minutes, 54 minutes. On 9/15/25 at 2:23 p.m., R3 stated there were times he had to wait up to 1 ½ hours for staff assistance in the last month. R3 stated this happens every so often but he does not keep track of the specific dates or times. On 9/15/25 at 2:34 p.m., R29 stated he had been on his bedpan for 1 ½ hours earlier that day and nobody came to help. R29 further stated it was not uncommon for him to wait 30-45 minutes daily for staff assistance. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/17/25 at 11:09 a.m., a provider who wanted to remain anonymous, stated the facility used a lot of agency staff and that could contribute to staffing problems. When arriving to the facility, the provider had observed nursing assistants (NA) and nursing staff sitting around instead of rounding on residents and not responding to call lights. The provider stated there did not seem to be structure at the facility, including oversight of nursing staff, ensuring residents received medications timely and as ordered, labs completed as ordered, and treatments completed as orders. The provider expressed concerns that leadership did not fully understand the facility operations such as timely nursing cares related to medication administration, labs completed, monitoring of vitals, blood glucose and weight monitoring. The provider questioned what guidance the new director of nursing (DON), would get and concluded they were not sure the facility would be able to sustain operations the way it is currently being run. RESIDENT STAFFING CONCERNS/ CALL-LIGHT LOGS R37's face sheet received on 9/19/25, included diagnoses of obstructive sleep apnea (intermittent airflow blockage during sleep), chronic pain, and pre-diabetes. R37's quarterly MDS assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R37 was dependent upon staff for most ADLs and did not walk. During an interview on 9/15/25 at 1:16 p.m., R37 stated he generally used his call light to request water or have his brief changed. R37 stated it was variable on how long it took for his call light to be answered. R37 stated he had sat in a soiled brief for up to five hours – could not recall when. R37 stated it took a long time for staff to answer call lights at shift change. R37's call light response times from 8/16/25, – 9/15/25, indicated 193 activations with ranges below: 20 minutes = 3 21 - 30 minutes = 22 31 – 40 minutes = 13 41 – 50 minutes = 10 51 - 60 minutes = 2 >61 minutes = 5 >70 minutes = 2 >90 minutes = 3 >Two hours = 3 During an interview on 9/18/25 at 9:10 a.m., R37 stated he felt (explicit language used) when he had to wait a long time for his call light to be answered. When staff finally came to his room, they apologized and say they had been busy. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R43 face sheet received on 9/19/25, included diagnoses of respiratory failure, morbid obesity and anxiety. R43's annual MDS assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. Section GG of the MDS assessment was listed as not assessed. During an interview on 9/15/25 at 2:06 p.m., R43 stated she sometimes waited a long time – over an hour for her call light to be answered, seemed more so on weekends. R43 stated, what would happen if I were having chest pain – worried staff would not response timely. R43's call light response times from 8/16/25, – 9/15/25, indicated 65 activations with ranges below: 20 minutes = 2 21-30 minutes = 8 31 – 40 minutes = 4 41 – 50 minutes = 2 51 - 60 minutes = 1 >61 minutes = 2 >70 minutes = 2 >80 minutes = 1 >90 minutes = 2 >3.5 hours = 1 During an interview on 9/18/25 at 9:03 a.m., R43 stated she felt like she wasn't sick enough for it to matter and that's why it took staff a long time to answer her call light. R43 stated she was not a high maintenance person, so in her opinion, figured staff thought she could wait. R23's face sheet received on 9/19/25, included diagnoses of congestive heart failure, obesity, diabetes, depression and anxiety. R23's quarterly MDS assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. Although R23's MDS assessment indicated R23 was independent with activities of daily living, after returning from the hospital on 9/1/25, R23 stated she had not been out of bed. During an observation and interview on 9/17/25 at 1:04 p.m., R23 who was lying in bed, stated she had been waiting since 6:30 a.m., to get changed out of a poopy diaper. R23 stated nursing assistant (NA)-B, who had been in her room multiple times, kept coming in to tell her she needed to find a second NA to assist her. R23 stated her gown and bed sheets were wet too. During observation on (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/17/245 at 1:16 p.m. R23 was observed to be assisted with cares, her gown and incontinent product were saturated, her skin was wrinkled and red in her peri-area, and inner thigh and stool was caked between her buttocks. NA-B stated the night shift should have cleaned her up, and that NA-B had been unable to find anyone to help her clean up R23 all day. Refer to F550. R23's call light response times from 8/16/25, – 9/15/25, indicated 198 call light activations with ranges below: 20 minutes = 2 21 - 30 minutes = 23 31 – 40 minutes = 11 41 – 50 minutes = 6 51 - 60 minutes = 1 >61 minutes = 1 >70 minutes = 1 >80 minutes = 2 >90 minutes = 2 >2 hours = 1 3 hours = 1 During an interview on 9/17/25 at 7:40 a.m., nursing assistant (NA)-B stated she had been employed by the facility for less than a year. NA-B stated she did not think leadership shared call light response time data with staff. Informed NA-B some residents had long call light response times - some over 30-60 minutes and longer. NA-A stated if she needed the help of another NA, it could take a long time to find him/her if they were in a room with a resident or if she had to wait for them to return from break. NA-A stated the facility did not use mobile communication - they had to physically go look for help if a coworker was not visible in the hallway. In addition, NA-A stated a lot of residents on her unit required assistance of two staff as many were obese. FACILITY ASSESSMENT Facility assessment dated 9/24, indicated 23 residents dependents for toileting, 12 residents dependent for transfers, and 14 residents dependent for dressing. In addition, the facility assessment indicated the facility used a contingency staffing plan and had a par level of staffing that was based on budgeted census and regulations. Fluctuations in census would trigger the staffing department to match the staffing to resident needs. The facility assessment further indicated the following staffing ratios: RN- 1:20 for LTC for days and evenings, 1:40 for overnight. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN- 1:20 for LTC for days and evenings, 1:40 for overnight. CNA- 1:10 for LTC for days and evenings, 1:20 for overnight. Staffing, Sufficient and Competent Nursing policy undated, indicated the following: 1. Licensed nurses and certified nursing assistants are available 24 hours a day, seven days a week to provide competent resident care services including assuring resident safety, attaining or maintaining the highest practicable physical, mental and psychosocial well-being of each resident, responding to resident needs. 2. Factors considered in determining appropriate staffing ratios and skills include an evaluation of the diseases, conditions, physical or cognitive limitations of the resident population, and acuity. 3. Minimum staff requirements imposed by the state, if applicable, are adhered to when determining staff ratios but are not necessarily considered a determination of sufficient and competent staffing.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure 1 of 4 residents (R23) reviewed for dignified care, was provided toileting assistance in a timely manner.Findings include: R23's face sheet provided on 9/19/25, included diagnoses of congestive heart failure, obesity, diabetes, depression and anxiety. R23's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R23's PHQ9 score (depression screening tool) indicated mild depression. Assessment indicated R23 was independent with activities of daily living.R23's physician orders dated 9/1/25, included monitoring R23 for signs and symptoms of depression, including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing negative statements, repetitive anxious or health-related complaints, and tearfulness, daily for 6 weeks. R23's care plan dated 5/7/25, indicated R23 had impaired coping skills. Care plan with revised date of 9/15/25, indicated R23 was at risk for depression due to diagnosis of anxiety and depression. During an observation and interview on 9/17/25 at 1:04 p.m., R23 who was lying in bed, stated she had been waiting since 6:30 a.m., to get changed out of a poopy diaper. R23 stated nursing assistant (NA)-B, who had been in her room multiple times, kept coming in to tell her she needed to find a second NA to assist her. R23 stated her gown and bed sheets were wet too. During an observation and interview on 9/17/25 at 1:16 p.m., NA-B and NA-E entered the room to give R23 a bed bath. As they removed R23's blue hospital-type gown, could see it was wet due to moisture making it darker in color. When NA-B pulled the front of the incontinent pad down and away from R23's skin, could see the absorbent material of the incontinent pad bulging and saturated. Steaks of greenish material were observed in the front of the incontinent pad as well. R23's labia were reddened in color. R23 stated her inner right thigh was sore which was observed to be reddened and with creases. R23 was turned onto her left side, and a large brown stool was observed between buttocks cheeks. The skin on her posterior thighs and buttocks had a large surface area with many creases. Once cares were completed and, in the hallway, NA-B stated the night shift staff should have changed R23. NA-B stated she couldn't find a second NA to assist her. NA-B stated she did not ask the nurse in the hallway on the medication cart, or the director of nursing (DON) to assist her in finding help, and therefore, had not provided toileting cares to R23 that morning. During an interview on 9/17/25 at 1:54 p.m., the DON and licensed practical nurse (LPN)-B came into R23's room to look at R23's skin. R23 informed the DON she told the night shift staff she needed to be changed and had told multiple people that morning she needed to be changed, and each person said they needed to find someone to help them. LPN-B stated twice she had offered to change R23, but R23 had declined. R23 denied having said that. The DON acknowledged she would have expected staff to respond to R23's call light the first time, and that it was not acceptable for R23 to wait hours in a soiled incontinent pad. During an interview on 9/18/25 at 8:54 a.m., while in bed, R23 stated she felt awful yesterday having to lay in a soiled incontinent pad, wet gown and wet sheets for hours. R23 stated she felt hopeless and angry, adding she sometimes had to holler to get staff attention. R23 stated, in her opinion - they are short staffed, although staff did not say that. R23 stated it was not uncommon for her to wait 30-60 minutes for her call light to be answered, adding it did not seem like one staff person was responsible for her and her cares. R23 stated she used to be independent with toileting prior to hospitalization in August 2025, but since returning from the hospital on 9/1/25, was now dependent upon staff for ADLs. Review of R23's call light response times from 8/17/25 to 9/16/25, indicated 198 activations. Forty-one response times were between 20 and 60 minutes. Eight were between 60 minutes and three hours. Facility Dignity policy undated, indicated each resident would be cared for in a manner that promoted and enhanced his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents were treated with dignity and respect at all times. Demeaning (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	practices and standards of care that compromised dignity were prohibited. Staff were expected to promote dignity and assist residents by promptly responding to a resident's request for toileting assistance.Facility Supporting Activities of Daily Living (ADLs) policy dated 2/28/25, indicated residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. Residents unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services would be provided for residents who were unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care) and elimination (toileting).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a homelike environment for 1 of 1 resident (R2) who had feeding tube formula hooked up to the feeding tube pump in R2's room after the feeding tube was removed. Findings include:R2's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, did not reject care, was very important to take care of personal items or things, had a diagnosis of malnutrition, and had a feeding tube. R2's Orders form indicated the following orders:6/11/25, regular diet, regular texture, and thin liquids.8/5/25, enteral feed order two times a day for tube feeding to be run 12 hours daily. Administer Nutren or Isosource (types of feeding tube formulas) 1.5 at 100 milliliters (ML) per hour via feeding tube. 9/5/25, consult with GI/colorectal for PEG (feeding tube) removal and colostomy reversal evaluation.R2's medication administration record (MAR) dated September 2025, indicated R2 received enteral feeding up until Saturday, 9/13/25, when a 9 was documenting in the 6:00 p.m., space, indicating other/see nurse notes ineffective date.R2's progress notes dated 9/13/25 at 3:25 p.m., indicated R2's feeding tube fell out and R2 did not want the feeding tube any longer. R2's progress notes dated 9/13/25 to 9/17/25, indicated R2 no longer had a feeding tube.R2's care plan dated 7/7/25, indicated R2 required extensive assistance with personal hygiene and total assistance with toilet use and further identified R2 had a colostomy. During interview and observation on 9/15/25, at 2:08 p.m., R2's feeding tube pole had an undated bag of 1000 ml of brownish fluid hanging on the pole with a Kangaroo Omni feeding tube pump. R2 stated the bag had been in her room for three days and further stated her feeding tube got pulled out and declined to go in to have it replaced. During interview and observation on 9/16/25, at 9:16 a.m., nursing assistant NA-(B) stated R2 had not had a feeding tube for a week and a half and verified there was still a feeding bag with formula in R2's room. NA-B stated R2's feeding tube was pulled out and R2 had been eating normal food. During observation on 9/16/25 at 11:39 a.m., R2 was not in her room and still had the bag of undated brown liquid attached to the feeding pump.During interview on 9/16/25 at 12:09 p.m., R2 stated the feeding tube equipment had been in her room for 5 days and did not want this in her room because she no longer used it and stated it bothered her that it was still there and did not feel very home-like.During interview and observation on 9/16/25 at 12:50 p.m., licensed practical nurse (LPN)-B was bringing R2 her medication and stated R2's feeding tube came out last week. R2 asked LPN-B when they were going to get rid of her bag. LPN-B verified the formula and feeding tube pump was still in R2's room and stated they should have gotten rid of it right away and stated R2 pointed the bag out to her. During interview on 9/18/25 at 8:49 a.m., the director of nursing (DON) stated R2 had been on a feeding tube for a while and did not want it reinserted and stated it was not a home-like environment to continue to have the nutrition in R2's room. Facility Homelike Environment policy dated February 2021, indicated residents were provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting which included a clean, sanitary and orderly environment.