STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E507	A. Building B. Wing	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southside Care Center	2644 Aldrich Avenue South Minneapolis, MN 55408

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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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure resident advance directives were accurately and consistently documented between the physician orders in the resident's electronic health record (EHR) and the Provider Order for Life-Sustaining Treatment (POLST) in the hard chart to ensure the resident's wishes would be followed in the event of a cardiac arrest. This resulted in immediate jeopardy for 2 of 13 residents (R2, R6) whose code statuses were not accurately documented, with an additional resident (R1) discrepancy found in a facility-wide audit.The immediate jeopardy began on [DATE], when interviews with the direct care nurse and director of nursing indicated they would implement incorrect procedures and not started CPR on R2 if found without a pulse and not breathing, and would have started CPR against R6's wishes under those same circumstances. The administrator and director of nursing (DON) were notified of the immediate jeopardy on [DATE], at 7:20 p.m. The immediate jeopardy was removed on [DATE]; however, non-compliance remained at an isolated scope with potential for more than minimal harm that is not immediate jeopardy (level D).Findings include: R2 R2's quarterly MDS dated [DATE], indicated the BIMS was completed, and R2 had a score of 15/15, indicating intact cognition. R2's quarterly MDS dated [DATE], indicated R2 was admitted to the facility on [DATE]. The MDS indicated that the BIMS and the staff assessment for mental status were not assessed. R2's care conference form dated [DATE], indicated R2's code status was a full code. R2's POLST dated [DATE], indicated attempt resuscitation/full treatment and was signed by R2 and the provider on [DATE]. R2's EMR order summary had an order dated [DATE] for Do Not Resuscitate (DNR). R2's Provider notes dated [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] include R2's code status as a full code. R2's care conference note dated [DATE], was reviewed and included a section please review POLST. It included a checkmark next to the point, If resident does not have POLST, please make arrangements to complete. The note did not include further information on the advance directive wishes. During an interview on [DATE] at 6:05 p.m., the administrator confirmed this was the most (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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	recent care conference note he could find for R2. R2's care plan dated [DATE], was reviewed and did not include a reference to R2's code status. R2's progress notes dated [DATE] to [DATE], were reviewed, and reference to code status was not found. R2's signed physician order report dated [DATE], indicated R2 was a full code. R2's provider note dated [DATE], indicated R2 had a history of diabetes, asthma, chronic anemia (low level of healthy red blood cells to carry oxygen throughout the body), alcohol and opioid use disorder, and obstructive sleep apnea (OSA, repeatedly stop and start breathing during sleep). R2's Profile dated [DATE], indicated R2 was her own responsible party. During an interview on [DATE] at 3:29 p.m., R2 stated that if her heart stopped beating and she stopped breathing, she wanted full resuscitation. During an interview on [DATE] at 3:30 p.m., licensed practical nurse (LPN)-A stated that if R2 was found not breathing and without a pulse, he would check the electronic medical record to see if he needed to start CPR. LPN-A stated the first place he would look at was the profile tab on the EMR, but he did not see the code status for R2 there, so LPN-A stated he would then look at the medical diagnosis, and he did not find code status there. LPN-A stated he would look next at the order summary and stated that R2's code status was DNR/DNI, so he would not start CPR.^ During an interview on [DATE] at 3:40 p.m., the director of nursing (DON) stated LPN-A would normally be the only nursing staff working at this time and during the evenings, as DON had only come to the facility for the survey. The DON stated if a resident was found with no pulse and was not breathing, she would expect the nurse to first look at the EHR profile and orders and then confirm the order with the POLST to ensure the orders matched. The DON stated that if they did not match, the nurse should follow the POLST. The DON confirmed R2's POLST and EHR order did not match. The DON stated she thought the POLST, which stated R2 was a full code, was correct, but she would double-check with the resident. The DON returned to the interview and stated that R2 wanted CPR, so the POLST was the correct one. The DON stated she thought the order had been entered incorrectly into the EHR, as the facility had recently switched over to using an EHR instead of solely using paper charts. The DON stated that when a new POLST was filled out, the floor nurse working oversaw ensuring the POLST code status matched the one in the EHR. The DON stated code status was very important, so she had reviewed the POLST code status with each resident when she started as DON about four months ago but confirmed she did not have a process in place for ensuring the POLST code status matched the EMR orders/documentation. R6 R6's quarterly MDS dated [DATE], indicated R6 had intact cognition and was independent with most personal cares. In addition, R6 had diagnoses of depression, diabetes, anxiety, and post-traumatic stress disorder. R6's provider notes dated [DATE], [DATE], [DATE], [DATE], [DATE] identified code status, He elects to be DNR and POLST on file at facility and uploaded to MAM [provider portal]. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R6's EMR profile, face sheet, care plan, and physician orders reviewed [DATE], failed to identify code status. During interview with LPN-A on [DATE] at 5:10 p.m., LPN-A stated he was a full-time employee. LPN-A stated he would locate resident code status on the EMR profile page and then look for clarifying physician orders. LPN-A looked at R6's EMR and stated, he is not DNR or DNI. LPN-A then pulled up R6's face sheet indicating the form would also have the code status on it. No advance directive mentioned [for R6]. LPN-A stated, I would do CPR on [R6]. If it is not on his face sheet. LPN-A stated importance of following resident code status was to follow their wishes. We must respect their wishes. Cracking ribs and causing more harm is not good. During interview with R6 on [DATE] at 5:21 p.m., R6 stated his wishes for DNR/DNI was communicated to facility when he was admitted . I know people who have had it done [CPR] to them and they are not the same. I don't want to go through that. I want [facility] to let me be. During interview with DON on [DATE] at 5:30 p.m., DON stated it was important for nursing staff to know where the code status was in the computer and paper chart. DON reviewed R6's EMR and verified code status was not on his profile or orders. I expect the staff to perform CPR on him. Then DON looked at R6's paper chart and verified signed POLST dated [DATE], which identified R6 as DNR/DNI. DON stated, [R6] EMR said he was full code but he wasn't. I will have to update that right now. R1 R1's comprehensive Minimum Data Set (MDS) dated [DATE], indicated that the Brief Interview for Mental Status (BIMS) and the staff assessment for mental status were not assessed. R1's quarterly MDS dated [DATE], indicated R1 was admitted to the facility on [DATE]. The MDS indicated that the BIMS and the staff assessment for mental status were not assessed. R1's Advanced Directive Order Form dated [DATE], indicated R1 wanted resuscitation and intubation and was signed by the resident on [DATE] and the provider on [DATE]. R1's care conference note dated [DATE], was reviewed and included a section please review POLST. It included a checkmark next to the point, If resident does not have POLST, please make arrangements to complete. The note did not include further information on the advance directive wishes. During an email communication on [DATE] at [DATE], the DON stated the last care conference note she could find for R1 was on [DATE]. R1's provider notes dated [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] indicated R1's code status was a full code- confirmed with patient today [DATE]. R1's progress notes dated [DATE] to [DATE] were reviewed and did not reference R1's code status wishes. R1's POLST dated [DATE], indicated DNR/allow natural death with selective treatment, which was signed by the resident and then signed by the provider on [DATE]. The POLST indicated it was prepared by the DON but did not include a prepared date. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's care plan dated [DATE], was reviewed and did not include a reference to R1's code status. R1's face sheet dated [DATE], indicated R1 was her own responsible party. R1's provider note dated [DATE], indicated R1 had a history of cocaine/alcohol abuse, dementia, and multiple sclerosis (MS, a chronic autoimmune disorder causing the breakdown of the protective covering of the nerves). R1's order summary dated [DATE], indicated R1 had two code status orders, one for full code dated [DATE], the other for full code: resuscitate and intubate dated [DATE]. The summary did not include an order for DNR/ allow natural death with selective treatment. During an interview on [DATE] at 9:24 a.m., R1 stated that if her heart stopped beating and she stopped breathing, she wanted staff to let me go and would not want anyone pushing on my chest. During an interview on [DATE] at 9:27 a.m., the DON stated that after the surveyor had asked about R2's code status and she had noticed an error between the EHR and the hard chart, she had begun to audit other residents' code statuses, including R1. The DON stated during this audit on [DATE], she noticed that R1's POLST indicated R1 did not want to be resuscitated, and the order summary was for a full code. The DON stated she believed the electronic medical record had not been updated after a new POLST was filled out, so after checking with R1, she updated the order summary in the EHR to indicate R1 was DNR. The DON stated R1 was alert, oriented, and able to make her own code status decisions. During an interview on [DATE] at 11:04 a.m., the medical director (MD) stated he had been notified by the administrator of the immediate jeopardy. The MD stated he would expect that the POLST matches the order summary in the EHR, so it was clear to staff what the resident's code status wishes were, and it would be