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) assessment was coded accurately for 2 of 2 residents (R14, R37) reviewed for MDS accuracy.Findings include:R14's face sheet received on 9/19/25, included diagnoses of chronic respiratory failure (lungs unable to adequately exchange oxygen and carbon dioxide over an extended period), high blood pressure, kidney failure and atrial fibrillation (irregular heart rate causing poor blood flow). R14's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, adequate hearing, clear speech, was understood and could understand. R14 required substantial assistance for activities of daily living (ADLs). R14's Section B of the MDS dated [DATE], indicated: ability to hear was adequate, which according to the MDS meant no difficulty in normal conversation, social interaction, listening to TV.R14's care plan dated 12/8/24, indicated risk for impaired communication. Revision on 7/9/25, indicated R37 used pen and paper to write and communicate. The care plan did not specifically identify R14 as being hard of hearing. In addition, R37 used a white board to communicate. During interview on 9/16/25 at 8:33 a.m., R14 was sitting in her wheelchair eating breakfast. Using the whiteboard to ask questions, R14 stated she had been hard of hearing for years.During an interview on 9/16/25 at 8:42 a.m., nursing assistant (NA)-F confirmed R14 was hard of hearing and used a white board to communicate.R37's face sheet received on 9/19/25, included diagnosis of pre-diabetes. R37's quarterly MDS assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R37 was dependent upon staff for most ADLs and did not walk. R37 received insulin injections seven days a week. R37's section N of the MDS dated [DATE], indicated: Insulin injections - record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days. Number entered was 7. R37's physician orders did not include insulin.R37's care plan did not indicate R37 received insulin. During an interview on 9/15/25 at 1:39 p.m., R37 stated he was not diabetic and had never used insulin. During a telephone interview on 9/17/25 at 10:03 a.m., the regional director of clinical reimbursement (RDCR)-O stated the facility had hired a new MDS nurse in June who left in August. RDCR-O stated the facility needed to make a number of modifications/changes after the MDS nurse left and must have missed R37's MDS indicating he received insulin injections, adding that was not accurate. During an email exchange on 9/17/25, at 3:23 p.m., RDCR-O confirmed R14 was hard of hearing and that Section B of her MDS assessment regarding hearing was incorrect. Facility Resident Assessment policy with reviewed date of 3/17/25, indicated a comprehensive assessment of every resident's needs was made at intervals designated by OBRA (Omnibus Budget Reconciliation Act) and PPS (Prospective Payment System) requirements. The resident assessment coordinator was responsible for ensuring that the interdisciplinary team conducted timely and appropriate resident assessments and reviews. The interdisciplinary team used the MDS form currently mandated by federal and state regulations to conduct the resident assessment. All members of the care team, including licensed and unlicensed staff members, were asked to participate in the resident assessment process. All persons who had completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the care plan included management and monitoring of an antipsychotic medication for 1 of 2 residents (R2) reviewed for antipsychotic use. Findings include:R2's Medical Diagnosis form indicated the following diagnoses: adjustment disorder with mixed anxiety and depressed mood, schizoaffective disorder, bipolar type, and post-traumatic stress disorder (PTSD). R2's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R2 had intact cognition, did not hallucinate or have delusions, did not have physical, verbal or other behavioral symptoms, did not reject care, and R2's behavior was the same since the previous assessment. Additionally, R2 had trouble falling or staying asleep or sleeping too much for 2 to 6 days and took an antipsychotic.R2's care area assessment (CAA) dated 6/26/25, triggered for psychotropic drug use because R2 took an antipsychotic and an antidepressant. The CAA indicated a potential problem and adverse consequences of antipsychotics that included cardiac arrhythmias (abnormal heart rhythms), and psychotropic drug use would be addressed in the care plan to avoid complications and minimize risks. Further the CAA indicated R2 could be at risk for sedation, memory loss or falls due to psychotropic medications. R2's care plan report lacked a specific care plan related to antipsychotic use.R2's physician orders dated 6/5/25, and discontinued on 6/30/25, indicated R2 took olanzapine (an antipsychotic) 5 milligram (MG) tablet orally one time a day for sleep and anxiety related to schizoaffective disorder, bipolar type.R2's physician orders dated 6/30/25 and discontinued 8/7/25, indicated R2 took olanzapine 5 mg tablet one time a day for delirium and sleep.R2's physician orders dated 8/7/25, indicated R2 took olanzapine 5mg tablet daily for delirium and sleep. During interview on 9/18/25 at 11:18 a.m., licensed practical nurse (LPN)-C stated physicians order medications and conduct an assessment and after an amount of time, the physician re-evaluates a medication to see if it was still necessary and nurses monitor for effectiveness, but did not know what the facility process was for monitoring medications.During interview on 9/18/25 at 2:13 p.m., the consulting pharmacist (CP)-J stated psychotropic medications should have a care plan with target behaviors and side effect monitoring and further stated R2 used olanzapine for delirium and sleep. During interview on 9/18/25 at 2:56 p.m., the vice president of clinical services, registered nurse (RN)-C stated antipsychotics were reviewed in the first 6 weeks a resident was at the facility and quarterly and expected R2 to have a care plan in place for an antipsychotic. VPCS-B viewed R2's care plan and stated R2 should have a care plan in place and did not and further stated it was important to monitor whether R2 needs the medication or if she requires any reductions and to look for additional side effects. Facility Care Plans, Comprehensive Person-Centered policy dated 1/20/25, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven days of the completion of the required MDS assessment, and no more than 21 days after admission. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Further, care plan interventions were chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making and assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team reviews and updates the care plan when there has been a significant change, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay, and at least quarterly in conjunction with the required quarterly MDS assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure care plans were revised and updated with current health status for 3 of 4 residents (R4, R27, R13) reviewed for care planning. Findings include: R4's face sheet printed 9/17/25, indicated diagnoses of congestive heart failure, diabetes type two, chronic kidney disease, and dependence on renal dialysis (treatment that replaces the function of the kidneys when they are no longer able to adequately filter waste products and excess fluid from the blood). R4's part A discharge Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, setup assistance with eating, dependent for toilet use and bathing, partial assistance with upper body dressing, dependent for lower body dressing, and use of wheelchair. R4's physician's orders printed 9/16/25, lacked any orders related to dialysis, including monitoring the dialysis site and communicating with dialysis company. R4's care plan revised 8/31/22 lacked information related to R4's specific dialysis needs, which arm his arteriovenous (AV) graft was in, which dialysis company serviced him, contact information for the dialysis company, and directions on when to assess the AV graft site. R4's care plan printed 9/17/25, indicated resident at risk for complications and required ongoing dialysis for renal failure. Interventions included coordinated services with dialysis servicer, do not draw blood or take blood pressure in arm with graft, resident receives dialysis Monday, Wednesday, Friday, and observe shunt for symptoms of infection or complication. During observation and interview on 9/15/25 at 5:00 p.m., R4 was in his room. R4 stated he had been to dialysis that afternoon. R4 further stated nurses do not look at his dialysis site and he took the dressings off himself. During interview on 9/16/25 at 1:16 p.m., licensed practical nurse (LPN)-A stated she was not sure where any specific directions were for dialysis care of R4, could not locate a number for the dialysis facility, was not sure how they communicated with dialysis and that she just knows to assess R4's site as basic knowledge. LPN-A stated she was not sure how an agency nurse would know that information. LPN-A further stated there was no dialysis information on R4's physician's orders and his care plan information was generic and not specific to him. During interview on 9/16/25 at 1:34 p.m., LPN-B stated she would not know where to find dialysis information. During interview on 9/16/25 at 2:52 p.m., director of nursing (DON) stated she was new to the facility but would expect R4's care plan to have specific information related to his dialysis needs so nurses knew how to care for him. During interview on 9/18/25 at 10:30 a.m., the vice president of clinical services, registered nurse (RN)-C stated R4's care plan was vague and not specific to his needs. RN-C further stated R4 should (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have assessments daily of his AV graft to ensure no infection or complication, and that should have been indicated on his care plan and physician's orders. R27's Optional State Assessment (OSA) dated 8/29/25, indicated moderate cognitive impairment and required limited assistance with bed mobility, transfers, toileting, and supervision for eating. R27's quarterly MDS assessment dated [DATE], indicated R27 did not reject care, had impairment on one side to her upper extremity and used a wheelchair. Further, R27's diagnoses included hemiplegia (paralysis of one side of the body) following a cerebral infarction (stroke) affecting her right dominant side, apraxia (the inability to plan and execute purposeful, skilled movements), other speech language deficits following cerebral infarction, dysphagia (difficulty swallowing foods or liquids) following cerebral infarction. Additionally, R27 did not have signs and symptoms of a possible swallowing disorder, was on a therapeutic diet. R27's physician orders form indicated the following orders: -8/28/25, lost dentures, speech language pathologist (SLP) wrote orders. -8/28/25, downgrade diet texture to mechanical soft with gravy, preference for soft foods and no breads (IDDSI MM5) with supervision during meals to cue alternating solid and liquid (sip, swallow, bite, swallow) and to stop eating to clear throat if she starts coughing. -8/28/25, diabetic diet, mechanical soft texture, thin liquids consistency. R27's care plan dated 7/7/25, indicated R27 was independent with eating and required set up help only. The care plan was not revised to indicate R27 required supervision and cueing according to R27's most recent OSA and orders. R27's care plan dated 8/26/25, indicated R27 had a nutritional problem or a potential nutritional problem due to a history of aphasia, apraxia, dysphagia, hemiplegia and interventions included to provide and serve diet as ordered. R27's care plan lacked information that R27 was missing or had dentures. During interview on 9/16/25 at 8:19 a.m., NA-C stated if a resident required supervision one of the aides or a nurse would sit with the resident the whole time and further stated R27 did not require supervision because she was independent. During interview on 9/16/25 at 12:01 p.m., NA-C stated she knew what cares a resident required based off the care plan. During interview on 9/16/25 at 8:52 a.m., the DON viewed point of care and did not see orders for R27's diet for the aides to know what diet R27 was on. During interview on 9/16/25 at 8:55 a.m., the DON verified R27's care plan indicated R27 was independent with eating. During interview on 9/17/25 at 12:38 p.m., RN-C stated staff should follow orders and verified R27's optional state assessment indicated R27 required supervision and R27's care plan indicated R27 was (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	independent after setting up for eating and the care plan had not been updated to reflect R27's orders. R13's significant change MDS assessment dated [DATE], indicated R13 had moderate cognitive impairment and diagnoses of chronic respiratory failure (long term lung disease that may require oxygen), cellulitis of the left lower extremity, and heart failure. Furthermore, R13 required oxygen. R13's provider order dated 8/17/25, indicated R13 required oxygen therapy at 1 liter (L) per nasal canula. R13's care plan revised 7/21/25, lacked indication R13 required cares or treatments related to oxygen therapy. An observation/interview on 9/15/25 at 12:38 p.m., R13 was sitting at their bedside and had a nasal canula in place. R13 stated they didn't start using oxygen until recently and now the staff want her to wear it all the time. When interviewed on 9/17/25 at 9:28 a.m., LPN-C verified R13's care plan did not indicate R13 required oxygen. LPN-C stated updates to the care plan were done by the MDS nurse or the DON, When interviewed on 9/18/25 at 10:22 a.m., the regional director of clinical reimbursement stated a new MDS nurse just started. Care plans were updated in morning meeting with the interdisciplinary team when due, however, the DON can update them as well at any time. When interviewed on 9/18/25 at 12:19 a.m., the DON and RN-C stated the care plan and Kardex was how staff obtained information for residents and their care. Nursing assistants do not carry sheets; however, they can refer to them as needed in their point of care charting. DON expected resident care plans to be updated with current interventions for oxygen orders. Facility Care Plans, Comprehensive Person-Centered, dated 1/20/25, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven days of the completion of the required MDS assessment, and no more than 21 days after admission. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Further, care plan interventions were chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making and assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team reviews and updates the care plan when there has been a significant change, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay, and at least quarterly in conjunction with the required quarterly MDS assessment.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure activities of daily living (ADL) assistance was provided for 1 of 1 resident (R27) reviewed for ADLs who required supervision and cueing during meals. Findings include:R27's Optional State Assessment (OSA) dated 8/29/25, indicated moderate cognitive impairment and required limited assistance with bed mobility, transfers, toileting, and supervision for eating. R27's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R27 did not reject care, had impairment on one side to her upper extremity and used a wheelchair. Further, R27's diagnoses included hemiplegia (paralysis of one side of the body) following a cerebral infarction (stroke) affecting her right dominant side, apraxia (the inability to plan and execute purposeful, skilled movements), other speech language deficits following cerebral infarction, dysphagia (difficulty swallowing foods or liquids) following cerebral infarction. Additionally, R27 did not have signs and symptoms of a possible swallowing disorder, was on a therapeutic diet.R27's care plan goal revised and discontinued on 3/8/24, indicated R27 had a behavior problem of taking food off of other people's plates and becoming aggressive if asked to give back what she took. R27's care plan revised on 7/7/25, indicated R27 was independent with eating and required set-up help only. R27's care plan dated 8/26/25, indicated R27 had a nutritional problem or a potential nutritional problem due to a history of aphasia, apraxia, dysphagia, hemiplegia and interventions included to provide and serve diet as ordered. R27's physician orders form saved on 9/16/25 at 8:44 a.m., indicated the following orders:8/28/25, lost dentures, speech language pathologist (SLP) wrote orders.8/28/25, downgrade diet texture to mechanical soft with gravy, preference for soft foods and no breads (IDDSI MM5) with supervision during meals to cue alternating solid and liquid (sip, swallow, bite, swallow) and to stop eating to clear throat if she starts coughing.R27's nursing progress notes dated 3/7/24 at 12:46 p.m., indicated R27 took regular food off another resident's plate and R27 was on a special diet for dysphagia and was educated on the importance of eating only from her tray to prevent aspiration.R27's nurse practitioner (NP) notes dated 8/28/25 at 12:52 p.m., indicated the NP met with the kitchen and SLP to discuss diet modification as R27 had been coughing and had phlegm and diet modifications were made and the kitchen was aware. R27's PMR (physical medicine and rehabilitation) note dated 9/13/25, indicated R27 was on a modified diet due to difficulty swallowing. R27's speech therapy (ST) evaluation note dated 8/26/25, indicated R27 was referred because she recently choked, had difficulty swallowing, could not find her dentures, and was having difficulty eating regular foods. Further R27 was previously on a regular diet and ST wrote orders to downgrade diet to SB6, soft and bite sized which translates to mechanical soft for the facility. During observation on 9/16/25 at 8:02 a.m., R27 was in the dining room and had an omelet, hashbrowns, and a donut on her plate, and had a bowl of cereal. An unnamed staff person assisted in putting sugar on the cereal and walked away. The activity director was in the dining room playing Yahtzee with another resident. R27 was not supervised by nursing staff in the dining room. During interview on 9/16/25 at 8:15 a.m., the cook (C)-A and the culinary director (CD) verified there were no nurses or nursing assistants in the dining room and stated R27 could have donuts. During interview and observation on 9/16/25 at 8:19 p.m., nursing assistant (NA)-C stated a nurse or a nursing assistant supervised residents who required supervision with eating and should sit with the resident the entire time a resident ate and added she knew who required supervision because when she was oriented, she learned what cares residents required and added R27 did not need