concerning if this did not match. During an email communication on [DATE] at 4:34 p.m., the DON stated that although they have had their EHR system in place for a while, the facility had only transitioned to using the EHR on [DATE]th (2026). The Cardiac or Respiratory Arrest policy dated 6/2018, indicated that staff members who witness cardiac or respiratory arrest will identify the individual's resuscitation status, but did not indicate where staff should find this information. The facility's Advanced Directives policy dated 9/2022, indicated the resident had the right to formulate an advanced directive, including the right to accept or refuse medical treatment, and this should be honored according to state law and facility policy. The policy indicated that advanced care planning should occur between individuals and their health care agents to plan for future healthcare decisions when individuals were not able to make their own healthcare decisions. The policy indicated that the advanced directives should be maintained in the same section of the residents' medical record and should be readily retrievable. The director of nursing services or designee should notify the attending physician so that appropriate orders can be documented in the resident's medical record and plan of care. The directive should be placed in a prominent, accessible location in the medical record and discussed during care planning meetings. The policy indicated the Interdisciplinary team (IDT) would review the advance directives annually. The policy indicated that changes or revocations of a directive must be submitted in writing to the administrator. The administrator may (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	require new documents if the changes are extensive. The immediate jeopardy that began on [DATE], was removed on [DATE], when the facility developed and implemented a systematic removal plan. The removal plan was verified through interview and document review as the facility corrected the code status' of R2 and R6, completed a facility-wide audit to ensure there were no other code status discrepancies and corrected any that weren't accurate and/or consistent including R1, reviewed related policies and procedures, and provided education for all staff involved in ensuring advance directives were honored on the CPR and POLST policies/procedures and their respective roles in the process.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to comprehensively assess, develop, and implement meaningful and engaging activities for 4 of 4 residents (R3, R4, R8, R9) reviewed who expressed concerns over a lack of activities at the facility. This had the potential to affect all 13 residents residing in the facility. Findings include: R3 R3's comprehensive Minimum Data Set (MDS) dated [DATE] identified R3 with intact cognition, did not reject care, was independent with most hygiene cares, and medical conditions of schizophrenia, diabetes, anxiety, and a psychotic disorder. The Activity Preferences portion of the MDS identified question of, How important is it to you to do your favorite activities? with response of, very important. R3's care plan (CP) interventions dated 3/21/25 identified, [R3] enjoys a balance between both independent and small group activities that meet her mental and psychosocial needs. [R3] Her favorite small group activities include pizza and ice cream socials along with bingo and Pokeno and very much enjoys winning prizes such as pop and junk food. During interview with R3 on 3/30/26 at 12:34 p.m., R3 stated, we don't really have activities, used to play bingo. They hired a new guy. Been a few months since [facility] had activities. During interview with R3 on 4/2/26 at 9:12 a.m., R3 was sitting at dining room table working on a word puzzle book. R3 stated, I wish we could do stuff as a group here but we don't. I have to find things out myself. R4 R4's admissions MDS dated [DATE] identified intact cognition, did not reject care, was independent in personal cares, and had diagnoses of post-traumatic stress disorder, personality disorder, diabetes and depression. The Activity Preferences portion of the MDS identified questions of, How important is it to you to do your favorite activities? with response of, very important. R4's Therapeutic Recreation Assessment Form dated 7/23/25 identified interest in crafts, television, conversing, and outings. R4's CP goal dated 7/30/25 identified, The resident will participate in activities of choice once weekly by review date and CP goal dated 10/30/25 of, The resident will express satisfaction with type of activities and level of activity involvement when asked through the review date. During interview with R4 on 4/2/26 at 7:52 a.m., R4 stated, I get so bored. R4 verified the facility planned no activities on weekends. I can't remember having anything set up other than to go downstairs on my own and grab a puzzle or cards. R8 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R8's admission Minimum Data Set (MDS) dated [DATE], indicated that R8 had intact cognition and was independent with most activities of daily living. The MDS indicated that it was very important for R8 to keep up with the news and get fresh air when the weather was nice, somewhat important to participate in religious services, and not very important to have reading materials, listen to music, be around animals, or do things with groups of people. R8's Care Area Assessment (CAA) 3/3/26, indicated R8's activity preference before admission was group activities, and the resident had a current problem with the stressor of a new living environment. R8's care plan dated 3/9/26, was reviewed and did not include a comprehensive person-centered activity care plan to address R8's activity needs. R8's medical record was reviewed, and further assessments of R8's activity preferences and needs were not conducted. During an interview on 3/30/26 at 1:47 p.m., R8 stated she would like to do bingo or something, but stated they didn't have anything to do at the facility. R8 stated that since she was admitted last month, the facility has not had any organized activities for her to participate in, and she found herself often bored. During an interview on 4/2/26 at 10:42 a.m., the director of nursing (DON) stated she did not think the activity assessment was completed for R8. The DON stated that normally, when the activity assessment was completed, it would automatically trigger the activity care plan, so since the assessment was not completed, the care plan would not be either. R9 R9's comprehensive MDS dated [DATE], identified R9 with intact cognition, did not reject care, was independent with most personal cares, and had diagnoses of panic disorder, seizure disorder, post-traumatic stress disorder, anxiety and depression. The Activity Preferences portion of the MDS was not completed. R9's CP dated 9/3/25 identified intervention of Encourage resident to have outside activities. CP intervention dated 1/26/26 identified, Assist the resident in developing a program of activities that is meaningful and of interest. Encourage and provide opportunities for exercise, physical activity. During interview with R9 on 4/2/26 at 8:26 a.m., R9 stated she had agoraphobia and was never offered or asked about preferences for activities. I don't like groups obviously but I do get bored. During interview with activities director (A)-A on 4/3/26 at 8:31 a.m., A-A stated he was hired in September 2025. A-A stated he was the only activities staff at the facility, and he created the monthly activities calendar. He stated, I am supposed to drive [residents] to appointments. A-A stated, nothing is scheduled for time or place of activities. A-A stated he did not write progress notes, update resident care plans with preferences and choices, or keep documentation of activity attendances. A-A stated he did not attend QAPI meetings either. During interview with cook (C)-A on 4/2/26 at 8:15 a.m., C-A stated, no activities here that I saw this week or last week or in the past several weeks. No group activities. [resident] activities is going to their doctor's appointment. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview with director of nursing (DON) on 4/2/26 at 8:29 a.m., DON stated facility did not have weekend activities. DON stated facility activities were, mostly cards, or puzzles. DON verified facility did not have attendance records or progress notes regarding activities participation. During interview with administrator on 4/2/26 at 9:49 a.m., administrator stated facility did not have a full-time activities employee and there were no activities on the weekends. During interview with former activities director (FA)-A on 4/2/26 at 2:34 p.m., FA-A stated he resigned in October of 2025 after working as activities director since 2012. FA-A stated C-A was hired one week before FA-A resigned. FA-A stated he documented paper form of MDS assessment portion regarding Preferences for every resident when it was assigned to him by the MDS coordinator. A-A stated he did not complete progress notes, attendance records, or care plans. A-A stated there were never weekend activities. During observations from 3/30/26 to 4/3/26 and 4/6/26 there were no activities performed or offered per activity calendar for March and April 2026, which was verified by DON and administrator. During an interview on 4/6/26 at 1:28 p.m., the administrator stated that he was aware they had an issue with activities not being offered. The administrator stated they had hired an activities aide (A)-A to try to solve this issue, but A-A ended up having to help out with doing activities such as facility shopping and running residents to appointments, so he did not have the time to lead activities for residents. Facility Activity Calendars for October 2025 through April 2026 identified one column titled Weeks with five rows below it and five columns titled, Monday, Tuesday, Wednesday, Thursday, Friday. Two activities were typed into each day. The Activity Calendars did not have times and locations of activities. Weekends were not included. Facility assessment dated [DATE], identified Services and care offered based on Residents' Needs to include, Find out what residents' preferences and routines are and incorporate this information into the care planning process and Provide opportunities for social activities/life enrichment (individual, small group, community). Facility policy titled Activity Evaluation with revision date of February 2023, identified, An activity evaluation is conducted as part of the comprehensive assessment to help develop an activities plan that reflects the choices and interests of the resident. Facility policy titled Activity Programs-Staffing with revision date of February 2023, identified, ensuring activity goals and approaches reflected in the residents' care plans are individualized to match the skills, abilities and interests/preferences of each resident. Facility policy titled Activities Attendance with revision date of June 2018, identified, Attendance and participation is recorded for every resident in group and individual activities on a daily basis. and Attendance records are maintained and secured for a minimum of three years. Also, Attendance records are used when completing residents' progress notes to determine their participation as it relates to their activity plan.