supervision and just needed her meal set up, but was fine to be independent and verified there were no aides in the dining room with R27. During observation on 9/16/25 at 8:25 a.m., R27 was in the dining room eating her donut and the only staff in the dining room was the activity director.During observation on 9/16/25 at 8:26 a.m., NA-C walked by R27 and assisted another resident and walked away. At 8:27 a.m., the only staff in the dining room (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was the activity director (AD). During observations 9/16/25, no staff provided R27 any cueing according to her orders during the breakfast meal.During interview on 9/16/25 at 8:30 a.m., the director of nursing (DON) stated she did not know why R27's diet orders did not transfer over to R27's meal ticket. During interview on 9/16/25 at 8:41 a.m., the DON stated she expected the diet to be changed and planned to have a meeting about reviewing diets in the system versus what was printed on the tickets and would provide education to the NA's who should be verifying diet orders and stated it was important because it could be a choking hazard.During interview on 9/16/25 at 8:52 a.m., the DON viewed point of care and did not see orders for the NA's to know what diet a resident was supposed to be on.During interview on 9/16/25 at 8:55 a.m., the administrator in training (AIT) stated the aides should be the staff providing supervision to residents requiring supervision during meals. The DON stated R27's care plan indicated R27 was independent with eating which was contrary to R27's diet orders.During interview on 9/16/25 at 9:31 a.m., AD stated she did not have training in assisting residents in eating and added she wore a lot of hats, but not that one.During interview on 9/17/25 at 9:56 a.m., speech therapist (ST)-E stated R27 was seen by ST for dysphagia and her diet had been downgraded due to not having dentures and could not fully chew food. ST stated R27 required supervision to ensure R27's food was mashed up adequately but was not something she has seen happen and expected an aide or a nurse provide supervision. During interview and observation on 9/17/25 at 12:30 p.m., R2 and R27 were sitting together at the same table. No staff were in the dining room assisting residents. R2 had chicken wild rice soup and a bread stick. R2's meal was mostly uneaten. R27 grabbed R2's soup when R2 began wheeling herself away from the table. Social worker (SW)-A was alerted by surveyor R27 took R2's food and SW-A stated R27 could not have R2's food and R2's meal tray was taken away. During interview on 9/17/25 at 12:38 p.m., the vice president of clinical services, registered nurse (RN)-C stated a nurse, or NA was responsible for providing supervision and verified if there was an order for supervision, she expected the order to be followed. RN-C stated she took the order off for supervision yesterday and would ask R27 about taking food off another resident's plate and verified R27's care plan indicated R27 was independent with set up help only and R27's optional state assessment indicated R27 required supervision. Facility Activities of Daily Living (ADLs), Supporting policy dated 2/28/25, indicated residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene bathing, dressing, grooming, and oral care, mobility, elimination, dining meals and snacks, and communication. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. A resident's ability to perform ADLs will be measured using clinical tools, including the MDS. The MDS definition defined supervision as oversight, encouragement or cueing provided 3 or more times during the last 7 days.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 document review, the facility failed to provide ADL (activities of daily living) care to 1 of 1 resident (R14) reviewed for ADLs and who was dependent upon staff for bathing. Findings include:R14's face sheet received on 9/19/25, included diagnoses of chronic respiratory failure (lungs unable to adequately exchange oxygen and carbon dioxide over an extended period), high blood pressure, kidney failure and atrial fibrillation (irregular heart rate causing poor blood flow). R14's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, adequate hearing, clear speech, was understood and could understand. R14 was continent of bowel and bladder; required substantial/maximal assistance for activities of daily living (ADLs) including bathing. R14's care plan dated 1/11/25, indicated R14 had a self-care deficit with bathing and preferences would be considered when providing care. Care plan dated 12/23/24, indicated choosing bath type was very important to resident. A paper shower schedule, undated, posted on a cupboard door in the second-floor west nurses station indicated R14 was to receive a shower on Wednesday and Saturday evenings. R14's progress note dated Wednesday 9/10/25 at 10:29 p.m., indicated shower completed.During interview on at 9/15/25 at 1:55 p.m., R14 was sitting in her wheelchair in her room. Using a white board to ask questions, R14 stated she had not had a shower since Wednesday 9/10/25, and was supposed to have a shower twice a week on Wednesday and Saturday. When she asked staff, they told her they didn't have time. R14 stated she had itching in her groin area.During interview on 9/15/25 at 7:01 p.m., nursing assistant (NA)-G stated every resident was scheduled two showers so that if one was missed due to staffing, he/she would still get one. During interview on 9/16/25 at 8:33 a.m., R14 stated no shower yet.During interview on 9/17/25 at 7:55 a.m., NA-E in room to get R14 up and dressed. NA-E stated R14 got a shower twice a week on the evening shift, adding she did not work the evening shift so didn't give R14 a shower. NA-E stated NA's documented showers in POC (Point of Care in the electronic medical record - EMR). During document review and interview on 9/18/25, at 2:35 p.m., from 9/13/25, through 9/17/25, R14 was to receive two showers: one on Saturday 9/13/25, and one on Wednesday 9/17/25. On Saturday 9/13/25, R14 stated she did not receive a shower. R14 stated she had asked staff but was told they did not have time. On Wednesday 9/17/25, R14 stated she asked staff at 9:00 p.m., and was told they did not have time.During document review in POC on 9/13/25, it was documented that R14 had received a shower despite R14 saying she did not. On 9/17/25, it was documented that R14 had refused a shower despite R14 saying she did not. During interview on 9/19/25 at 9:52 a.m., R14 stated she had not had a shower since 9/10/15, nine days ago. R14 stated not getting a shower upset her; I like my showers. On 9/19/25 at 11:30 a.m., left phone message for NA-H to ask about R14's shower the evening of Wednesday 9/17/25. No response. During interview on 9/19/25 at 12:15 p.m., informed the director of nursing (DON) of findings regarding R14's showers. The DON stated she would expect staff to provide showers to residents as scheduled unless there was a specific reason, such as resident not in building, or declined. Informed there was documentation in POC that R14 received a shower on 9/13/25, but R14 stated she did not, and documentation R14 refused a shower on 9/17/25, but R14 stated she did not. Facility Supporting Activities of Daily Living (ADLs) policy dated 2/28/25, indicated residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. Residents unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services would be provided for residents who were unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure wound care orders were implemented for 2 of 2 residents (R13, R26) who had venous ulcers (skin openings caused by weak blood circulation), failed to ensure provider-ordered leg measurements were completed and documented for 1 of 1 resident (R29) reviewed for edema management, and failed to obtain a weight upon admission and follow orders for 1 of 3 residents (R46) reviewed for hospitalization. Findings include: IMPLEMEATION OF WOUND CARE ORDERS- NON-PRESSURE WOUNDS R13's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R13 had moderate cognitive impairment and diagnoses of venous insufficiency (poor blood flow to lower extremities), cellulitis (skin infection) of the left lower extremity, and heart failure. Furthermore, R13 had 3 venous ulcers and was at risk for skin breakdown R13's skin care area assessment (CAA) dated 7/25/25, indicated R13 was at risk for skin breakdown related to cognitive loss and incontinence. R13's care plan revised 7/21/25, indicated R13 had a vascular wound. Interventions included encourage resident to elevate legs and provide wound care per treatment orders. R13's skin and wound assessment dated [DATE], indicated R13 had a venous wound on the right shin that was stable and had a provider diagnosed infection of cellulites. R13 also had a venous wound on the front left lateral lower leg that had a suspected infection. R13's integrated wound care provider note dated 9/11/25, indicated R13's cellulitis to right shin was stable and venous ulcer to left lateral calf was deteriorating. R13's treatment plan was updated. The treatment plan included: -cellulites of right shin: cleanse wound with wound cleanser and pat dry, skin prep, leave open to air 3 times a week and as needed. -Venous ulcer left lateral calf: cleanse wound with wound cleanser, pat dry, skin prep to peri wound. Apply calcium alginate and super absorbent, wrap and change 3 times a week and as needed. R13's medical record showed this progress note was uploaded on 9/11/25, and there were no signatures or sign off the treatment orders being transcribed. R13's provider order dated 8/26/25, indicated R13 required wound care to right and left lower legs; cleanse with wound cleanser, pat dry, and apply xeroform dressing, then apply non-adherent/adherent dressing daily and as needed for wound care. This order was discontinued on 9/14/25; 3 days after R13's new treatment orders were sent to the facility. R13's provider order dated 9/14/25, indicated R13 required skin prep to the right shin topically every Tuesday, Thursday, Saturday and as needed for venous ulcer/cellulites treatment. This order was started on Tuesday 9/16/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's provider order dated 9/14/25, indicated R13 required calcium alginate dressing applied to left lateral calf daily on Tuesday, Thursday, and Saturday for wound treatment. This order was started on Tuesday 9/16/25. R13's medication administration record (MAR) dated 9/2025, showed the following: -R13 received the daily wound care to left and right lower extremities until 9/14/25, which was 3 days after the new treatment order should have been initiated. -R13's new wound treatment was not initiated until 9/16/25, which showed the Saturday 9/13/25 wound care was not completed per the new treatment orders. An observation and interview on 9/15/25 at 12:38 p.m., R13 was sitting up in a chair in their room. R13's legs were not elevated. The left lower extremity was wrapped. R13 stated she had sores on her legs but was not sure if she had any infection or if they were getting better. When interviewed on 9/18/25 at 7:17 a.m., nursing assistant (NA)-B stated care sheets were not used. NAs completed shift to shift report and even when new NA's train, they just learn the residents and get to know what their needs are. NA-B further stated any cares they provide were documented electronically. NA-B verified R13 was an assist of one and only needed help changing their brief and in the shower. NA-B was not aware of any interventions for R13 about her leg wounds or any need to encourage leg elevation. When interviewed on 9/18/25 at 8:08 a.m., registered nurse (RN)-A stated when wound rounds occur, the provider would give orders to the rounding nurse and following wound rounds, those would be entered right away. RN-A verified R13's wound care orders were not transcribed after wound rounds and R13 was not started on the new treatment until 9/16/25. R26's annual MDS assessment dated [DATE], indicated R26 was cognitively intact and had diagnoses of chronic venous hypertension and lymphedema (tissue swelling caused by an accumulation of fluid that's usually drained through the body's lymphatic system). R26 was not at risk for skin breakdown/injury. R26's care plan revised 8/13/25, indicated R26 was at risk for impaired skin integrity due to a history of cellulitis. Interventions included wound nurse consult as needed and use pressure relieving devices on appropriate surfaces. R26's skin and wound assessment dated [DATE], indicated R26 had a venous wound on the right lateral lower leg and left lateral lower leg. Both wounds were deteriorating and had suspected infections. R26's integrated wound care provider note dated 9/11/25, indicated R26's venous wounds were deteriorating. R26' treatment plan was updated and indicated R26 required cleansing of wound with wound cleanser, pat dry, skin prep to peri wound, calcium alginate and superabsorbent dressing and wrap daily and as needed for bilateral lower legs. R26's medical record showed this progress note was uploaded on 9/11/25 and there were no signatures or sign off the treatment orders being transcribed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R26's provider order dated 8/11/25, indicated R26 required cleansing of the wound bed with wound cleanser, moisten with Vashe, apply to wound bed for 5 minutes and remove and pat dry. Apply Atractain cream to dry and intact skin on feet and legs. Please [NAME] ag non adherent contact layer 4x5 to fit the wounds, cover with ABD dressing and secure with kerlix every other day and as needed. This order was discontinued on 9/14/25, three days after R26's new treatment orders were sent to the facility. R26's provider orders dated 8/15/25, indicated R26 required cleansing of the right and left lower extremity wound with Vashe. Keep moist gauze with Vashe on wound for 5 minutes and pat dry. Skin prep to peri wound and apply calcium alginate and superabsorbent dressing and wrap daily and as needed. R26's medication administration record (MAR) dated 9/2025, indicated R26 received every other day wound care to left and right lower extremities until 9/15/25, which was 3 days after the new treatment order should have been initiated. R26 received the daily dressing changes as of 9/16/25. An observation and interview on 9/15/25 at 12:12 p.m., R26 was sitting in a chair at bedside in their room. R26's legs were not elevated, and a towel was under their feet. Both legs were wrapped in kerlix wrap. Dressings appeared dry. R26 stated the towel was on the floor in case the wounds started leaking. R26 stated plenty of days the dressings were leaking, and it was hard to find anyone to change them. R26 further stated he was not sure if the wounds were getting better. R26 had problems with wounds before, but dressings were changed more often and so they healed, but there was no consistent dressing changes and so they “just leak”. When interviewed on 9/16/25 at 1:27 p.m., licensed practical nurse (LPN)-B stated R26 received dressing changes right away in the morning and sometimes in the afternoon. R26 was sleeping and last time LPN-B looked, the dressings appeared to be clean. LPN-B further stated if R26 was sleeping, we let him sleep as he can be very verbal and angry when woken up. When interviewed on 9/18/25 at 7:17 a.m., NA- B stated R26 was independent with walking and his wheelchair and did not require much assistance. R26 often was angry and sometimes refused staff coming into his room. NA-B was aware of R26's wounds on the skin and wasn't aware of any interventions or tasks to support with wound healing. When interviewed on 9/18/25 at 7:31 a.m., RN-B stated resident cares were known by the verbal report or the treatment plan. RN-B verified R26 had daily wound cares daily to both legs. RN-B stated R26's wounds would leak at times and extra dressing changes were needed. RN-B stated R26 can be resistant to cares at times and would easily anger and removed the dressings himself when they were soaked. RN-B verified R26's wound care orders were not started until 9/15/25, and the treatment was scanned into the chart on 9/11/25. RN-B stated he was not sure why the wound care orders were not entered to start right away as when orders were received, they were transcribed and started. When interviewed on 9/18/25 at 12:10 p.m., nurse practitioner (NP)-A stated during wound rounds, any changes are talked about with the rounding nurse. After wound rounds, I complete my notes and send them to the facility, so they have the notes and the treatment orders. NP-A expected staff to update orders to start right away as delays could impact wound healing. When interviewed on 9/18/25 at 12:19 a.m., the director of nursing (DON) and registered nurse (RN)-C, known as the vice president of clinical services stated orders come through on the fax machine and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the nurses who were working retrieve them and place them in the computer. Wound orders may be given the day of wound rounds, but the facility waits until the treatment comes through so the order could be entered based on that. This was to make sure the provider didn't change anything when completing the documentation. The orders were then co-checked by another nurse. DON expected staff to enter new orders when received. This was