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to have a qualified therapeutic recreation specialist (i.e., activities director) whom was successfully qualified and/or credentialed, as required, to ensure competent assessment and implementation of activities programming within the care center. This had potential to affect all 13 residents at the time of survey.Findings include:See F679:During interview with activities director (A)-A on 4/3/26 at 8:31 a.m., A-A stated he was hired in September 2025. A-A stated he was only activities staff at facility and that he created monthly activities calendar and I am supposed to drive [residents] to appointments. A-A stated, nothing is scheduled for time or place of activities. A-A stated he did not write progress notes, update resident care plans with preferences and choices, or keep documentation of activity attendances. A-A stated he did not attend QAPI meetings either. A-A stated he had no previous training, licensure, or full-time experience to be a qualified activities director.During interview with director of nursing (DON) on 4/2/26 at 8:29 a.m., DON stated facility did not have weekend activities. DON stated facility activities were, mostly cards, or puzzles. DON verified facility did not have attendance records or progress notes regarding activities participation.During interview on 4/2/26 at 9:49 a.m., administrator stated facility did not have a full-time activities employee and there were no activities on the weekends.During interview with former activities director (FA)-A on 4/2/26 at 2:34 p.m., FA-A stated he resigned in October of 2025 after working as activities director since 2012. FA-A stated C-A was hired one week before FA-A resigned. FA-A stated he documented paper form of MDS assessment portion regarding preferences for every resident when it was assigned to him by the MDS coordinator. A-A stated he did not complete progress notes, attendance records, or care plans. A-A stated there were never weekend activities.Facility assessment dated [DATE], identified Services and care offered based on Residents' Needs to include, Find out what residents' preferences and routines are and incorporate this information into the care planning process and Provide opportunities for social activities/life enrichment (individual, small group, community). According to Basic Staffing Plan portion, the Position column identified Social Services/Activities Director and Health Unit Coordinator for Medical Appointments. Column adjacent identified Full-Time-Approx. 60 hours/pay period.During interview with administrator on 4/2/26 at 9:49 a.m., administrator stated facility did not have a full-time activities employee and there were no activities scheduled or planned on the weekends. The administrator also verified A-A was not licensed or registered to assume the activities director role. In addition, the administrator stated A-A previous employment was as a direct support professional (DSP) for group homes where he assisted with personal cares, transportation to and from appointments, and participated in group home activities. Administrator stated A-A never worked full-time job in therapeutic activities prior to being hired at the facility.Facility policy titled Activity Programs-Staffing with revision date of February 2023, identified, Our activity programs are staffed with personnel who have appropriate training and experience to meet the needs and interests of each resident. In addition:Our activity programs are under the direct supervision of a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the state in which practicing; [NAME] eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; ORHas two (2) years of experience in a social or recreational program within the last five (5) years, one (1) of which was full-time in a patient activities program in a health care setting; [NAME] a qualified occupational therapist or occupational therapy assistant; ORHas completed a training course approved by the state.The activity director/coordinator's responsibilities include:Completing or delegating the completion of the activities component of the comprehensive assessment;Ensuring that the activity goals and approaches reflected in the residents' care plans are individualized to match the skills, abilities and interests/preferences of each resident;Monitoring and (continued on next page)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	evaluating the residents' responses to activities and revising the approaches as appropriate; andDeveloping, implementing, supervising and evaluating the activity programs at least quarterly.

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	24E507	A. Building B. Wing	04/06/2026

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and document review, the facility failed to ensure a registered nurse (RN) was scheduled for a minimum of eight consecutive hours each day. This had the potential to affect all 13 residents who resided at the facility.Findings include: Review of the Payroll Based Journal (PBJ) Staffing Data Report, submitted for the first quarter of 2026 (October 1-December 31), identified no RN hours for the following dates: 11/5/25, 11/8/25, 11/16/25, 11/20/25, 12/21/25. Review of the facility timecards dated 10/1/25 to 12/31/25, indicated that on 11/5/25, 11/16/25, 11/20/25, and 12/21/25, the facility had no RN hours. During an email communication on 3/31/26 at 4:21 p.m., the building owner (O)-O stated that on:11/5/25: An RN had been scheduled to work, but an LPN had to cover this shift.11/8/25: An RN was scheduled to work and did per timecard data.11/16/25: An RN called in, and an LPN ended up covering for her.11/20/25: An RN was scheduled for a shift, and an LPN ended up covering his shift.12/21/25: An RN was scheduled to work, and an LPN ended up covering the shift. During an interview on 4/2/26 at 10:28 a.m., March 2026 timecard data was reviewed with the administrator, with no gaps in RN hours identified. The administrator stated the facility used to have an issue with consistently filling RN hours, especially on the weekends, but they had been working to fix the issue, including using agency staff, and it had not been a problem recently. The facility's Sufficient and Competent Nursing Staff policy dated 4/2025, indicated that the facility would staff an RN at a minimum of eight consecutive hours a day, seven days a week.

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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 record review, the facility failed to ensure food items were properly stored, dated and disposed of to reduce the risk of cross contamination and potential foodborne illnesses in the main production kitchen. In addition, the facility failed to ensure the main production kitchen refrigerator freezer unit was adequately cleaned and maintained and failed to ensure staff followed appropriate infection control techniques while preparing food when staff were observed to prepare food without a hairnet. This deficient practice had the potential to affect all 13 residents who consumed food prepared by the facility.Findings include:During initial kitchen tour on 3/30/26 at 11:50 a.m., cook (CK)-A reviewed the main floor refrigerator and attached freezer unit with State Surveyor. The following items were observed:Main refrigerator contents included one opened 3-pound container of sour cream, one 64-ounce container each of orange juice and apple juice, one 32-ounce container of strawberry jam, one gallon of milk, and seven unpasteurized eggs. CK-A verified that all contents were not dated or labeled except their product expiration/use-by dates. CK-A stated expectations of all food to be dated and labeled with the date the product was opened. CK-A stated, I do not know when they were first opened.Main freezer content included one undated package of breakfast muffin (English muffin with egg, cheese, and sausage patty) that did not have a manufacturer name, date or label on the wrapper, and an open pitcher of clear fluid sitting on bottom of unit. The entire inside bottom of the freezer unit had half an inch of frozen yellow-tan content with the pitcher frozen to it along with the breakfast muffin. The door seal of the freezer unit had dark black matter on entire door seal. CK-A stated, I have no idea what that is [freezer contents and the seal]. It does not look good. Probably should be cleaned. CK-A stated he had never cleaned the freezer unit before, despite working two days per week for the past five months. CK-A stated he had, on occasion wiped down the refrigerator.The tour continued with dry spices that were in a shelving unit above countertop in main kitchen. Contents included numerous large containers of spices, creamy peanut butter spread, two containers of breadcrumbs and fried onions which were opened and undated. A bottle of chili garlic sauce had a product expiration date of 12/23/25. CK-A stated the breadcrumbs and fried onions look and smell stale and I go by the product expiration date. A large plastic container with worn off name of product stated the product expiration date of 4/22/22. CK-A stated he did not know what it was or how long it was in the spice cabinet.A form titled, Kitchen Checklist for March 2026 was noted on the clipboard next to the refrigerator. CK-A stated the checklist was the daily cleaning schedule for the kitchen and each cook was responsible for ensuring it was completed daily. In addition, the form also stated, Food service employees wear hair restraints and clean clothing.Another form attached to the Kitchen Checklist for March 2026 stated, All dry foods must be stored in a container with a tight-fitting lid, labeled and dated. At 12:53 p.m., CK-A verified missing documentation and stated all three cooks were responsible for cleaning. During observation and interview with CK-B on 3/31/26 at 8:28 a.m., CK-B stated expectations of all three cooks to document daily refrigerator, freezer temperature logs and cleaning logs. CK-B observed the main refrigerator/freezer unit that contained the undated packaged breakfast muffin (English muffin with egg, cheese, and sausage patty), an open pitcher of clear fluid sitting in the half inch of frozen yellow-tan substance including the seal of the freezer unit with dark black matter on entire visible seal. That is not sanitized. Bottom freezer does not look good. Needs to be cleaned. CK-B stated, That looks bad. [It] hasn't been done in a while. During observation of refrigerator and spice unit and verified he used the products every meal of every day. CK-D verified, Most are not labeled with open date. Should be dated so we know how old it is. CK-B state it was important, to know so we do not use products that could be old and make people sick.During interview with administrator on 3/31/26 at 8:58 a.m., administrator stated his expectation of all food products to be dated and labeled with the date the product was opened. In addition, the administrator stated it was expectation of all logs, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	including the cleaning logs, to be completed and documented every day by the cooks. Accurate and daily cleaning and temp logs is important to ensure no illness occur from food.During observation and interview on 3/31/26 at 2:30 p.m., CK-B was cooking hamburger in a saucepan on the stovetop without wearing a hair net. CK-B stated, Yes, I should always wear one when I am cooking.During interview with infection control preventionist (IC)-MDS on 4/1/26 at 1:09 p.m., IC-MDS stated expectation of staff to wear hair nets when handling food to prevent bacterial contamination and cooks are supposed to wear hair nets at all times.During observation and interview with CK-C on 4/3/26 at 10:43 a.m., CK-C stated he was the main cook for facility and that three cooks total were employed by facility. CK-C stated expectations of all three cooks to perform and document daily cleaning logs, and he was not aware of who was responsible for auditing and ensuring the logs were filled out. CK-C stated expectations of open food products to be dated and labeled, and stated he wasn't surprised the food in the fridge and spices were not dated or labeled.Facility Food Storage and Procurement Policy and Procedure, updated 03/30/2025, indicated opened bags of food must be labeled with the date the food was opened and staff would discard spoiled or contaminated food. The policy directed staff to label food prepared at the facility with the name of the food, date the food was made, and use by date.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and document review, the facility failed to ensure a comprehensive Quality Assurance and Performance Improvement (QAPI) plan was identified, implemented, and maintained to ensure acceptable levels of performance and continual improvement. In addition, the facility failed to identify and prioritize problems, such as quality deficiencies that the facility was/should have been aware of and then develop and implement appropriate actions utilizing ongoing QAPI activities. This deficient practice affected all 13 residents residing in the facility.Findings include: The facility's QAPI Program policy dated 2/2020, indicated the facility should develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for its residents. The policy indicated the facility would develop a process for:-Tracking and measuring performance.-Establishing goals and thresholds for performance measurements.-Identifying and prioritizing quality deficiencies.-Systematically analyzing underlying causes of systematic quality deficiencies.-Developing and implementing corrective actions or performance improvement actions.-Monitoring/evaluating the effectiveness of corrective action/performance improvement activities and revising as needed.The policy indicated the facility met monthly to review reports, evaluate data, monitor QAPI-related activities, and adjust the QAPI plan as needed. Further documentation, such as a QAPI plan detailing the facility's developed process to meet the above requirements, was requested and not received. See also F679: Based on observation, interview, and document review, the facility failed to comprehensively assess, develop, and implement meaningful and engaging activities for 4 of 4 residents (R3, R4, R8, R9) reviewed who expressed concerns over a lack of activities at the facility. This had the potential to affect all 13 residents residing in the facility. See also F812: Based on observation, interview, and record review, the facility failed to ensure food items were properly stored, dated and disposed of to reduce the risk of cross contamination and potential foodborne illnesses in the main production kitchen. In addition, the facility failed to ensure the main production kitchen refrigerator freezer unit was adequately cleaned and maintained and failed to ensure staff followed appropriate infection control techniques while preparing food when staff were observed to prepare food without a hairnet. This deficient practice had the potential to affect all 13 residents who consumed food prepared by the facility.QAPI meeting notes dated 10/14/25, 11/11/25, 12/9/25, 1/13/26, 2/10/26, and 3/10/26 were reviewed and did not include reference to activities or to the dietary department/kitchen practices.A review of the Certification and Survey Provider Enhanced Reporting (CASPER) system report (a quality measure report for nursing facilities), last updated 3/24/26, indicated the facility had the following deficiencies:- F679 Activities Meet Interest/Needs of Each Resident cited on surveys with the exit dates of 10/2022, 11/2023, and 2/3/25.- F812 Food Procurement, Store/Prepare/Serve Sanitary cited on surveys with the exit dates of 11/2023 and 2/3/25.- F865 QAPI Program/Plan, Disclosure/Good Faith Attempt cited on surveys with the exit dates of 10/2022, 11/2023, and 2/3/25.- F867 QAPI/QAA Improvement Activities cited on surveys with the exit dates of 11/2023 and 2/3/25.- F868 QAA committee cited on the survey with the exit date 2/3/25. During an interview on 4/6/26 at 1:28 p.m., the administrator stated that the facility held QAPI meetings monthly, but the QAPI committee was fairly new. The administrator stated they did not currently have a formal process in place for collecting data to track and measure performance or a formal plan for QAPI at the moment. The administrator confirmed the facility did not have any established goals or had any quality deficiencies that they had identified, such as issues with the activities program or the kitchen, that they were analyzing and developing corrective action plans for.

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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 document review and interview, the facility failed to maintain a Quality Assurance and Performance Improvement (QAPI) committee that effectively identified and responded to quality deficiencies, and developed procedures for feedback, data collection, and monitoring systems. In addition, the facility failed to provide evidence of a Performance Improvement Project (PIP), which focused on high-risk or problem-prone areas. This deficient practice had the potential to affect all 13 residents currently residing in the facility. Findings include: QAPI meeting notes dated 10/14/25, 11/11/25, 12/9/25, 1/13/26, 2/10/26, and 3/10/26 were reviewed and lacked tracking of data-driven quality metrics over time or performance improvement projects (PIPs). During an interview on 4/6/26 at 1:28 p.m., the administrator stated that the facility held QAPI meetings monthly, but the QAPI committee was fairly new. The administrator stated they did not currently have a formal process in place for collecting data to track and measure performance or a formal plan for QAPI at the moment. The administrator confirmed the facility did not have any established goals or any quality deficiencies that they had identified, such as issues with the activities program or the kitchen, that they were analyzing and developing corrective action plans for. The administrator stated the facility did not have a PIP in place currently and did not have a process in place to collect data for identifying high-risk, high-volume, or problem-prone areas or collecting information from residents or staff. The facility's QAPI Program policy dated 2/2020, indicated the facility should develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for its residents. The policy indicated the facility would develop a process for:-Tracking and measuring performance.-Establishing goals and thresholds for performance measurements.-Identifying and prioritizing quality deficiencies.-Systematically analyzing underlying causes of systematic quality deficiencies.-Developing and implementing corrective actions or performance improvement actions.-Monitoring/evaluating the effectiveness of corrective action/performance improvement activities and revising as needed.The policy indicated the facility met monthly to review reports, evaluate data, monitor QAPI-related activities, and adjust the QAPI plan as needed. Further documentation, such as a QAPI plan detailing the facility's developed process to meet the above requirements, was requested and not received.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and document review, the Quality Assurance (QA) committee failed to ensure that the required members of the committee attended the meetings. This had the potential to affect all 13 residents who resided at the facility. Findings include: QAPI meeting notes dated 10/14/25, 11/11/25, 12/9/25, 1/13/26, 2/10/26, and 3/10/26 were reviewed and indicated that only four members regularly attended the meetings, including the administrator, the director of nursing (DON), the medical director, and the consultant pharmacist. The notes did not indicate that the infection preventionist attended. During an interview on 4/6/26 at 11:36 a.m., the infection preventionist (IC-MDS) stated she did not regularly attend QAPI meetings. During an interview on 4/6/26 at 1:30 p.m., the administrator stated they had four staff members who regularly attended QAPI which included himself, the DON, the medical director, and the pharmacist. The administrator stated he had tried to include the IC-MDS in the past, but it did not work with her schedule. The administrator stated he was aware they needed additional staff members to attend QAPI meetings, but they had scheduling conflicts. The facility's Quality Assurance and Performance Improvement (QAPI) Program-Governance and leadership policy dated 3/2020, indicated the facility would maintain a QAA committee which would meet at least quarterly, and the structure of the committee would consist of the administrator, the medical director, the DON, the infection preventionist, and members of pharmacy, social services, activity services, environmental services, human resources, and medical records as requested by the administrator.