important to ensure residents were not delayed in care and received the proper care or treatments. Facility Pressure Ulcer/Skin Breakdown policy revised 6/2025, directed staff to review the residents care plan and identify risk factors as well as interventions to reduce or eliminate modifiable risks. Facility Medication and Treatment Orders policy revised 6/30/24, directed staff to immediately record verbal orders into the residents chart by the person receiving the order and must include the date, time, prescribers last name and credentials. LEG MEASUREMNETS R29's significant change in status MDS assessment dated [DATE], indicated R29 was admitted [DATE], cognitively intact, utilized a manual wheelchair, independent with upper body dressing, personal hygiene, transfers, diagnoses included diabetes, respiratory failure, chronic pain, obstructive sleep apnea, and morbid obesity. R29's care plan dated 6/12/25, indicated risk for impaired skin integrity: educate resident / representative on factors to maintain skin integrity. R29's medication administration record (MAR) dated 9/1/25-9/30/25, indicated start date 8/22/25, measure and document circumference of both thighs at same point daily X 7 days and then weekly one time a day every Thursday. The MAR on 9/4/25, and 9/11/25, had staff initials and check mark indicating completion of the task, however no documentation of the measurements were indicated. R29's provider encounter note dated 8/8/25 at 3:04 p.m., nurse practitioner (NP)-L indicated edema, right upper thigh, quite possibly lymphedema, patient lies on his right side, daily weights x 4 days, continue measurements of thighs and chart the values, nursing called regarding the patient's request to have something done with his right leg because that is a little bit bigger than the left leg, complaining of pain, chronic pain at baseline, complaints of right lower extremity being an inch and a half larger than the left side, pain in that right lower extremity, follow through with the orders that were written regarding measurement, documentation of pain , surveillance for infection, and referral for outside lymphedema provider. Measure BL (bilateral) thighs at same point and document daily for 7 days then weekly. R29's provider encounter note dated 8/11/25 at 12:28 p.m., NP-L indicated R29 complained of his right thigh being bigger than his left thigh latter part of last week measurements and orders were placed, claims it is painful. Ultrasound of bilateral lower extremities negative. Orders were written will continue to monitor. Continue measurements of thighs and chart the values. R29's progress note dated 8/13/25 at 9:59 p.m., nursing note indicated thigh and calf were measured this shift. Both thighs were measured at 35.0, right calf at 19.2 and left calf at 19.0 R29's progress note dated 8/14/25 at 1:29 p.m., indicated measure and document circumference of both thighs at same point daily X 7 days and then weekly one time a day L (left)=63cm (centimeters) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and R (Right)=66cm, upper calf L=45cm and R=52cm On 8/15/25 at 1:54 p.m., nursing note indicated R29's thigh R=66cm and L=63cm calf R=52cm and L=45cm. R29's progress note dated 8/17/25, measure and document circumference of both thighs indicated L 66 cm, R 64 cm. On 8/16/25 at 2:09 p.m., nursing note indicated R29 refused thigh measurement. R29's progress note dated 8/18/25 at 3:51 p.m., NP-L indicated hard to tell if there is a difference between R29's left upper thigh and his right upper thigh based on his habitus and how he lays on his right side in his bed and his large abdomen and pannus distort his abdomen, R29 convinced that his left upper thigh is 7 cm larger than his right thigh, placed referral for lymphedema. R29's progress note dated 8/20/25 at 8:09 a.m., measure and document circumference of both thighs at same point daily X 7 days and then weekly one time a day related to indicated notified therapy of this situation, review of records indicated no measurements were documented. R29's record review after 8/20/25, found no documentation of further measurements of R29's thighs. On 9/15/25 at 2:34 p.m., R29 was lying in bed, and stated he had been having ongoing thigh and calf swelling and stated in did not know if staff were doing about the swelling On 9/16/25 at 1:31 p.m., LPN-B stated R29 had weekly thigh measurements. LPN-B reported she completed R29's thigh measurements on 9/11/25, but did not document them in the electronic medical record (EMR) as expected. LPN-B stated measurements were expected to be documented in a nursing note, as there was no place in the MAR or TAR. LPN-B further stated she would look through her handwritten personal notes to try to find the measurements. On 9/16/25 at 2:16 p.m., LPN-E stated when taking measurements of R29's legs the documentation was expected in the nursing note. On 9/16/25 at 2:19 p.m., the DON stated she was aware R29 had weekly leg measurements and confirmed she expected the measurements documented in the EMR to monitor for changes. The DON acknowledged documentation was a problem, especially with agency staff, and stated agency nurses sometimes claimed they did not have EMR access. On 9/16/25 2:59 p.m., LPN-B stated she found her handwritten notes of R29's leg measurements and would enter a late note in the EMR. LPN-B acknowledged documentation was expected at the time measurements were obtained but admitted she often did not enter them right away due to workload. On 9/17/25 at 11:01 a.m., NP-L confirmed R29 had orders for weekly thigh measurements, which were important due to R29's body habitus. NP-L stated nursing staff were expected to document the weekly measurements and notify the provider of changes. NP-L stated without documentation, neither nursing nor providers would be able to detect changes in R29's thigh circumference. On 9/17/25 at 12:14 p.m., registered nurse (RN)-C, known as the vice president of clinical services, confirmed weekly thigh measurements were required and expected to be documented. RN-C stated if (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	measurements were not documented, staff would not know whether R29 had experienced a change in condition. OBTAINING WEIGHT R46 admission MDS assessment dated [DATE], indicated R46 was admitted [DATE], cognitively intact, dependent on toilet hygiene, showers/bath, required set up with dressing and personal hygiene, and partial/moderate assistance with roll left and right, diagnoses included heart failure and acute peptic ulcer, weight was not entered, high risk drugs included: diuretic. R46's care plan dated 6/23/25, indicated risk for malnutrition anemia, ETOH (alcohol) abuse, anxiety, esophageal varices, GI (gastrointestinal), depression, sepsis, lymphedema and interventions included evaluate exact height obtain weight per facility policy. R46's clinical admission document dated 6/18/25, indicated arrived on 6/18/25, via ambulance, section for weight was not documented, new onset right and left lower leg +3 pitting edema (moderate degree of swelling). R46's hospital discharge document dated 6/18/25, indicated weigh per facility protocol, medications orders included: potassium bicarbonate-citric acid 20 meq (milliequivalents) for potassium replacement 1 tab two times a day, and last documented weight on 6/18/25, 399 lb (pounds) 9.6 oz (ounces), R46's medication administration record (MAR) dated 6/1/25-6/30/25, start dated 6/19/25, indicated obtain resident weight upon admission, the next day, weekly x 2 weeks then monthly one time a day every 7 days for weight assessment, potassium bicarbonate-citric acid 20 meq for potassium replacement 1 tab two times a day R46's record review indicated the only weight documented at the facility was on the MAR dated 6/26/25, indicated a weight of 420.4 pounds. R46's record review failed to indicate a weight was taken upon admission, or the next day after admission as per orders indicated. R46's MAR dated 6/1/25-6/30/25, potassium bicarbonate medication order documentation twice daily indicated “9” (other/see progress notes); and no documentation indicated the medication was administered. R46's progress note indicated : 6/19/25 at 9:10 a.m., potassium bicarbonate medication order waiting for delivery from pharmacy, med is not available in the Omnicell (medication dispensing machine). 6/23/25 at 11:59 a.m., potassium meds not available, called pharmacy and said will deliver it tonight. 6/23/25 at 6:28 p.m., potassium waiting for delivery from the pharmacy. 6/24/25 at 10:45 a.m., potassium Unavailable and ordered (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/24/25 at 11:36 a.m., obtain resident weight upon admission, the next day, weekly x 2 has gotten out of bed and no chair. 6/24/25 at 5:06 p.m., potassium awaiting delivery R26's admission record indicated on 6/26/25 at 4:30 p.m., R46 was discharged to acute care hospital. On 6/26/25 6:35 p.m., order from nurse practitioner (NP)-L send R46 to the ER (emergency room) due to platelet 24, 911 was called, resident was transported to hospital via stretcher/ambulance at approximately 5:45 p.m. R26's hospital encounter dated 6/27/25, R46 reports orthopnea and >20 lb. weight gain since recent discharge, bed weight at facility today was 426 lb, was 399 [pounds] on DC (discharge), unsure of dry weight but believes it is around 385 lbs. BNP (Brain Natriuretic Peptide, lab test to detect signs of heart failure) increased over prior, CXR (chest x-ray) showing pleural effusions (fluid accumulates in the space between the lungs). Received IV (intravenous) Lasix (used to treat fluid retention) 60mg in ED (emergency department). R46's document titled weights and vitals on 6/26/25 at 2:00 p.m., indicated weight of 420.4 lbs. (mechanical lift). On 9/17/25 at 10:52 a.m., during a telephone interview NP-L stated obtaining a resident's weight upon admission to the facility was important to establish a baseline. NP-L stated the facility had ongoing problems with staffing and not having enough licensed staff to complete physician orders. NP-L stated this had been a concern, including with the failure to obtain resident weights as ordered. NP-L stated daily weights were expected for any resident on a diuretic; however, she reported receiving pushback from facility leadership, who wanted only weekly or monthly weights. NP-L stated she had discussed this with leadership and clarified that every other day was the longest interval she would accept without a weight for a resident receiving diuretics with a diagnosis of heart failure. NP-L stated she would have expected a documented admission weight for R46, followed by at least every-other-day weights. NP-L further stated she expected potassium to be administered as ordered, and if the facility could not obtain potassium from the pharmacy, the nurse was expected to notify her for an alternative medication. NP-L emphasized potassium was critical for residents with heart failure to ensure potassium remained at an optimal level. On 9/17/25 at 12:20 p.m., RN-C, known as the vice president of clinical services, stated residents were expected to have weights obtained upon admission. RN-C confirmed R46 did not have any documented weights other than from the hospital transfer on 6/26/25. RN-C further stated staff were expected to administer medications as ordered and notify the provider if a medication was unavailable. On 9/17/25 at 3:30 p.m. LPN-B and RN-D stated weights, and vital signs were required upon admission, followed by documentation per the orders in the MAR/TAR. On 9/17/25 at 3:35 p.m., LPN-B stated resident weights, and vital signs were expected upon admission and then according to the frequency specified in the MAR/TAR. LPN-B stated the weights and vitals were expected to be documented in the electronic medical record (EMR). LPN-B also stated that if a medication was not available, the nurse was expected to notify the pharmacy and the provider. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Standing orders Obtain weekly vital signs (TPR, BP, O2, weight) for four weeks, then monthly thereafter unless directed otherwise. Transitional Care/Short-Stay: Daily vital signs (TPR, BP, and Oˆ saturation) unless directed otherwise. Weekly weights for patients without Heart Failure unless directed otherwise. Heart Failure Management Daily weights for patients with Heart Failure unless directed otherwise. Call for weight gain 3 pounds or greater in 24 hours or 5 pounds in one week weight unless directed otherwise. Assess lung sounds, peripheral edema, and respiratory effort daily unless directed otherwise. Facility admission Notes dated 11/30/21, indicated: Height and weight of the resident Facility Weight Assessment and Intervention policy dated 1/4/24, indicated 1. Residents are weighed upon admission and at intervals established by the interdisciplinary team. 2. Weights are recorded in each unit's weight record chart and in the individual's medical record. 3. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. a. If the weight is verified, nursing will immediately notify the dietitian in writing.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a palm brace was used for 1 of 1 resident (R27) reviewed for range of motion.Findings include:R27's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R27 did not reject care, had impairment on one side to her upper extremity and used a wheelchair. Further, R27's diagnoses included hemiplegia (paralysis of one side of the body) following a cerebral infarction (stroke) affecting her right dominant side, apraxia (the inability to plan and execute purposeful, skilled movements), other speech language deficits following cerebral infarction. Additionally, R27 did not have physical therapy (PT) or occupational therapy (OT) and was not on a restorative nursing program for range of motion or splint or brace assistance. R27's care plan revised 7/7/25, indicated R27 had a functional maintenance plan for the potential for contracture and R27 refused to use the splint that was provided. R27's goal was to maintain her level of function and interventions included applying a palm brace, and nursing rehab/restorative toileting program to place R27 on the toilet every 2 hours while awake (? If relevant). The care plan lacked interventions for direction on what staff should do when R27 refused the splint and further lacked directives when the splint should be applied.R27's care plan revised 7/7/25, indicated R27 required one-person physical assist with bed mobility, dressing, personal hygiene, and transfers. R27's care plan revised 7/7/25, indicated R27 had impaired cognitive short term memory loss related to a history of CVA and interventions included asking yes or no questions to determine resident's needs.R27's orders were reviewed on 9/16/25 at 8:44 a.m., and lacked information R27 had a splint. R27's medication administration record (MAR) and treatment administration record (TAR) dated August 2025, lacked information R27 had a splint. R27's Behavior Monitoring and Interventions tasks form was reviewed from 8/18/25, to 9/16/25, and indicated R27 did not have behaviors.R27's progress notes dated 5/17/24, indicated R27 was discharged from therapy on 5/15/24, and was to wear a right resting hand splint overnight and during the day as desired by resident and remove for meals and hygiene. R27's progress notes dated 2/25/25 at 7:04 a.m., indicated R27 had weakness in the right hand. R27's PMR (physical medicine and rehabilitation) consultation progress note dated 9/13/25 at 8:23 p.m., indicated R27 had muscle atrophy and deconditioning secondary to prior stroke and was referred to therapy services for decreased functional status and muscle weakness, with a focus on improving mobility, strength and overall functional independence. Further, R27 had limited range of motion to the right upper extremity and right lower extremity and did not move her right upper extremity against gravity and no spasticity was appreciated. The note further indicated R27 was at high risk for functional impairment in developing contractures if not receiving adequate therapy.R27's progress notes were reviewed from 5/17/24, through 9/16/25, and lacked information R27 refused to use a right-hand splint. During interview and observation on 9/15/25 at 2:59 p.m., R27 shook her head no when asked if staff did any kind of exercises for her right hand. R27's right hand was curled, and her right arm was limp and denied using any kind of brace and was not wearing a brace. During interview on 9/16/25 at 11:40 a.m., R27 was in the dining room and did not have a brace on her right hand. During interview on 9/16/25 at 11:44 a.m., nursing assistant (NA)-A stated they looked at the computer to know what cares a resident required and stated they documented refusals on the computer and the nurse also had to document if a resident refused. NA-A stated R27 did not refuse care except for occasionally not wanting to use the toilet and did not know whether R27 wore a brace. During interview on 9/16/25 at 12:01 p.m., NA-C stated they had to look on the computer to know what cares a resident required under point of care and further stated they documented refusals in each care plan and further stated R27 did not have behaviors. NA-C stated R27 had a splint, but thought she took it off sometimes. At 12:03 p.m., NA-C went to R27's room and stated R27 may have put the splint somewhere and verified R27 did not have (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a splint on and further stated she did not apply a splint this morning because R27 was already dressed and stated she thought the splint was in R27's room. During interview on 9/16/25 at 11:54 a.m., licensed practical nurse (LPN)-A stated missing items were reported to family and management and the resident's room is searched to try to locate the missing item. During interview on 9/17/25 at 10:10 a.m., the director of rehab (DOR) who was also a certified occupational therapy assistant (COTA)-G stated R27 has not had any referrals for her hand for OT or PT, and was picked up by OT in February 2024 for dressing, toileting, a history of CVA on the right side and had a home exercise program to increase her ROM on the right. COTA-G did not know what kind of ROM R27 required and stated it would be on her care plan and added the goal was for both passive and active ROM and the discharge summary for her goal was R27 was independent for ROM and required splinting for the left upper extremity. COTA-G thought that left was a typo when questioned about which side the splint was for. Further, COTA-G stated she expected the splint to be applied if the splint was care planned and if R27 refused the splint, expected staff to communicate the refusals to the therapy department and if they had, therapy would have screened R27 and picked her back up and added it was important because not having the splint could lead to worsening contractures which could impair R27's functional abilities to do a variety of her activities of daily living (ADLs) and R27's skin integrity. During interview on 9/17/25 at 8:09 a.m., NA-C stated she did not know where R27's splint was, but if it was care planned, the nurse was good about asking about it and verified R27 did not have a splint on and added, it could be the nurse's responsibility. During interview on 9/17/25 at 8:12 a.m., NA-D stated he normally worked with R27, and worked at the facility for one and a half years. NA-D brought R27 back to her room and stated he had not seen R27's splint in a long time and asked R27 if she had worn the splint in a while and R27 shook her head no. R27 shook her head yes when asked if she wanted to wear the splint. NA-D viewed R27's care plan and stated R27 does refuse the splint but added he could not locate the splint and verified R27 indicated she wanted to wear it.During interview on 9/17/25 at 8:41 a.m., LPN-C stated they knew what care a resident required by looking at the care plan and if a resident refused, the aides had to reapproach and when the resident refuses, the NA's must document refusals and then the nurses are updated and must document the refusals as well. LPN-C stated R27 did not refuse cares and stated R27 was cooperative and further stated if R27 had a splint, it was new because she had not seen it before. Additionally, LPN-C stated if the splint was care planned, she expected staff to apply the splint and if R27 refused, staff would have to talk to her and explain why it was needed and if she did not want it, they would have to update the physician so they could find other things R27 would be willing to use. During interview on 9/17/25 at 9:35 a.m., vice president of clinical services, registered nurse (RN)-C stated staff read the Kardex to know what cares a resident required and if a resident refused, staff should reapproach and the nurses document refusals in a progress note and the NA's document refusals on point of care. RN-C was not aware R27 had a splint and stated R27 was here for hemiplegia following a stroke with right sided weakness. RN-C viewed R27's care plan and stated R27 had a potential for contractures and refuses the splint and would have to ask therapy if the splint needed to be discontinued if she was not wearing it or give an alternative and added if it was on the care plan, expected staff to offer the splint and locate the splint, and contact the physician and therapy. RN-C viewed R27's progress notes and verified documentation lacked refusals for the splint and did not see any documentation from the aides regarding refusals and added the schedule in the computer was not turned on to make the aide document the frequency. Further, RN-C stated NA's were supervised by viewing the documentation and if the schedule was turned on they would have the documentation for review and added it would be important to make sure contractures didn't get worse. Facility Range of Motion Exercises policy dated 2/7/22, indicated to verify there was a physician's order for exercises and to review the resident's care plan to assess for any special needs of the resident and assemble the equipment and supplies as needed. The following information should be recorded in the resident's medical record: if the resident refused the treatment, the reason(s) why and the intervention taken. Notify the (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supervisor if the resident refuses the exercises. The policy lacked information on donning/doffing splints.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a nutritional supplement was ordered and implemented per the dietician recommendation for 1 of 1 resident (R3) reviewed for food. Findings include: R3's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated moderately impaired cognition, no rejection of care, setup assistance for eating, and diagnosis included severe protein-calorie malnutrition.R3's care plan revised dated 7/29/25, indicated R3 impaired nutrition. severe protein-calorie malnutrition and interventions encourage resident / representative participation in meal planning provide, serve diet/supplement as ordered, monitor intake and record every meal.R3's dietary note dated 7/29/25 at 2:55 p.m., registered dietician (RD)-N no significant weight changes noted, weight fluctuations are expected related to ETOH (alcohol) abuse and severe protein-calorie malnutrition. RD recommends offering Glucerna (meal replacement product) or similar HNS (house nutritional supplement) TID (three times a day) between meals to help with weight/nutrition, no complaints of chewing or swallowing difficulties noted, exhibits potentially inadequate nutrition as evidenced by weight loss with fair intake records, potential for altered nutrition related to diagnosis and history.R3's progress note dated 8/21/25 at 10:05 a.m., nurse practitioner (NP)-L indicated R3 requiring additional resources due to degree of malnutrition during hospital stay. Dietitian following with the following nutrition therapy plan, supplements BID (twice daily) encourage adequate po intake.R3's physician's orders dated 9/17/25, failed to include an order a nutritional supplement.On 9/16/25 at 1:42 p.m., R3 was lying in bed and stated he had not received or been offered a supplement drink or any type of nutritional drink since admission to the facility.On 9/17/25 at 8:51 a.m., licensed practical nurse (LPN)-B was observed reviewing R3's electronic medical record (EMR). LPN-B stated R3 did not have an order for any nutritional supplement drinks. LPN-B further stated the dietician writes orders when at the facility and provides them to a nurse. The nurse is then expected to enter the order into the EMR and communicate it to the dietary department to ensure the resident receives the nutritional supplement.On 9/17/25 at 9:37 a.m., registered dietician (RD)-N stated they come to the facility weekly on Mondays and review residents based on the MDS schedule or referrals sent by the director of nursing (DON). RD-N stated they saw R3 on 7/29/25, and recommended a nutritional supplement. RD-N stated that on 7/29/25, an email was sent to the previous DON to implement the recommendation for R3, and they expected the order to be entered and R3 to receive the supplement. RD-N further stated that with the new DON in place, they now email the new DON and registered nurse (RN)-C, vice president of clinical services, with recommendations.On 9/17/25 at 11:08 a.m., nurse practitioner (NP)-L stated they would expect the orders emailed from the dietician to be implemented.On 9/17/25 at 12:12 p.m., RN-C stated the former DON would have received an email from RD-N regarding R3's supplement and stated they would expect the order to be entered into the EMR and implemented per the dietician's recommendations.Facility High Calorie/High Protein Supplements policy dated 2017, indicated:Supplement acceptance will be documented in progress notes, care plans and/or assessments as appropriate. Individual acceptance of supplements will be monitored, and adjustments will be made as needed.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to follow physician orders to provide appropriate gastrostomy/jejunostomy (GJ Tube) tube feeding (TF) solution and to use appropriate tube to administer medication for 1 of 1 resident (R41) reviewed for tube feeding administration. Findings include:G-J tube is a tube placed through the skin into the stomach and fed into the small intestine. There are 3 ports on the tubing outside of the skin that serve different purposes. The gastric port tube sits in the stomach and is used to give medications, vent air and drain fluids. The Jejunal port sits in the small intestines and is used for feeding. (John Hopkins Medicine, undated). R41's face sheet received on 9/19/25, identified current diagnoses including acute hemiplegia (one-sided paralysis) following cerebral infarction (stroke) affecting the right dominant side, protein-calorie malnutrition, metabolic encephalopathy (change in brain function due to an underlying health issue), dysphagia (difficulty swallowing) following cerebral infarction, and aphasia (damage to the areas of the brain responsible for language that impaired language expression and comprehension) following cerebral infarctionR41's quarterly Minimum Data Set (MDS) assessment dated [DATE], included R41 sometimes understands but rarely understood and had severely impaired cognitive decision making skills. R41 had no speech. R41 received tube feeding for 51% or more calories. R41 received an anticoagulant and hypoglycemic medication. R41's plan of care dated 7/2/25, included that R41 required tube feeding related to dysphagia. Interventions included that R41 needed the head of bed elevated minimally at 30 degrees during and thirty minutes after tube feeding. Staff were to obtain and monitor lab/diagnostic work as ordered, report results to physician and follow up as indicated. The registered dietician was to evaluate quarterly and as needed. Staff were to monitor caloric intake, estimate needs and make recommendations for changes to tube feeding as needed. R41's provider orders included administering Isosource 1.5 calorie solution (high-calorie, high-protein, high-fiber tube-feeding formula for increased calorie needs and/or limited fluid tolerance) at 90 milliliters per hour for 16 hours daily. Start feeding at 6:00 p.m.During observation on 9/15/25 at 6:36 p.m., the TF was not attached to R41, and the current Isosource bag had 100 cc present in it. No label was present on the bag and did not indicate the date or time the bag was started. During observation on 9/15/25 at 7:48 p.m., the TF bag tubing was no connected to R41, the pump was not on and the same Isosource solution hung on the pump next to the bed. During observation 9/16/25 at 8:48 a.m., R41 was asleep in his bed. The head of the bed was elevated 30 degrees. The TF pump was on and infusing at 90 ml per hour. There was 700 cc present in the Isosource bag, which had no label on the bag when the solution was hung and TF started. During interview on 9/16/25 at 8:50 a.m., licensed practical nurse (LPN)-A stated R41's TF would run until 10:00 a.m. that morning. When questioned about what time the TF was started the previous evening, LPN-A looked at medication administration record (MAR) and stated 6:06 p.m. She was Informed that at 7:48 p.m. the TF was not running, and she stated the nurse on the evening shift was new but should know it needed to be started timely within an hour of scheduled time. LPN-A confirmed that the bag should have been labeled with resident name, date hung and time started. During observation and interview on 9/16/25 at 2:20 p.m., LPN-A labeled the Isosource 1.5 ml solution bag with date and time. LPN-A stated she had notified the provider of the observation that R41's TF had not been started on time and that the provider ordered the TF to start at 2:00 p.m. and end at 6:00 p.m. LPN-A went to hang the TF but R41 was outside. The TF was not started at 3:40 p.m. when resident returned to his room using the port labeled J. During observation on 9/17/25 at 8:19 a.m., R41's TF pump was running at 90cc per hour. There was 750 mls of solution was present in the bag. A label on the Isosource bag stated new bag hung on 9/17/25 at 5:00 a.m. with TF started at 2:00 p.m. On 9/16/25, R41's MAR indicated the TF should have been discontinued at 6:00 a.m. During observation and interview on 9/17/25 at 11:14 (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.m., LPN-B entered R41's room, and stopped TF solution and placed pump on hold. LPN-B drew up water in a syringe, hooked it to the port labeled J and flushed with water. Carvedilol 3.125 mg oral tablet was crushed and levetiracetam 750 mg solution were mixed with water in separate medication cups and administered through the port labeled J tube, flushing with 60 mls of water in between medications and flushed with 120 mls of water after medication administration was completed. LPN-B then hooked the TF solution to the J tube port and started pump at 90cc/hr. A sign on the wall above the resident's bed indicated that medications were to be given through the connector labeled G tube and LPN-B stated, oh yeah, I was supposed to use the other tube. LPN-B did not think it would affect the resident as he still got his medications. LPN-B stated the TF runs the whole time R41 was in bed and if he got up into a chair, they would stop the TF infusion. During interview on 9/17/25 at 9:32 a.m., registered dietitian (RD)-N stated that the TF should run for the 16 hours he had recommended, or R41 may not get enough or might get too many calories. RD-N stated that generally an hour either way of starting late or stopping early was within standard of care. RD-N stated he had requested weekly weights to ensure R41's weight remained stable. RD-N stated that orders such as 16 hours per day versus amounts such as 1500 ml of solution were common for residents who get long term TF.During interview on 9/17/25 at 9:50 a.m., nurse practitioner (NP)-L stated it was important to infuse the TF per orders to attain appropriate calorie levels. NP-L stated staff need to make it a priority to start or stop the infusion when it should be, otherwise residents could be over- or underfed. NP-L stated that generally, staff were allowed an hour prior or after, which was acceptable.During observation 9/17/25 at 1:19 p.m., R41's continued to receive TF via pump running at 90 cc/hr. During interview on 9/17/25 at 3:45 p.m., pharmacist (P)-O stated that generally the J tube was smaller than the G tube, which could cause clogs in the tube. P-O stated that administration in the J tube lacked gastric breakdown but added it would be just as effective. P-O evaluated carvedilol and levetiracetam solution and indicated there would not be any effect on overall absorption or effectiveness of medication for R41, so did not believe it was a significant medication error, but added that it was a medication error in the route used for administration.During interview on 9/17/25 at 1:35 p.m., the director of nursing (DON) stated that R41's TF should have run for the 16 hours as ordered, or R41 could have been over- or underfed. The DON confirmed that per order it was not a continuous infusion for TF. The DON stated that they should have followed the schedule on the MAR. The DON stated that if the medications were given via the J tube and not the G tube as ordered, this would be considered a medication error.Facility Enteral Feedings - Safety Precautions policy dated 4/24/25, included: Preparation- All personnel responsible for preparing, storing and administering enteral nutrition formulas will be trained, qualified and competent in his or her responsibilities.- The facility will remain current in and follow accepted best practices in enteral nutrition.Preventing errors in administration-Check the enteral nutrition label against the order before administration. Check the following information:1. Resident name, ID and room number;2. Type of formula;3. Date and time formula was prepared;4. Route of delivery;5. Access site;6. Method (pump, gravity, syringe); and7. Rate of administration (mL/hour).- On the formula label document initials, date and time the formula was hung/administered, and initial that the label was checked against the order.Preventing misconnection errorsEnsure that all enteral formula labels indicated not for IV use. Instruct all non-clinical staff, residents and families not to reconnect any tubing or lines, but instead to notify a nurse if tubing becomes disconnected. Regularly inspect tubing for proper connections. Reconnect tubing only under goo dlighting. Trace tubing back to the source prior to reconnecting. Do not modify or try to adapt connections to enteral devices. Do not use IV pumps to administer enteral feedings. Use labels or color-coded enteral tubes, devices and connectors to distinguish them from catheters and other tubing. Use only enteral syringes to deliver enteral feedings and medications.