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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. Based on observation, interview, and record review, the facility failed to ensure proper infection control practices were maintained during laundry services. This had potential to affect all 13 residents who resided in the facility.Findings include: During observation and interview with housekeeper (HK)-A on 3/30/26 at 2:01 p.m., HK-A stated facility had one washing machine and one clothes dryer located in basement of facility. HK-A stated she was responsible for all personal and facility laundry in addition to sweeping, dusting, vacuuming and washing hard surfaces. HK-A stated she was the facility's only housekeeper and worked 5 days per week. HK-A was observed walking downstairs to basement with soiled resident laundry in an uncovered plastic laundry basket that had holes/openings around it. HK-A stated she did not cover laundry when transporting it from resident rooms to the basement and when transporting clean linen to resident rooms and facility closets where linen and towels were located. HK-A verified she also did not wear personal protective equipment (PPE) gown when sorting and handling soiled and clean linen.During observation and interview on 3/31/26 at 7:35 a.m., HK-A walked to basement with both arms full of resident personal laundry. It was not covered. I do not cover laundry.During continuous observation on 4/1/26 from 7:10 a.m. to 7:27 a.m., R10 walked down the stairs to basement with both arms full of personal laundry. The washing machine was running so she placed her laundry on top of the utility sink next to the washing machine and walked back upstairs. The dryer had clean linen on it that was folded. It contained 3 blankets and a bed sheet. Nothing was covered. HK-A walked downstairs and placed the clean linen that was on top of the dryer to an uncovered plastic laundry basket and walked upstairs past R10's soiled personal linen (which was sitting on top of the utility sink). HK-A walked back downstairs with the uncovered plastic laundry basket that contained soiled linen. She placed contents of the washing machine into the dryer and then placed the soiled linen from laundry basket into the washing machine. HK-A stated she had never washed or sanitized laundry baskets between soiled linen gathering and bringing clean linen back to residents and the facility unless the baskets were visibly dirty. HK-A verified she did not wear a PPE gown when sorting and handling soiled and clean laundry.During observation and interview with infection control preventionist (IC)-MDS on 4/1/26 at 1:09 p.m., IC-MDS stated expectation of housekeeping to cover linen when transporting and to clean the laundry baskets after each use to prevent contamination.Facility policy titled Housekeeping and Laundry reviewed 10/20/25 identified: -gown and gloves are available for workers to wear while sorting linens;-linen is covered during transport to prevent contamination while being moved through the facility;-soiled linen should be bagged or contained; and-Carry linen away from your body and uniform-Do NOT place soiled linen on furniture, floor, or other surfaces.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and document review, the facility failed to implement an active antibiotic stewardship program which included development of protocols and a system to monitor appropriateness of antibiotic including prophylactic antibiotic use to prevent antibiotic resistance and help prevent the spread of infectious diseases. This had the potential to affect all 13 residents of facility who might use antibiotics. Findings include:During entrance conference with administrator on 3/30/26 at 12:00 p.m., the administrator stated the infection control preventionist (IC)-MDS was responsible for the facility's infection control, surveillance, and antibiotic stewardship program.During interview with infection control preventionist (IC)-MDS on 4/1/26 at 12:48 p.m., IC-MDS stated she worked part time at facility since the fall of 2025 and visited facility once per week. IC-MDS stated she usually review the [resident] medication administration records (MARs) for antibiotics and anything that goes with it. In addition, IC-MDS stated, I am notified via email or when I arrive here weekly of signs and symptoms of potential illness. IC-MDS verified there is no communication to her regarding any residents being started on antibiotics prior to her weekly visits. IC-MDS stated she participated in an internal monthly meeting with DON [director of nursing], administrator, and our company operations manager that did not include the medical director. IC-MDS stated she had contact information for the medical director but had never attended meetings with the medical director, either in-person or on-line. IC-MDS stated, I just put the data in the binder (Infection and Antibiotic use Monthly Tracking form) and pharmacy and provider can look at the binder to see what is going on with new and ongoing signs and symptoms. IC-MDS stated she utilized a Monthly Tracking Sheets to monitor any resident infections or antibiotic use. IC-MDS verified June 2025, December2026, and January 2026 tracking forms were not filled in, indicating there were no infections identified during those months.Infection and Antibiotic use Monthly Tracking forms for the previous 12 months were reviewed and lacked multiple elements required in an antibiotic stewardship program, to include resident name, diagnostic testing and results, whether standardized criteria were used, resident symptoms, timeouts, and response to antibiotics.During interview with IC-MDS on 4/4/26 at 11:36 a.m., IC-MDS stated there was nothing written down for me to use as a guide for my part in the antibiotic stewardship program including antibiotic timeouts or reviews. Also, IC-MDS stated she was not involved in any discussion on periodic review of prescribing practices because, the physician and pharmacist [can] look at that. IC-MDS stated she did not attend monthly QAPI meetings and could not speak to the facility's reports on antibiotic used, antibiotic resistance patterns, practices and facility assessment involvement.Facility policy titled Antibiotic Stewardship Program, dated 6/16/19 identified, information gathered will include at a minimum: Resident name Unit and room number Date symptoms appeared Name of antibiotic Start date of antibiotic Pathogen identified-if known Site of infection Date of culture; if applicable Stop date Total days of therapy Outcome Adverse events, if applicableThe Infection Preventionist and the Pharmacy Consultant will provide regular feedback on antibiotic use and outcomes to facility staff and the QAPI committee. Feedback will also be provided to providers on their individual prescribing patterns of cultures ordered and antibiotics prescribed, as indicated.Education: Facility staff will be educated on the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents and the overall community.Training and education will include the relationship between antibiotic use and: Gastrointestinal disorders Opportunistic infections (e.g., C. difficile, candida albicans, etc.) Development of drug-resistant organisms Medication interactionsResidents, families and clinicians will also be provided with resources to learn more about antibiotic stewardship. Other educational opportunities identified thru the Antibiotic Stewardship Program will be provided as needed.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. During observation, interview and record review the facility failed to ensure facility was maintained in good repair which had the potential to affect all 13 residents, staff, and visitors of the facility.Findings include: Facility Assessment (FA) dated 7/21/2025, identified resident population must be ambulatory and not require a wheelchair. In addition, the Physical Environment-building needs portion of the FA identified, Outside grounds and building is maintained/repaired using the on-line maintenance work-order system.During entrance conference with administrator and director of nursing (DON) on 3/30/26 at 11:30 a.m., State Agency (SA) requested a list of residents who smoked. At 3:13 p.m., an email was received from administrator which identified 6 of the 13 residents (R2, R3, R4, R5, R8, R9) as smokers.During observation and interview with R11 in his shared room on 3/30/26 at 1:07 p.m., R11 pointed to door jamb of his closet which had missing 3 inches of wood where the strike plate and the door latch met. R11 shrugged and said it had been there as long as he could remember and that it did not look well maintained. A window air conditioner unit resting on the window jamb had several gaps surrounding it where the outdoors was visible. R11 stated he was unable to use it because it trips the breaker. A small fan which was not operating had visibly soiled fins and was pointed towards R11. R11 stated it had never been wiped down or cleaned despite being used weekly.During observation on 3/30/26 at 12:00 p.m., the front of building on second floor facing the street had a large piece of window casing trim hanging in front of resident window. The wood was hanging directly above smoking patio which encompassed the entire front of the building, with two residents sitting under it.During interview with director of nursing (DON) on 3/31/26 at 11:38 a.m., DON stated the residents were all mobile.During interview with administrator on 4/1/26 at 9:07 a.m., the administrator stated the facility did not have a system to document and follow up on resident concerns regarding environmental issues such as a water leaks, pest control, electrical issues, rooms too hot or cold, torn carpet, wall and window issues. Administrator stated he would try to fix things himself or contract for services if he was unable to perform them. Administrator stated facility did not have maintenance staff to monitor and audit environmental issues.During observation and interviews on 4/6/26 at 10:23 a.m., R4 and R9 were in their shared bedroom above the smoking patio with the hanging window casing trim. The room had three windows facing the street. All three windows had cracked, peeling, and missing paint along entire inside casing of windows. R4 stated one of the windows is so rotted it doesn't even stay open [when I open it]. R9 stated the hanging wood piece outside her bedroom window looks awful. That piece is going to drop on someone and looks like it needs to be replaced. R4 stated she had complained about the inside window casing and the hanging piece of wood but nothing gets done. R4 stated she gave up hope they will fix it. R9 stated she thought the hanging piece of wood was unsafe for the people below it and worried that someone could get hurt if it disconnected from the frame of the house.During observation and interview on 4/6/26 at 10:51 a.m., with director of nursing (DON), DON looked at the hanging piece of wood at front of building overhanging the smoking patio. DON stated, that is so dangerous. DON also pointed out a large hole in the concrete patio sidewalk that connected the smoking patio to the side of the facility for wheelchair accessibility. The hole measured 12 inches by 5 inches. DON stated, this is not safe and had not noticed it before and did not recall if she was informed of it by a resident, staff, or visitor. DON then walked back into facility and walked upstairs to R4 and R9's shared room and observed the window ledges and inside jambs. DON verbalized that the condition of window jambs was rotted and needed to be replaced. DON stated she believed the condition of the windows were too far gone and I would hate that at my house. Looks bad and is bad.Facility policy titled Grounds, revised May 2008 identified, areas around the buildings (i.e., sidewalks, patios, gardens, etc.) shall be maintained in a safe and orderly manner at all times.