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure continuous positive airway pressure (CPAP) therapy was used in accordance with physician orders to meet the individual needs for 1 of 3 residents (R6) reviewed for respiratory care and services. Findings include:R6's face sheet received on 9/8/25, included diagnoses of morbid (severe) obesity, heart failure, acute respiratory failure, chronic pain, and obstructive sleep apnea (breathing repeatedly stops and starts during sleep due to obstruction in upper airway). R6's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, no behaviors including refusal of care. Activities of daily living (ADL's) included R6 does not walk, and was independent with all transfers, eating and personal hygiene. Special treatments included CPAP and oxygen use. R6's plan of care dated 8/13/25, included administer oxygen as prescribed or per standing order at 4 liters per nasal cannula, CPAP per order, evaluate pulse oximetry, head of bed elevated at 30 degrees at all times and observe for sleep apnea risk factors. R6's physician orders dated 8/10/25, included empty water from CPAP/BIPAP humidity chamber and fill with warm soapy water and shake. Rinse and allow to air dry one time a day. Wash CPAP/BIPAP face mask and tubing with warm soapy water and rinse weekly. Mix 1 part vinegar and 3 parts water in basin weekly. Soak mask, tubing and leave in solution for 30 minutes. Rinse with water and allow to air dry. Place order for CPAP supplies for hose, mask, filters and reservoirs and other necessary supplies (dated 8/13/25). On observation and interview 9/16/25 at 1:31 p.m., R6 was lying in his bed with oxygen on at 4 liters per nasal cannula. Present on the bedside table was a CPAP machine with no mask, tubing or cord present. R6 stated he hasn't worn his CPAP since he has been at the facility as the mask and tubing was old and was thrown away. R6 added somehow the plug in cord got lost also after arrival and hasn't been found. R6 stated he has had the machine for years but didn't always wear it. R6 stated at his last hospitalization in July, the physician explained the importance of using his CPAP and upon return informed staff (could not identify who) he wanted to start wearing it but needed supplies and a power cord. On interview 9/16/25 at 1:50 p.m., licensed practical nurse (LPN)-B stated she had informed registered nurse (RN)-E, also identified as care coordinator, about a month ago and she was going to work on getting replacement tubing, mask and cord. LPN-B stated had not received further updates. On observation and interview 9/17/25 at 8:14 a.m., R6 was sitting on the edge of his bed eating breakfast. A CPAP machine remained sitting on bedside table without mask, tubing or cord. R6 stated staff have not addressed replacing his CPAP machine cord or replacing the mask and tubing since he first asked about it at the end of July. R6 stated he would like to start using the CPAP machine. On interview 9/17/25 at 9:53 a.m. nurse practitioner (NP)-L stated she was not aware R6 was not wearing his CPAP machine. NP-B stated someone should have replaced the supplies or if having difficulty getting them let her know they were not available if the machine is old. NP-L stated how important it is for R6 to wear the CPAP when he sleeps due to his heart failure.On interview 9/17/25 at 12:45 p.m., RN-E stated a nurse reported the missing CPAP equipment to her and she notified the director of nursing. RN-E stated the last she heard about a month ago, was that the machine came from a different company, and they were having a hard time replacing the mask, tubing and power cord. RN-E stated she hasn't heard anything else since that time. On interview 9/17/25 at 1:38 p.m., the director of nursing (DON) stated she was not aware of R6's CPAP not having the proper equipment. The DON confirmed it is important for R6 to wear his CPAP mask due to his diagnosis. Facility CPAP/BiPAP Support policy dated 11/1/21, included:Purpose1. To provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen.2. To improve arterial oxygenation (PaO2) in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease.3. To promote resident comfort and safety.Preparation1. Only a qualified and properly trained nurse or respiratory therapist should administer oxygen through a CPAP mask.2. Review the resident's medical (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record to determine his/her baseline oxygen saturation or arterial blood gases (ABGs), respiratory, circulatory and gastrointestinal status.3. Review the physician's order to determine the oxygen concentration and flow, and the PEEP pressure (CPAP, IPAP and EPAP) for the machine.4. Review and follow manufacturer's instructions for CPAP machine setup and oxygen delivery.5. Resident should be NPO for at least 2 hours before using a full-face mask. Equipment and Supplies6. NO SMOKING sign for the resident's room;7. CPAP/BiPAP system (flow generator);8. Disposable circuit tubing with mask and head strap;9. Large bore tubing (6 foot);10. Humidification system;11. Filter; and12. Pulse oximeter.Steps in the Procedure1. Explain the procedure to the resident. Ask his/her permission to continue.2. Explain the safety precautions required during oxygen administration (if used).3. Explain possible side effects of CPAP and instruct to report any discomfort to the nurse.4. Wash your hands.5. Connect filter to air flow outlet.6. Connect one end of the large-bore tubing to the outlet port of the humidifier and the other to the CPAP circuit tubing.7. Position the exhalation port of the mask away from the resident's face and free from obstruction.8. Set mode, CPAP, IPAP and EPAP settings on the machine, as prescribed.9. Attach pulse oximeter to the resident.10. Holding the mask to the resident's face, turn on the machine and allow him/her to become acclimated to the pressure.11. Once the resident is acclimated, secure mask on his/her face.1. The mask should fit firmly but does not need to be airtight.2. Placing the mask on too tightly increases the chance of aspiration and skin breakdown.12. Connect supplemental oxygen (Note: Connect oxygen after the CPAP machine has been turned on and disconnect before it has been turned off.) and adjust flow rate as prescribed.13. Monitor the oxygen saturation of the resident.DocumentationDocument the following in the resident's medical record:1. General assessment (including vital signs, oxygen saturation, respiratory, circulatory and gastrointestinal status) prior to procedure;2. Time CPAP was started and duration of the therapy;3. Mode and settings for the CPAP/IPAP/EPAP;4. Oxygen concentration and flow, if used;5. How the resident tolerated the procedure; and6. Oxygen saturation during therapy.Reporting7. Notify the physician if the resident refuses the procedure.8. Notify the physician if the resident experiences any adverse consequences, including (but not limited to) respiratory distress and marked change in vital signs.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, and staff interview, the facility failed to ensure provider-ordered pain medications were administered for 1 of 3 residents (R29) reviewed for pain management.Findings include:R29's significant change in status Minimum Data Set (MDS) assessment dated [DATE], indicated R29 was admitted [DATE], cognitively intact, utilized a manual wheelchair, independent with upper body dressing, personal hygiene, transfers, diagnoses included diabetes, chronic pain, polyneuropathy (malfunction of many peripheral nerves throughout the body causes painful tingling or burning sensations), and morbid obesity.R29's care plan dated 6/12/25, indicated acute pain/chronic pain, apply hot or cold packs for comfort, establish a pain management treatment plan, evaluate for non-verbal indicators of pain.R29's medication administration record (MAR) dated 9/1/25-9/30/25, indicated start date 8/12/25, buprenorphine (manage moderate to severe pain) sublingual (applied under the tongue) tablet 2 mg (milligrams) two times a day for chronic pain.R29's MAR documentation on 9/13/25 at 8:00 a.m., and 8:00 p.m., and 9/14/25 at 8:00 a.m., indicated 9 (9=other / see progress notes)R29's progress notes indicated:9/13/25 at 11:41 a.m., buprenorphine not available9/13/25 at 8:09 p.m., buprenorphine med not on hand9/14/25 at 12:49 p.m., buprenorphine not availableR29's progress note dated 9/11/25 at 3:00 p.m., nurse practitioner (NP)-P indicated R29 reports pain in BLE (bilateral lower extremities) 10/10 and continues to feel that his pain is not well managed, recommend nursing monitor pain level closely and report significant changes.R29's document titled Weights and Vitals Summary indicated:On 9/14/25 at 9:25 p.m., pain level 0On 9/14/25 at 7:40 p.m., pain level 10On 9/14/25 at 7:33 p.m., pain level 8On 9/14/25 at 5:51 p.m., pain level 2On 9/14/25 at 2:27 p.m., pain level 7On 9/13/25 at 5:11p.m., pain level 7On 9/13/25 at 4:58 p.m., pain level 7On 9/13/25 at 4:54 p.m., pain level 10On 9/13/25 at 4:53 p.m., pain level 9On 9/13/25 at 10:29 a.m., pain level 10On 9/12/25 at 9:00 p.m., pain level 0On 9/15/25 at 2:34 p.m., R29 was observed lying in bed and stated he had not received pain medications all weekend. R29 reported experiencing 10/10 pain in both feet and legs over the weekend and stated the facility was out of the medications. R29 stated staff had called the pharmacy but he still did not receive his medication, and there was no follow-up with him regarding the delay.On 9/17/25 at 8:47 a.m., licensed practical nurse (LPN)-B stated that medications were expected to be reordered when there are approximately eight tablets remaining. LPN-B further stated that nurses can reorder medications through the electronic medical record (EMR) system, and if unable to do so, they were expected to call the pharmacy. LPN-B stated that if R29's buprenorphine was unavailable, staff were expected to notify the provider to obtain the medication or an alternative so that the resident's pain would not worsen.On 9/17/25 at 9:03 a.m., LPN-C stated that missed medication doses due to the facility not having residents' medications available was a known issue. LPN-C stated that nurses do not always have the time to reorder medications, follow up with providers, or call the pharmacy, resulting in missed doses for residents.On 9/17/25 at 11:01 a.m., nurse practitioner (NP)-L confirmed that R29 was prescribed pain medications for pain in his feet and legs. NP-L stated that medications should be administered as prescribed, and the pharmacy was available to deliver medications the same day. If medications were not available, NP-L stated the facility should have alternative means to obtain them and expected the provider to be notified so an alternative medication could be addressed.On 9/18/25 at 9:04 a.m., registered nurse (RN)-C, vice president of clinical services, indicated via email that the facility had no medication errors for the past 30 days and confirmed that a missed medication was considered a medication error.On 9/18/25 at 11:10 p.m., RN-C stated that nursing staff should notify the pharmacy if a medication was unavailable, and that the pharmacy can deliver medications within four hours, with a cut-off delivery time of 11:00 p.m. RN-C stated medications should be reordered when there are three days' supply left. RN-C further stated that the provider should be notified for replacement medication if medications were unavailable. RN-C acknowledged that missed medications and (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication errors occurred on 9/17/25 and confirmed that medication errors are expected to be reported via incident reports and investigated.Facility Pain - Clinical Protocol policy dated 6/9/25, indicated1. The physician will order appropriate non-pharmacologic and medication interventions to address the individual's pain.a. Pain medications should be selected based on pertinent treatment guidelines. Generally, and to the extent possible, an analgesic regimen should utilize the simplest regimen and lowest risk medications before using more problematic or higher risk approaches.2. Staff will provide the elements of a comforting environment and appropriate physical and complementary interventions; for example, local heat or ice, repositioning, massage, and the opportunity to talk about chronic pain.3. For the individual who is receiving opioid analgesics, the physician will order a regimen of laxatives and other measures to prevent constipation.Monitoring1. The staff will reassess the individual's pain and related consequences at regular intervals; at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain.a. Review should include frequency, duration and intensity of pain, ability to perform activities of daily living (ADLs), sleep pattern, mood, behavior, and participation in activities.2. The staff will evaluate and report the resident/patient's use of standing and PRN analgesics.a. Depending on the characteristics of pain, the physician may start with PRN doses or supplement standing doses with PRN doses for breakthrough pain.b. If there are more than occasional analgesic requests, the physician will consider changing to regular administration of at least one analgesic with another medication for PRN use, increasing the standing dose of an existing analgesic, switching to another analgesic, and/or adding nonpharmacological measures.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure ongoing assessment of resident's condition and monitoring for complications before and after dialysis treatments and failed to ensure ongoing communication and collaboration with the dialysis facility regarding dialysis care and services for 1 of 1 resident (R4) reviewed for dialysis services.Findings include:R4's face sheet printed 9/17/25, indicated diagnoses of congestive heart failure, diabetes type two, chronic kidney disease, and dependence on renal dialysis. R4's part A discharge Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, setup assistance with eating, dependent for toilet use and bathing, partial assistance with upper body dressing, dependent for lower body dressing, and use of wheelchair.R4's physician's orders printed 9/16/25, lacked any orders related to dialysis, including monitoring the dialysis site and communicating with dialysis company.R4's care plan revised 8/31/22, lacked information related to R4's specific dialysis needs, which arm his arteriovenous (AV) graft was in, name of dialysis company, contact information for the dialysis company, and directions on when to assess the AV graft site.R4's care plan printed 9/17/25, indicated resident at risk for complications and required ongoing dialysis for renal failure. Interventions included coordinated services with dialysis servicer, do not draw blood or take blood pressure in arm with graft, resident receives dialysis Monday, Wednesday, Friday, and observe shunt for symptoms of infection or complication.On 9/15/25 at 5:00 p.m., R4 was in his room. R4 stated he had been to dialysis that afternoon. R4 further stated nurses do not look at his dialysis site and he took the dressings off himself.During interview on 9/16/25 at 1:16 p.m., licensed practical nurse (LPN)-A stated she was not sure where any specific directions were for dialysis care of R4, could not locate a number for the dialysis facility, was not sure how they communicated with the dialysis and that she just knows to assess his site as basic knowledge. LPN-A stated she was not sure how an agency nurse would know that information. LPN-A further stated there was no dialysis information on R4's physician's orders and his care plan information was generic and not specific to him.During interview on 9/16/25 at 1:34 p.m., LPN-B stated she would not know where to find dialysis information for R4. During interview on 9/16/25 at 3:02 p.m., LPN-F stated there were no directions in point click care (PCC) electronic medical record (EMR) related to assessing the AV graft site or any orders about dialysis in general. LPN-F further stated she did not know how they communicated with the dialysis company and R4 rarely returned with information from dialysis LPN-F stated she did not know where she would find a phone number to call the dialysis. During interview on 9/16/25 at 2:52 p.m , director of nursing (DON) stated she was new to the facility but would expect R4's care plan to have specific information related to his dialysis needs so nurses knew how to care for him. DON further stated she would expect some type of nurse to nurse communication between facility nurses and dialysis nurses but did not know if or how that was happening.During interview on 9/18/25 at 10:30 a.m., registered nurse (RN)-C, who was known as the vice president of clinical service stated R4's care plan was vague and not specific to his needs. RN-C further stated R4 should have assessments daily of his AV graft to ensure no infection or complication, and that should have been indicated on his care plan and physician's orders so any nurse working could access the information. RN-C further stated the phone number for dialysis should be posted for the nurses and the nurses should be communicating with the dialysis company.Review of facility electronic medical record (EMR) from 7/25 through 9/25 indicated no assessment of AV graft on the following dates R4 received dialysis treatment: 7/14/257/18/257/21/257/23/257/25/257/28/258/11/258/15/258/18/258/29/259/8/259/10/259/15/25Two phone calls placed to Davita dialysis were not returned.A dialysis policy was requested but not received.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 document review, the facility failed to ensure a medication error rate of less than 5 percent (%). 3 medication errors occurred out of 35 opportunities resulting in an error rate of 8.57% for 2 of 5 residents (R41, R19) observed during medication administration. Findings include: G-J tube is a tube placed through the skin into the stomach and fed into the small intestine. There are 3 ports on the tubing outside of the skin that serve different purposes. The gastric port tube sits in the stomach and is used to give medications, vent air and drain fluids. The Jejunal port sits in the small intestines and is used for feeding. (John Hopkins) R41's face sheet provided on 9/19/25, identified that R41's current diagnoses included acute hemiplegia (one-sided paralysis) following cerebral infarction (stroke) affecting the right dominant side, protein-calorie malnutrition, metabolic encephalopathy (change in brain function due to an underlying health issue), dysphagia (difficulty swallowing) following cerebral infarction, and aphasia (damage to the areas of the brain responsible for language that impaired language expression and comprehension) following cerebral infarction R41's quarterly Minimum Data Set (MDS) assessment dated [DATE], included that R41 sometimes understands but rarely understood and had severely impaired cognitive decision making skills. R41 had no speech. R41 received tube feeding for 51% or more calories. R41 received an anticoagulant and hypoglycemic medication. R41's provider orders dated 6/2/25, included Carvedilol 3.125 mg tablet. Give 2 tablets by mouth two times a day into gastric feeding tube two times a day. Levetiracetam oral solution 100 milligrams/milliliter (mg/mL). Give 7.5 ml via “G” tube two times a day for seizures. During observation and interview on 9/17/25 at 11:14 a.m., LPN-B entered R41's room, placed pump on hold and disconnected tube feeding solution from the “J” tube. LPN-B drew up water in a syringe, hooked it to the port labeled “J” and flushed with water. Carvedilol 3.125 mg oral tablet was crushed and levetiracetam 750 mg solution were mixed with water in separate medication cups and administered through the port labeled “J tube, flushing with 60 mls of water in between medications and flushed with 120 mls of water after medication administration was completed. LPN-B then hooked the TF solution to the “J” tube port and started pump at 90cc/hr. A sign on the wall above the resident's bed indicated that medications were to be given through the connector labeled “G” tube and LPN-B stated, “oh yeah, I was supposed to use the other tube”. During interview on 9/17/25 at 3:45 p.m., pharmacist (P)-O, stated that generally the “J” tube was smaller than the “G” tube which could cause clogs in the tube. P-O stated administration via the “J” tube lacked gastric breakdown but added it would still be just as effective. P-O evaluated carvedilol and levetiracetam solution and indicated there would not be any effect on overall absorption or medication effectiveness and did not believe a significant medication error but added was a medication error due to the route given. During interview 9/17/25 at 1:35 p.m., the director of nursing (DON) stated R41's medications given via the “J” tube instead of the “G” tube as ordered, were considered a medication error. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R19's quarterly MDS dated [DATE], indicated R19 had mild cognitive impairment and diagnoses diabetes, bipolar disorder and parkinsonism (umbrella term for brain conditions that cause tremors and rigidity). R19's provider orders dated 8/5/25, indicated R19 required Sinemet oral tablet 25-100 milligrams (mg) 1 tablet three times daily for parkinsonism. (a medication that is needed to be taken at the same time each day to ensure effectiveness) This medication was ordered to be given at 8:00 a.m., 2:00 p.m., and 8:00 p.m. During observation on 9/16/25 at 10:12 a.m., LPN-B was administering morning medications to R19. Included in the medication was Sinemet oral tablet 25-100mg. This medication was administered late. When interviewed on 9/16/25 at 10:20 a.m., LPN-B verified R19's Sinemet was administered late and verified the importance of giving this medication on time. LPN-B further stated there were 21 residents to give medications to and she tried to prioritize giving residents medications that are due closer together, for example a medication that was needed at 8:00 a.m. and then again at 12:00 p.m. first. LPN-B stated medications come first, however there are other requests for help from staff and residents as well. LPN-B stated with only 2 nurses, it can be challenging to get everything done and done on time. LPN-B further stated medications were supposed to be given an hour before to an hour after the scheduled time. When interviewed on 9/17/25 at 10:14 a.m., the director of nursing (DON) expected medications to be given on time. Furthermore, this was important to ensure the medications would not be given to close together and ensure the resident wouldn't have any worsening symptoms. Facility Administering Medications policy revised 3/6/25, directed staff to administer medications according to prescriber orders, including required time frame and to determine times by resident need and benefit and not staff convenience to enhance optimal therapeutic effect. Furthermore, the policy directed staff to verify three times the right resident, right medication, right dosage, right time and right method or route of administration.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure antibiotics were administered as prescribed for 1 of 1 resident (R13) reviewed for infection, thus leading to a significant medication error. Findings include: R13's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R13 had moderate cognitive impairment and diagnoses of chronic respiratory failure, cellulitis (common bacterial infection of the skin and underlying tissues which causes inflammation, redness, swelling, and pain) of the left lower extremity, and heart failure. R13's provider order dated 9/11/25, indicated R13 required doxycycline hyclate capluse100 milligrams (mg) twice daily for 7 days for cellulitis. R13's medication administration record (MAR) dated 9/2025, indicated R13 received doxycycline hyclate on the evening of 9/11/25. The MAR indicted the dose was not available for the morning of 9/12/25 and then was discontinued. R13's Automatic Therapeutic Interchange Communication form dated 9/12/25, indicated the pharmacy initiated a therapeutic substitution (the practice of replacing a prescribed medication with another medication from the same pharmacologic class and will provide the same therapeutic effect) and requested staff to discontinue the doxycycline hyclate 100mg twice daily and replace with and order the doxycycline monohydrate 100mg twice daily. The form directed nursing staff to verify and transcribe the new order into the resident medical record. There was no nursing signature on the form indicating this was completed. A pharmacy form titled Packing Slip dated 9/12/25, indicated R13's doxycycline monohydrate 100mg was sent to the facility. R13's provider order dated 9/14/25, indicated R13 required doxycycline monohydrate capsule100mg twice a day for 7 days. This was two days after the therapeutic order change and medication was delivered to the facility. R13's MAR dated 9/2025, indicated R13 missed two doses of doxycycline monohydrate on 9/12/25 and 9/13/25. During interview on 9/18/25 at 8:08 a.m., registered nurse (RN)-B stated when antibiotics were ordered, sometimes the provider will give an order to take from the emergency kit until the pharmacy delivers the medication. If there was a substitution for the medication, the pharmacy will send communication to let staff know to dc (discontinue) the previous order and order the substitute order. The nurse who is on duty will update the orders. When medications are delivered, they go to the nurse who is assigned that resident and there is a signature. Those medications should get reviewed and put away. RN-B verified the missed doses of R13's antibiotics but wasn't sure why they were started and then stopped. During interview on 9/18/25 at 10:22 a.m., the clinical pharmacist (CP) stated if antibiotics were not started right away or if there were missed doses, this would be significant. This can lead to the infection worsening. Furthermore, CP stated missing doses can lead to antibiotic resistance. CP verified the therapeutic medication change for R13 and would have expected staff to continue the antibiotic when it arrived on 9/12/25. During interview on 9/18/25 at 12:19 a.m., RN-C and the director of nursing (DON) stated at times pharmacy would substitute the medications. When this happens two orders were sent, one to dc the current medication and one to start the substituted medication. The nurses who were on duty were expected to transcribe these orders when received and ensure there is not a delay in treatment. Facility Adverse Consequences and Medication Errors policy revised 9/18/25, directed staff to evaluate medication usage to prevent adverse consequences and medication related problems. Staff should follow clinical guidelines for use, dose, administration, and monitoring. Furthermore, the policy defined medication error included omitting a medication when ordered.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and document review, the facility failed to timely refer 1 of 2 residents (R27) to dental services reviewed for dental services. Finding include:R27's Optional State Assessment (OSA) dated 8/29/25, indicated moderate cognitive impairment, and required supervision for eating. R27's quarterly Minimum Data Set (MDS) dated [DATE], indicated R27 had moderate cognitive impairment, did not reject care, had impairment on one side to her upper extremity and used a wheelchair. Further, R27's diagnoses included hemiplegia (paralysis of one side of the body) following a cerebral infarction (stroke) affecting her right dominant side, apraxia (the inability to plan and execute purposeful, skilled movements), other speech language deficits following cerebral infarction, dysphagia (difficulty swallowing foods or liquids) following cerebral infarction. Additionally, R27 did not have signs and symptoms of a possible swallowing disorder, was on a therapeutic diet, and did not have broken or loosely fitting full or partial dentures. R27's Orders form indicated the following orders:8/28/25, lost dentures SLP (speech language pathology) wrote diet orders.8/28/25, downgrade diet texture to mechanical soft with gravy, preference for soft foods and no breads (IDDSI MM5) with supervision during meals to cue alternating solid and liquid sip, swallow, bite, swallow, and to stop eating to clear throat if/when she starts coughing. 8/28/25, diabetic diet, mechanical soft texture, thin liquids consistency.R27's care plan goal revised and discontinued on 3/8/24, indicated R27 had a behavior problem of taking food off of other people's plates and becoming aggressive if asked to give back what she took. R27's care plan revised 8/26/25, indicated R27 had a nutritional problem or a potential nutritional problem due to aphasia, apraxia, dysphagia, hemiplegia, CVA and diabetes. Interventions indicated to provide and serve diet as ordered and monitor intake and record every meal. R27's care plan was reviewed and lacked information R27 had dentures, or that her dentures were missing. R27's Kardex dated 9/17/25, lacked information that R27 had dentures, or that her dentures were missing. R27's progress notes dated 8/26/25 at 3:17 p.m., indicated a speech therapy evaluation was indicated due to concerns with new coughing with eating and drinking.R27's progress notes dated 8/26/25 at 9:04 p.m., indicated R27 was on a diabetic diet with regular texture, and thin liquid consistency with weight loss noted and fluctuations were expected related to dysphagia and previous CVA among other things and exhibited good nutrition as evidenced by stable weight and good intake records. R27's SLP evaluation and plan of treatment note dated 8/26/25, indicated R27 was on regular diet textures and thin liquids and was observed to choke and have difficulty swallowing. Additionally, R27 could not find her dentures and was having difficulty eating regular foods. Further, SLP downgraded R27's diet to SB6, soft and bite sized, (foods should be soft and moist, not dry or hard for those with limited chewing ability) which translated to mechanical soft with the request to provide R27 with soft foods.R27's progress note dated 8/28/25 at 3:48 p.m., indicated R27 had dentures.R27's progress note written by licensed practical nurse (LPN)-A dated 9/1/25 at 10:53 a.m., indicated a phone message was left for family member (FM)-A to return the call. R27 had a missing upper denture and had a lower denture in R27's room but did not wear the bottom and when family returned the call, LPN-A would inform them of the missing denture. Additionally, R27's room was searched and R27 did not know what happened to the denture. R27's progress notes were reviewed and lacked information a dental appointment was set up for R27 or a reason for a delay.R27's care conference note dated 9/5/25, indicated R27 and family or responsible party attended R27's care conference, was on a diabetic diet, mechanical soft texture, and thin liquids and R27's current appetite and fluid intake was poor, and nursing identified a concern for choking as R27 lost her dentures. Further, under a heading, Any referrals needed podiatry was listed, and under a heading, Any resident or family concerns voiced during this meeting? indicated Missing denture. Writer will help search resident's room thoroughly for the missing denture. If not found, writer will reach out to HIM to schedule an appt. with dentist. Resident's son would like to know the cost if insurance does not cover. Further, R27's diet was (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	downgraded to mechanical soft meats with gravy and was educated on safe swallow strategies and recommendations to choose soft foods, small bites, and alternate solids and liquids. During interview and observation on 9/15/25 at 2:55 p.m., R27 pointed to her mouth and had no teeth in her mouth and when asked where R27's teeth were, R27 shook her head no. Asked R27 if she needed help finding her teeth and R27 shook her head indicating yes. R27 stated, uh-huh and nodded her head yes when asked if she had trouble chewing her food.During observation on 9/16/25 at 11:40 a.m., R27's lunch was in front of her and had mashed up unrecognizable food on her plate along with rice and R27 was pushing her meal tray away. R27 did not have teeth in her mouth.During interview on 9/16/25 at 11:44 a.m., NA-A stated she did not know how long R27's dentures had been missing.During interview on 9/16/25 at 11:54 a.m., LPN-A stated missing items are reported to the family and management and the room is searched and they had to notify the nurse practitioner for R27 because of her diet and speech therapy and added R27 had been missing her dentures and was not sure how long but they had been missing since 9/1/25 or around that time and added they had not been found. LPN-A stated she notified R27's representative when they came into the facility of the missing dentures on that weekend and further stated there was no plan yet for R27 to get new dentures. During observation on 9/16/25 at 12:07 p.m., R27 was eating watermelon and staff offered something else and R27 shook her head no.During interview on 9/16/25 at 1:02 p.m., social worker (SW)-A stated the facility was not responsible for valuables and if a resident was missing glasses or dentures, they conduct a search and a grievance is completed and they help coordinate an appointment to get them replaced and most likely insurance pays for the items and if insurance does not pay, they reach out to the person or family and added they were not responsible. SW-A stated she was advised not to complete a grievance and thought R27's dentures went missing this month and planned to help R27 search for the denture one more time this week before looking into a dentist appointment and once they search and are unable to find the dentures they would set up an appointment to be fitted. During interview on 9/16/25 at 1:41 p.m., SW-A stated she was waiting to do a room search because she needed enough time to search and wanted to do a deeper dive and this week was going to be the week she looked, however surveyors showed up to the facility and planned to wait until she could block some time out. During interview on 9/16/25 at 3:37 p.m., family member (FM)-A stated they were perplexed and unsure where R27's dentures could have gone. FM-A stated they were not sure whether family or R27 was responsible for paying for the dentures and added it had been 2.5 to 3 weeks since they went missing. Further, FM-A stated he did not know how much priority had