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure staff completed mandatory resident rights training for 1 of 5 staff members (registered nurse (RN)-B) reviewed for training requirements. This had the potential to affect all 13 residents residing in the facility. Findings include: The facility assessment dated [DATE], indicated that clinical staff were to receive training on resident rights annually. Review of personnel records indicated that RN-B had not completed education that included resident rights in the last year. During an interview on 4/6/26 at 11:40 a.m., when asked about abuse training, resident rights training, QAPI training, and infection control training, the director of nursing (DON) stated she would expect staff to complete training twice a year. During an interview on 4/6/26 at 12:35 p.m., the human resources analyst (HRA) stated the facility did not usually have staff who continued employment past a year as RN-B had, so she had missed re-assigning her training for resident rights, abuse, and infection control, and confirmed the last time these were completed for RN-B was in 2024. The facility's Sufficient and Competent Nursing Staff policy dated 4/2025, indicated that licensed staff would demonstrate the skills and techniques necessary to care for resident needs, including resident rights.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure staff completed mandatory abuse/vulnerable adult training for 1 of 5 staff members (registered nurse (RN)-B) reviewed for training requirements. This had the potential to affect all 13 residents residing in the facility. Findings include: The facility assessment dated [DATE], indicated that clinical staff were to receive training on vulnerable adults/abuse annually. Review of personnel records indicated that RN-B had not completed education that included abuse/vulnerable adult training in the last year. During an interview on 4/6/26 at 11:40 a.m., when asked about abuse training, resident rights training, QAPI training, and infection control training, the director of nursing (DON) stated she would expect staff to complete training twice a year. During an interview on 4/6/26 at 12:35 p.m., the human resources analyst (HRA) stated the facility did not usually have staff who continued employment past a year as RN-B had, so she had missed re-assigning her training for resident rights, abuse, and infection control, and confirmed the last time these were completed for RN-B was in 2024. The facility's Abuse Prevention Policy dated 5/30/25, indicated staff would complete abuse training annually and upon hire.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure staff completed mandatory quality assurance and performance improvement (QAPI) training for 5 of 5 staff members (director of nursing (DON), registered nurse (RN)-A, RN-B, licensed practical nurse (LPN)-A, LPN-B) reviewed for training requirements. This had the potential to affect all 13 residents residing in the facility. Findings include: The facility assessment dated [DATE], indicated that clinical staff were to receive training on QAPI annually. Review of personnel records indicated that the DON, RN-A, RN-B, LPN-A, and LPN-B had not completed education that included QAPI in the last year before survey entrance. During an interview on 4/6/26 at 11:40 a.m., when asked about abuse training, resident rights training, QAPI training, and infection control training, the director of nursing (DON) stated she would expect staff to complete training twice a year. During an interview on 4/6/26 at 12:35 p.m., the human resources analyst (HRA) stated that at some point, training requirements had changed, and the QAPI training had not automatically been added. The HRA stated she had added QAPI training during the survey when she had realized the requirements were not being met. The facility's Sufficient and Competent Nursing Staff policy dated 4/2025, indicated that licensed staff would demonstrate the skills and techniques necessary to care for resident needs, but did not specify that QAPI training would be completed.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure staff completed mandatory infection control training for 1 of 5 staff members (registered nurse (RN)-B) reviewed for training requirements. This had the potential to affect all 13 residents residing in the facility. Findings include: The facility assessment dated [DATE], indicated that clinical staff were to receive training on infection control annually. Review of personnel records indicated that RN-B had not completed education that included infection control in the last year. During an interview on 4/6/26 at 11:40 a.m., when asked about abuse training, resident rights training, QAPI training, and infection control training, the director of nursing (DON) stated she would expect staff to complete training twice a year. During an interview on 4/6/26 at 12:35 p.m., the human resources analyst (HRA) stated the facility did not usually have staff who continued employment past a year as RN-B had, so she had missed re-assigning her training for resident rights, abuse, and infection control, and confirmed the last time these were completed for RN-B was in 2024. The facility's Sufficient and Competent Nursing Staff policy dated 4/2025, indicated that licensed staff would demonstrate the skills and techniques necessary to care for resident needs, including infection control.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview, and document review, the facility failed to ensure private and confidential resident information was secure and not visible to residents and staff members who did not require access, when documents were found stored in an unprotected manner. This had the ability to affect 9 of the 13 residents (R1, R2, R3, R4, R5, R7, R9, R10, R12) residing at the facility whose medical documents were found unprotected.Findings include: Basement During a continuous observation starting at 3/30/26 at 1:04 p.m., a staircase leading down to a small room was observed. On the left side of the small room were two desks and a small cabinet with a pile of paper that was approximately two feet high. The documents were reviewed and included documents for R1, R2, R3, R4, R5, R7, R9, R10, R12 as well as multiple discharged residents. The pile included documents such as resident order summary sheets and medication administration records, and the documents reviewed were dated from 6/2025 to 1/2026. On the right side of the room was a clothes washer and dryer, and various cleaning supplies. The room then had a hallway leading out of the far side, which led to food storage. [NAME] (C)-A was observed occasionally walking past the desks down the hallway to the food storage. Housekeeper (HK)-A was observed occasionally walking down the stairs and grabbing supplies or using the washer and dryer. During observation and interview with cook (C)-A on 3/30/26 at 12:10 p.m., C-A walked downstairs to the unsecured and open office, walked past the desk and washer and dryer, and entered the dry food storage room that also has four refrigerators with attached freezers. C-A stated he was required to get the food for every meal from the basement storage area walking up and down the stairs several times per day. During interview with R6 on 3/30/26 at 1:15 p.m., R6 stated he was independent with all cares and I bring my own laundry downstairs. During interview with R9 on 3/30/26 at 1:27 p.m., R9 stated, I do [laundry] myself or I can ask them to do it. During interview with R4 on 3/30/26 at 2:38 p.m., R4 stated, I do my own laundry. [HK-A] is very good and she would do it if I ask. She does a lot of people's laundry. We all have to do our own laundry on the weekends. No one [else] to do it. During observation and interview with housekeeper (HK)-A on 3/31/26 at 7:35 a.m., HK-A stated she was the only housekeeper in facility and was responsible for all personal and facility laundry including cleaning and vacuuming the facility. HK-A walked downstairs to the unsecured and open office with desk to the washer and dryer unit carrying a basket of personal laundry to the washing machine. HK-A stated, some people will do their own laundry. During observation and interview with C-B on 3/31/26 at 8:28 a.m., C-B walked downstairs to the unsecured and open office, walked past the desk and washer and dryer, and entered the dry food storage room that also has four refrigerators with attached freezers. C-B stated he was required to get the food for every meal from the basement storage area walking up and down the stairs several times per day. C-B stated the door from the stairs to the basement was never locked. In addition, C-B stated he was expected to bring the food deliveries downstairs to the storage room whenever the (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	deliveries occurred which were a couple times a week. During interview with R14 on 3/31/26 at 9:26 a.m., R14 stated, I go downstairs to [do] my own laundry if I want to. During observation on 4/1/26 at 7:10 a.m., R10 walked downstairs to the unsecured and open office with desk and attempted to throw her soiled personal laundry into the washing machine before discovering it was already running. R10 then placed her armload of soiled personal laundry onto the top of the utility sink (next to the washing machine) and returned upstairs. During an observation and interview on 4/1/26 at 2:48 p.m., a small cabinet with a pile of papers that was approximately two feet high remained in the basement. The administrator stated the stack of papers in the basement had been there since he started last year. The administrator stated that when he had started, they had documentation all over. The administrator stated after looking through the documents on top of the pile, some of the papers should be uploaded to PCC, and the papers should not be stacked unprotected here in general. The administrator stated he would talk with the director of nursing (DON) to take care of these. During observation and interview with C-C on 4/3/26 at 10:43 a.m., C-C walked downstairs to the unsecured and open office, walked past the desk and washer and dryer, and entered the dry food storage room that also has four refrigerators with attached freezers. C-C stated he was required to get the food for every meal from the basement storage area, walking up and down the stairs several times per day. In addition, C-C stated he was expected to bring the food deliveries downstairs to the storage room when they were delivered. Dining Room During observation on 4/1/26 at 7:52 a.m., in dining room, a portable shelving unit was in front of a series of windows facing South. On top of the shelving were several unsecured three ring binders. Five residents were seated at dining room tables in the room at this time. The binders were titled and included: Medication error Reports: which dated from 2014. Several forms were filled out including resident names, addresses, dates of birth, medication lists, and orders. Ominicare Papers: was filled to over three inches that included prescription delivery forms with resident names, addresses, dates of birth, medication lists, and orders. Unlabeled blue binder: with written list of residents to the pharmacy to be faxed and filled out, including resident list with 14 resident names, room numbers and glucose readings and vital sign and weigh information. Medication orders and physician order paper forms dated to 2024. Unlabeled white binder with prescription receipt that was delivered to facility for R2 on 1/3/26. Nothing else in binder. Contractual Agreements: dating to 2006 including pest control statements. During interview with registered nurse (RN)-A on 4/1/26 at 8:20 a.m., RN-A was standing at medication cart in the dining room during meal service and stated, I believe this is a central area with (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	people coming and going. I consider this a public area. RN-A viewed the unsecured binders in the dining room with five residents eating and stated, This is personal information. During interview with director of nursing (DON) on 4/1/26 at 9:38 a.m., DON stated it was important to protect resident rights and privacy, and stated, we are not to disclose or display personal information such as name, medical information and address unless we get approval. DON verified the unsecured binders in the dining room, Contain private personal and medical information for all our patients. It should not be out in the open. That stuff should be out of the dining room. Everyone comes down here for meals and visitors too. This is a very public space for all people to come and go. During interview with administrator on 4/1/26 at 2:52 p.m., administrator stated, private information should not be left out in the open. It should be filed away into the computer or downstairs filing cabinet. The med lists and pharmacy order forms and all that information in the dining room is not private and can be seen by anyone who wants to look. It is not secured. During interview with R11 on 4/2/26 at 8:24 a.m., R11 stated no one should see my personal information unless I want them too. My identity is my own and no one's[sic] business to snoop or see my health care stuff. During interview with R9 on 4/2/26 at 8:26 a.m., R9 stated, My health care information is my own. No one has the right to look at it. I would be upset if my personal information was out in the open for anyone to see. That is how identity theft occurs. During interview with R6 on 4/2/26 at 8:27 a.m., R6 stated, It would make me very, very angry if anyone were able to see my private information like diagnosis and meds. That ain't right. Facility policy titled, Protected Health Information (PHI), Management and Protection of, revised April 2014 identified: It is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure. The facilities Release of Information policy dated 11/2009, indicated that each resident would receive confidential treatment of his or her personal and medical records. The policy indicated that access to the residents' medical records would be limited to the staff and consultants providing services to the residents. The policy indicated that closed or thinned medical records would be maintained in the medical records department and should be available only to authorized personnel, including: nursing staff, physicians, consultants, support services such as dietary, activities, and social, administrator, government agencies, and the resident/resident representative.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and document review, the facility failed to ensure medications were stored in a manner to reduce the risk of unauthorized access for 5 of 5 residents (R1, R2, R3, R4, R5) observed to have medications stored in an unsecured facility refrigerator.Findings include:During an observation and interview on 4/1/26 at 9:21 a.m. in the facility dining room, a medication cart with a small mini refrigerator next to it was observed. The mini fridge was not observed to have a lock on it. Registered nurse (RN)-A stated that they stored medications that needed refrigeration in the small mini refrigerator. RN-A was observed to open the mini fridge door and show that they have a small lock box inside, but they did not use it now. No medications were observed inside the lock box. Inside the medication fridge, multiple boxes of medication were observed, including Copaxone (an injection medication used to treat multiple sclerosis), Ozempic (an injection medication used to treat diabetes), and Trulicity (an injection medication used to treat diabetes).During an interview on 4/1/26 at 12:46 p.m., the director of nursing (DON) stated that about two to three months ago, she had moved the medications from a locked box in the main refrigerator where food was stored to this new mini refrigerator. The DON stated she had not thought about the medication fridge needing a lock and confirmed the medication refrigerator did not currently have one.During email correspondence on 4/6/26 at 2:12 p.m., when asked for the names of the residents whose medications were kept in the small medication fridge, the administrator stated R1, R2, R3, R4, and R5.The facility's Medication, Labeling, and Storage policy dated 2/2023, indicated the facility would store all medications in a locked compartment, and only authorized personnel would have access to the keys.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and document review, the facility failed to ensure recommended influenza and pneumococcal vaccinations, as outlined by the Centers for Disease Control (CDC), were offered and/or provided in a timely manner to reduce the risk of severe disease for all 13 residents reviewed for immunizations.Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated March 2025, identified several tables with corresponding recommendations for patient on when to receive various versions of the pneumococcal vaccine depending on their age and diagnoses. In addition, recommendations identified importance of shared clinical decision-making with their provider. During interview with director of nursing (DON) on 3/31/26 at 11:38 a.m., DON stated the facility did not have a process in place to document vaccination status of all residents. DON stated the residents were all mobile and we send them to Walgreens and ask for a copy [of their vaccination information]. DON reviewed resident paper charts and electronic medical records (EMR) of all 13 residents and stated they lacked immunization records. ?[it is] hard to tell who needs a vaccine or not at this time. In addition, DON stated facility lacked documentation or messaging to providers to determine or ask about immunization status.Facility policy titled Pneumococcal, reviewed 10/20/25 identified: 1. Upon admission to the facility (within 5 days), all residents will be assessed for current immunization status and eligibility to receive the pneumococcal vaccine, and within 30 days of admission, will be offered the vaccine, when indicated, unless the resident has already been vaccinated or the vaccine is medically contraindicated.2. If resident's immunization status is unknown, facility staff will contact resident's physician to determine record of immunization status from resident's permanent clinic record.3. If the vaccination is medically contraindicated, this will be documented in the resident's medical record.4. Before receiving a pneumococcal vaccine, the resident or resident representative shall receive information and education regarding the benefits and possible side effects of the pneumococcal vaccine. (See current Vaccine Information Statements (VIS) on the CDC website for educational materials.) This education will be documented in the resident's medical record.5. Pneumococcal vaccination will be administered at their own medical clinic, per physician and CDC recommendations, and will be documented in the resident's medical record.6. Resident/resident's representative has the right to refuse vaccination. If refused, the date of the refusal will be documented in the medical record.7. Documentation will include the date of the vaccination.Facility policy titled Influenza Outbreak Prevention and Treatment reviewed 10/20/25 identified: 3. All residents will be interviewed upon admission and annually by the designated nurse to determine their current influenza season.5. If the vaccination is medically contraindicated, this will be documented in the resident's medical record.6. A resident's refusal of the vaccine (for reasons other than medical contraindication) will also be documented in the medical record.7. Documentation in the medical record will include the date of the vaccination.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and document review, the facility failed to establish and maintain documentation of COVID-19 vaccination status for all 13 residents of facility. In addition, facility failed to establish and maintain documentation of COVID-19 vaccination status for cook (CK)-B to include being offered and/or provided education regarding the benefits and potential risks associated with COVID-19 vaccination. This had the potential to affect all 13 residents and staff of facility.Findings include: Residents:During interview with director of nursing (DON) on 3/31/26 at 11:38 a.m., DON stated the facility did not have a process in place to document vaccination status of all residents. DON stated the residents were all mobile and we send them to [pharmacy] and ask for a copy [of their vaccination information]. DON reviewed resident paper charts and electronic medical records (EMR) of all 13 residents and stated they lacked immunization records. ?[it is] hard to tell who needs a vaccine or not at this time. In addition, DON stated facility lacked documentation or messaging to providers to determine or ask about immunization status.Staff:Review of Centers for Disease Control and Prevention (CDC) Clinical Guidance for COVID-19 Vaccination, updated 10/31/24, directed the following guidance: People 5-64 years: should receive 1 dose of an age-appropriate 2024-2025 COVID-19 vaccine; People 65 years and older: should receive 2 doses of any 2024-2025 COVID-19 vaccine, spaced 6 months apart.During interview with CK-B on 3/31/26 at 8:27 a.m., CK-B stated he was hired as a cook for facility for almost one year. On 4/2/26 at 10:28 a.m., CK-A stated he had never been asked about his COVID-19 immunization status upon hire. CK-B stated facility never provided education on the benefits, risks, or side effects of the vaccine.During interview with director of nursing (DON) on 4/2/26 at 11:15 a.m., DON stated facility failed to have documentation of offering and providing education on the benefits, risks, or side effects of COVID-19 vaccine to CK-A and whether he declined.Facility policy titled Resident and Staff COVID-19, updated 07/25/2023, identified, All residents and staff members will be provided SARS-CoV-2 education and offered an opportunity to be immunized unless contraindicated or declined and documentation to be completed.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During observation and interview, the facility failed to reasonably accommodate resident preference for a private and usable space for R6 who shared a room.Findings include:R6's quarterly MDS dated [DATE], indicated intact cognition and was independent with most personal cares. In addition, R6 gad diagnoses of depression, diabetes, anxiety, and post-traumatic stress disorder.During observation on 3/30/26 at 1:15 p.m., R6 was lying in his bed in his two-person room. R6's twin sized bed was located inside the door frame to the hallway. The bed was parallel to and against the North wall of room. The footboard of his bed was against a closet which extended from North wall by 20 inches. A privacy curtain attached to the ceiling started at the closet above the foot of his bed and draped around a dresser which measured 18 inches deep by 30 inches long. The curtain was pulled out to encompass the dresser and then immediately parallel and against R6 bed to the head of his bed and [NAME] wall. There was no carpet or floor area for R6 to stand in that was inside the curtained or privacy area making it impossible to obtain his clothes and get dressed without standing outside the privacy curtain. R6's bed measured 46 inches by 96 inches for a total of 30.67 square feet of space enclosed by privacy curtain. R6 stated, my area is the smallest [in the facility]. Curtain goes around my bed and that is all. R6 stated he would like my space in this bedroom to be much bigger but there ain't a bigger space so I have to deal with this.During observation and interview with administrator on 4/2/26 at 9:54 a.m., the administrator verified measurements of R6's privacy curtain and agreed that the curtain wrapped around the bed with no floor space to stand or move unless [R6] was outside the curtained area.During observation and interview with director of nursing (DON) on 4/6/26 at 11:11 a.m., DON looked at R6's room and stated that is not enough room to move around privately in [R6's] room. There is barely any floor to walk on inside the privacy curtain.During interview with co-owner (O)-O of facility on 4/6/26 at 1:36 p.m., O-O stated facility was licensed for 17 beds and there were concerns that the rooms are tight. O-O stated R6's personal space provided by the privacy curtain in his shared room was, much tighter than I would like in my room. I did not take into account the usable square foot for [R6].