been placed to R27's case as R27 had been on a diet she was not accustomed to and did not love and were going to try to look for them when they got around to it. FM-A had not been informed if the search had been made and would have hoped staff would have taken steps to be farther along as they were still in a discovery phase.During interview on 9/16/25 at 3:37 p.m., SW-A stated they did not have a policy for dentures and explained if anything went missing, it was not the facilities responsibility.During observation on 9/17/25 at 8:09 a.m., R27 had a mechanical soft diet and was pushing her food away. During interview and observation on 9/17/25 at 8:12 a.m., NA-D pushed R27 back to her room and when asked where R27's dentures were, stated that was a good question, because NA-D reported the missing dentures sometime in August and stated they still haven't taken care of it. NA-D stated R27 wanted her dentures all the time and had been trying to look for them ever since they were missing and stated they went missing on a weekend in August and had worked at the facility over a year and normally worked with R27. During interview on 9/17/25 at 8:23 a.m., the activities director (AD) stated R27 did not want her noon meal yesterday because R27 lost her teeth and added they looked for them and could not find them and talked about getting R27 a dental appointment yesterday because not having her teeth caused her not to like her food. AD stated this was the first time R27 has not had her teeth and was not used to her diet, and they tore her room apart to make sure they were not in her room.During interview on 9/17/25 at 8:41 a.m., LPN-C stated she did not know how long R27's dentures had been missing and stated the health information manager (HIM)-I set up appointments. Additionally, LPN-C stated if dentures went (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	missing, appointments were set up as soon as possible because people need to eat. During interview on 9/17/25 at 8:54 a.m., HIM-I stated she was responsible for scheduling appointments and stated they were working on getting a dentist to come out and verified R27 did not currently have a dentist appointment set up and they had a handful of residents that required an appointment and were trying to wait to get everyone seen at once. HIM -I stated R27 lost her upper denture and if they did not hear anything by the end of the day would go ahead and make R27 an appointment. During interview on 9/17/25 at 9:01 a.m., the administrator stated they had no specific denture policy and added it was under the personal items in the admission agreement if someone lost their dentures, they would assist in arranging an appointment and getting a replacement.During interview on 9/17/25 at 9:43 a.m., the vice president of clinical services, registered nurse (RN)-C stated R27's dentures had been missing approximately 1 to 1.5 weeks and hadn't been missing long, and everyone looked and would have expected an appointment be set up by now and further stated it was important because R27 could not eat properly. RN-C stated their policy for missing dentures was in the admission agreement that indicated a resident agree not to hold the facility liable for well-being, health, safety, or theft or loss of personal property while resident is not at the facility or under its supervision. Reviewed concern for lack of a specific dental policy per requirements and RN-C stated there was likely another policy somewhere and would follow up. During interview on 9/17/25 at 9:56 a.m., speech therapist (ST)-E stated she was seeing R27 for dysphagia in the oral prep phase and chewing bits for swallowing. ST-E stated R27 came on the caseload due to a stroke and had difficulties swallowing and R27's diet was downgraded due to not having dentures and could not fully chew food and had not heard whether R27 liked her diet or not and thought staff were in the process of finding or getting R27 new dentures but added that having the dentures would help R27 not have to have the downgraded diet. During interview and observation on 9/17/25 at 12:30 p.m., R2 and R27 were sitting together at the same table. No staff were in the dining room assisting residents. R2 had chicken wild rice soup and a bread stick. R2's meal was mostly uneaten. R27 grabbed R2's soup when R2 began wheeling herself away from the table. Social worker (SW)-A was alerted by surveyor R27 took R2's food and SW-A stated R27 could not have R2's food and R2's meal tray was taken away. Facility Dental Services policy dated December 2016, and provided on 9/17/25 at 1:09 p.m., indicated routine and 24-hour emergency dental services were provided to residents through a contract agreement that comes to the facility monthly, referral to the resident's personal dentist, referral to community dentists, or a referral to other health care organizations that provide dental services. A list of community dentists available to provide dental services to our residents is available from social services or HIM. Direct care staff will assist residents with denture care, including removing, cleaning and storing dentures. Dentures will be protected from loss or damage to the extent practicable, while being stored. Lost or damaged dentures will be replaced at the resident's expense unless an employee or contractor of the facility is responsible for accidentally or intentionally damaging the dentures. If dentures are damaged or lost, residents will be referred for dental services within 3 days. If the referral is not made in 3 days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting the dental services; and the reason for the delay. All dental services are provided in the resident's medical record.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide a diet as ordered for 1 of 1 resident (R27) reviewed for correct diet textures.Findings include:R27's Optional State Assessment (OSA) dated 8/29/25, indicated moderate cognitive impairment and required limited assistance with bed mobility, transfers, toileting, and supervision for eating. R27's quarterly Minimum Data Set (MDS) dated [DATE], indicated R27 did not reject care, had impairment on one side to her upper extremity and used a wheelchair. Further, R27's diagnoses included hemiplegia (paralysis of one side of the body) following a cerebral infarction (stroke) affecting her right dominant side, apraxia (the inability to plan and execute purposeful, skilled movements), other speech language deficits following cerebral infarction, dysphagia (difficulty swallowing foods or liquids) following cerebral infarction. Additionally, R27 did not have signs and symptoms of a possible swallowing disorder, was on a therapeutic diet.R27's care plan dated 8/26/25, indicated R27 had a nutritional problem or a potential nutritional problem due to a history of aphasia, apraxia, dysphagia, hemiplegia and interventions included to provide and serve diet as ordered. R27's physician orders form indicated the following orders:8/28/25, lost dentures, speech language pathologist (SLP) wrote orders.8/28/25, downgrade diet texture to mechanical soft with gravy, preference for soft foods and no breads (IDDSI MM5) with supervision during meals to cue alternating solid and liquid (sip, swallow, bite, swallow) and to stop eating to clear throat if she starts coughing. 8/28/25, diabetic diet, mechanical soft texture, thin liquids consistency.R27's progress notes dated 8/26/25 at 9:04 p.m., indicated R27 was on a regular texture, thin liquid consistency diabetic diet. R27's nurse practitioner (NP) notes dated 8/28/25 at 12:52 p.m., indicated the NP met with the kitchen and SLP to discuss diet modification as R27 had been coughing and had phlegm and diet modifications were made and the kitchen was aware. R27's PMR (physical medicine and rehabilitation) note dated 9/13/25, indicated R27 was on a modified diet due to difficulty swallowing. R27's speech therapy (ST) evaluation note dated 8/26/25, indicated R27 was referred because she recently choked, had difficulty swallowing, could not find her dentures, and was having difficulty eating regular foods. Further R27 was previously on a regular diet and ST wrote orders to downgrade diet to SB6, soft and bite sized which translates to mechanical soft for the facility. R27's ST note dated 9/10/25, indicated R27's goal was to find foods and ways to eat regular food, so she did not have to eat puree. R27's meal ticket dated 9/16/25, indicated R27 had a regular diet for breakfast, lunch, and dinner and the breakfast meal consisted of orange juice, baked cheese omelet, sausage link, bread, breakfast pastry, milk, salt, pepper, sugar packets, coffee with cream and diet sugar, and a banana. R27's meal ticket continued to indicate R27 was on a regular diet despite R27's orders being downgraded on 8/28/25. During observation on 9/16/25 at 8:02 a.m., R27 was in the dining room and had an omelet, hashbrowns, and a donut on her plate, and had a bowl of cereal. An unnamed staff person assisted in putting sugar on the cereal and walked away. The activity director (AD) was in the dining room playing Yahtzee with another resident. R27 was not supervised by nursing staff in the dining room. During interview on 9/16/25 at 8:12 a.m., AD stated she was not an aide or a nurse. During interview on 9/16/25 at 8:15 a.m., the cook (C)-A and the culinary director (CD) verified there were no nurses or nursing assistants in the dining room and stated R27 could have donuts. During observation on 9/16/25 at 8:25 a.m., R27 was in the dining room eating her donut and the only staff in the dining room was the AD.During interview on 9/16/25 at 8:29 a.m., nursing assistant (NA)-A stated she did not think R27 could have donuts because R27 did not have dentures and added they should smash them on the plate and verified R27 had regular dry donuts on R27's plate.During interview on 9/16/25 at 8:30 a.m., the director of nursing (DON) asked CD whether R27 could have donuts on her plate and the AD stated R27's meal ticket indicated R27 had a regular diet. The CD stated R27 would not eat if they provided R27 with minced and moist diet and (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	added R27 should not have a donut. The CD asked when R27's diet was changed and provided a lunch meal ticket that indicated R27 was on a regular diet and the DON stated she did not know why the diet did not switch over in the kitchen. CD verified R27's meal ticket still indicated R27 was on a regular diet despite R27's orders being downgraded on 8/28/25. During interview on 9/16/25 at 8:41 a.m., the DON stated she expected staff to change R27's diet and planned to have a meeting regarding review of the diets in their computer system versus what printed on the residents' meal tickets. The DON further stated they would provide education to the NA's to verify the diets and stated it was important because it was a choking hazard. During interview on 9/16/25 at 8:52 a.m., the DON viewed R27's chart and verified R27's diet orders were not in point of care for the NA's to know what diet R27 was supposed to be on. During interview on 9/17/25 at 9:56 a.m., speech therapist (ST)-E stated R27's diet was downgraded due to not having dentures and was seen for dysphagia and could not fully chew food. ST-E further stated donuts were considered bread and verified R27 should not have had them. During interview on 9/17/25 at 9:43 a.m., the vice president of clinical services registered nurse (RN)-C stated she heard about the diet order and stated R27 shouldn't have received a donut and stated it was important to follow the diet order to prevent accidents. Facility Transmission of Diet Orders policy dated 9/17/25, indicated the food and nutrition service department will receive written notification of a resident's diet order as soon as possible after admission, readmission, or following a diet order change. When the food and nutrition services department has been made aware of a new admission but has not been notified regarding the diet order, a regular diet will be served. Staff should make every attempt to get the proper diet order first. Meal identification cards and tickets will be adjusted to reflect changes in diet and food preferences as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Chateau Health and Rehabilitation Center	2319 West Seventh Street Saint Paul, MN 55116

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure their antibiotic stewardship program was implemented for 1 of 1 resident (R13) who was taking an antibiotic. Findings include:R13's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R13 had moderate cognitive impairment and diagnoses of chronic respiratory failure, cellulitis (common bacterial infection of the skin and underlying tissues which causes inflammation, redness, swelling, and pain) of the left lower extremity, and heart failure. R13's provider order dated 9/14/25, indicated R13 required doxycycline monohydrate capsule100mg twice a day for 7 days for cellulitis on the lower legs.R13's medical record lacked indication R13 had monitoring in place for the cellulitis infection. R13's care plan revised 7/21/25, indicated R13 was at risk for infection due to vascular ulcers on bilateral lower extremities. Interventions included to monitor for signs and symptoms of infection. When interviewed on 9/17/25 at 10:03 a.m., licensed practical nurse (LPN)-C stated when residents were placed on antibiotics, there were other orders that were also placed for monitoring and vital signs each shift. LPN-C verified R13 was on an antibiotic for cellulitis and verified there were no monitoring orders in place. LPN-C stated whoever entered the antibiotic order must have forgotten to add the monitoring orders. When interviewed on 9/17/25 at 1:44 p.m., Registered nurse (RN)-C and acting infection preventionist, stated staff were expected to monitor for signs and symptoms of worsening infections, and there was an assessment that should be completed. IP acknowledged staff had not been doing this.When interviewed on 9/18/25 at 12:19 a.m., registered nurse (RN)-C and the director of nursing (DON) stated there should be an assessment or note documenting monitoring for worsening or improved infection when residents were on antibiotics. RN-C further stated they were aware of this issue and understood infection monitoring while on antibiotics were lacking. Facility Antibiotic Stewardship policy revised 5/12/25, indicated the purpose of the antibiotic stewardship program was to monitor the use of antibiotics in the residents. The policy lacked guidance on how nursing staff monitored residents who were on antibiotics for signs and symptoms of improving or worsening infection or a time out period.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. Building B. Wing	09/19/2025

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 2 of 5 residents (R6 and R35) were offered, educated on risks and benefits and administered or refused the pneumococcal vaccine in accordance with the Center for Disease Control (CDC) recommendations. Findings include:R6's face sheet received 9/18/25, included diagnoses of morbid (severe) obesity, heart failure, acute respiratory failure, chronic pain, and obstructive sleep apnea (breathing repeatedly stops and starts during sleep due to obstruction in upper airway). R6's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R6 had intact cognition, no behaviors including refusal of care. Activities of daily living (ADL's) included R6 did not walk, and was independent with all transfers, eating and personal hygiene. Special treatments included CPAP and oxygen use. R6's Immunization Report undated, did not include offer, refusal or education on risks and benefits of the pneumoccal vaccine. R6 was [AGE] years of age, and had a history of heart failure, high blood pressure and respiratory failure placing him in a high risk category per CDC recommendations. On interview 9/17/25 at 8:32 a.m., R6 stated no one had offered the pneumovac vaccine to him since his admission to the facility. R6 stated due to his respiratory issues and multiple hospitalizations, would be interested in receiving the vaccine. R35's face sheet received 9/19/25, included diagnoses of chronic obstructive pulmonary disease, high blood pressure, obesity and chronic pain syndrome. R35's quarterly MDS dated [DATE], indicated R35 had intact cognition, no refusals of care, and understands and is understood. R35's vaccination records undated, included pneumovax 23 was given 5/31/12. The medical record lacked documentation any further offers of pneumovax vaccine, education of risks and benefits or refusal of vaccination. On 9/18/25 at 10:36 a.m., the director of nursing (DON), also identified as infection preventionist, confirmed R6 and R35 had not been offered the pneumococcal vaccine during the previous year. The DON added R35 initially declined the pneumococcal vaccine in 2023 but was not offered or provided further education in 2024. Facility Pneumococcal Vaccine Policy dated 1/18/22 included: - All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. - Before receiving pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education will be documented in the resident's medical record. - Administration for the pneumococcal vaccines or revaccinations will be made in accordance with current Center for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.