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to immediately report incidents of potential resident-to-resident abuse to the state agency (SA) within two hours, as required for 2 of 2 residents (R2, R8) reviewed for abuse.Findings include:R2R2's quarterly Minimum Data Set (MDS) dated [DATE], indicated the Brief Interview for Mental Status (BIMS) was completed, and R2 had a score of 15/15, indicating intact cognition.R2's quarterly MDS dated [DATE], indicated R2 was admitted to the facility on [DATE]. The MDS indicated that the BIMS and the staff assessment for mental status were not completed. The MDS indicated R2 was diagnosed with anxiety and depression.R2's progress notes were reviewed and lacked an indication that R2's allegations of resident-to-resident abuse were reported to the SA.R8R8's admission MDS dated [DATE], indicated that R8 had intact cognition and had verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) one to three days during the look back period (LBP). The MDS indicated R8 was diagnosed with schizophrenia. R2's and R8's MDS data were reviewed, and indicated they resided in the same room.R8's progress note dated 3/30/26 at 5:59 a.m., indicated R8 was observed taking cigarettes from her roommate without permission and became verbally aggressive toward the roommate, including name-calling and threatening to physically fight her.R8's progress note dated 3/31/26 at 1:20 p.m., indicated R8 was currently experiencing significant behavioral disturbances and paranoid delusions, including accusations that others had poisoned her or harmed her father. The note indicated these symptoms frequently manifested as verbal aggression, as she would direct death threats and profanity towards staff when her hourly demands for cigarettes were not met. The note indicated R8's behaviors had profoundly impacted her roommate, whom she targeted with disparaging remarks about her critically ill mother, leading to significant emotional distress. R8's progress notes were reviewed and lacked an indication that R2's allegations of resident-to-resident abuse were reported to the SA.R8's progress note dated 4/1/26 at 12:11 a.m., indicated R8 had been transferred to the hospital after appearing visibly agitated, internally preoccupied, and making suicidal statements, including verbal threats of self-harm.During an interview on 3/30/26 at 1:25 p.m., R2 stated she had trouble with her roommate. R2 stated she had been roommates with R8 since February and didn't have any issues until recently. R2 stated recently that R8 had been calling her a fat (expletive), threatening her, and asking to fight her. R2 stated she does not feel safe living with R8. R2 stated staff were aware of R8's behaviors toward her and were trying different things to help, checking on her often, and offered to let her move rooms, but she did not want to.During a follow-up interview on 4/1/26 at 10:58 a.m., R2 stated R8 had said a lot of vile nonsense to her yesterday. R2 stated R8 had stolen her phone from her and thrown it in the neighbor's yard. R2 stated she had a history of PTSD from an abusive ex-partner, so having someone yell at her was very triggering to her. R2 stated staff had been assessing her anxiety, intervening as needed, and trying to keep them separated as much as possible, such as having her smoke on the back patio instead of the front patio, which had been helpful. R2 stated R8 was admitted to the hospital last night after making comments related to self-harm, and she slept a lot better with R8 not in the room.During an interview on 4/1/26 at 11:05 a.m., the director of nursing (DON) stated R8's behaviors had been getting a lot worse over the last couple of days before her hospitalization last night. The DON stated R2 had told her on Monday (3/30/26) that R8's behaviors and statements toward her made her anxious. The DON talked about multiple interventions that had been attempted to assure both R2 and R8's safety, but when asked about reporting the incident to the SA, the DON stated she had not. The DON stated the verbal altercations between R2 and R8 had not been reported, as she was unaware that she had to report incidents of resident-to-resident verbal abuse and thought it was just for physical or sexual abuse.The facility's Abuse Prevention Policy dated 5/30/25, indicated that allegations of abuse, serious bodily injury, or suspicion of a crime must be reported to the SA within two hours.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure complete and comprehensive Minimum Data Set(s) (MDS) were completed for 1 of 5 residents (R7) reviewed for assessment accuracy.Findings include:The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2025, identified the MDS as an assessment tool that facilities are required to use. The manual directed comprehensive assessments, include the completion of both the MDS and the CAA process, as well as care planning. The CMS RAI manual also identified that the RAI process (i.e., MDS) was completed to help evaluate residents' strengths and areas for care planning.R7's annual MDS dated [DATE], included the following information:-Section C- Cognitive Patterns: indicated C0100 (Should Brief Interview for Mental Status (C0200-C0500) be Conducted?) was not assessed, as well as Sections C0200 through C1310, fields regarding mental status, memory, cognitive skills, and signs of delirium.-Section D- Mood: indicated D0100 (Should Resident Mood Interview be Conducted?) was not assessed, as well as the entirety of Section D, an interview assessing the resident's mood/ a staff assessment of R7's mood.-Section F-Preferences for Customary Routine and Activities: indicated F0300 (Should Interview for Daily and Activity Preferences be Conducted?) was not assessed along with the entirety of section F, an interview for daily preferences/staff assessment of daily and activity preferences.-Section GG-Functional Abilities: indicated the entirety of the assessment was not assessed/dashed except one question, Does the resident use a wheelchair and/or scooter? which was coded as no.During an interview on 4/1/26 at 1:20 p.m., the infection control preventionist/ MDS coordinator (IC-MDS) stated that the facility had transitioned from using paper charts to using an electronic health record (EHR) at the beginning of the year. The IC-MDS stated the facility did not have a good process in place for ensuring MDS assessments were completed and documented during this time. The IC-MDS stated there was poor implementation and poor training of staff during the transition, so a lot of the MDS assessment areas had been missed during this period, such as R7's.The facility's MDS Completion and Submission Timeframe policy dated 3/2025, indicated the facility's assessment coordinator or designee was responsible for submitting the MDS assessment according to the RAI manual. The policy did not further discuss the facility's process for MDS completion before submission.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure that quarterly Minimum Data Set(s) (MDS) were completed in a thorough manner for 2 of 5 residents (R1, R2) reviewed for assessment accuracy.Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2025, identified the RAI consists of three basic components, including the MDS, the Care Area Assessment (CAA), and the utilization guidelines and this process (i.e., use of the entire RAI) was mandated by CMS. The manual outlined that a quarterly assessment was a non-comprehensive assessment which was to be completed every 92 days and was used to track a resident's status between comprehensive assessments . to ensure critical indicators of gradual change in a resident's status are monitored. The manual included a section labeled, SECTION C: COGNITIVE PATTERNS, which outlined how the section would be used to help determine the resident's attention, orientation, and ability to register or recall information, adding, These items are crucial factors in many care-planning decisions; with provided methods and instructions to ensure accurate, thorough coding of the MDS. Further, the manual included another section labeled, SECTION D: MOOD, which outlined the section would be used to help address mood distress and social isolation adding, Mood distress is a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity, and again, the manual provided methods and instructions to ensure the comprehensive evaluation of these conditions. R1's quarterly MDS dated [DATE], included the following information:-Section C- Cognitive Patterns: indicated C0100-C1000, Brief Interview for Mental Status/ the Staff Assessment for Mental Status was not assessed.-Section D- Mood: indicated D0100 (Should Resident Mood Interview be Conducted?) was not assessed, as well as the entirety of Section D, an interview assessing the resident's mood/ a staff assessment of R7's mood.-Section GG-Functional Abilities: indicated GG0130 (the self-care assessment, including eating, oral hygiene, toileting hygiene, bathing, dressing, etc.) and GG0170 column five (mobility assessment regarding bed mobility, transferring, walking) were not assessed/dashed. R2's quarterly MDS dated [DATE], included the following information:-Section C- Cognitive Patterns: indicated C0100-C1000, Brief Interview for Mental Status/ the Staff Assessment for Mental Status was not assessed. During an interview on 4/1/26 at 1:20 p.m., the infection control preventionist/ MDS coordinator (IC-MDS) stated that the facility had transitioned from using paper charts to using an electronic health record (EHR) at the beginning of the year. The IC-MDS stated the facility did not have a good process in place for ensuring MDS assessments were completed and documented during this time. The IC-MDS stated there was poor implementation and poor training of staff during the transition, so a lot of the MDS assessment areas had been missed during this period, such as R1's. The facility's MDS Completion and Submission Timeframe policy dated 3/2025, indicated the facility's assessment coordinator or designee was responsible for submitting the MDS assessment according to the RAI manual. The policy did not further discuss the facility's process for MDS completion before submission.

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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 interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded with the potential for inaccurate federal reimbursement and resident care planning for 2 of 5 residents (R1, R3) reviewed for MDS accuracy.Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded with the potential for inaccurate federal reimbursement and resident care planning for 2 of 5 residents (R1, R3) reviewed for MDS accuracy.Findings include:R1's quarterly MDS dated [DATE], indicated under Section I: Active Diagnoses, that R1 did not have a diagnosis of non-Alzheimer's dementia.R1's Diagnosis Report dated 12/22/25, indicated R1 had a diagnosis of vascular dementia added on 12/22/25.R1's provider note dated 12/8/25, indicated R1 had a diagnosis of vascular dementia, and there had been some progression of this dementia.R3's quarterly MDS dated [DATE], indicated under Section N - Medications, that R40 had received 1 day of insulin injection(s) during the review period.R3's Medication Administration Record (MAR) dated 3/1/26 through 3/31/26, indicated R3 had received a single dose of Trulicity (a diabetes medication injection) during the lookback period (LBP); however, had not received any insulin during that time.During an interview on 3/31/26 at 9:27 a.m., the director of nursing (DON) stated R1 did have a diagnosis of dementia and some related cognitive decline, and this year had been requiring more prompting from staff on things like personal care, but was still alert and oriented for things like making her own code status decisions.During an interview on 4/1/26 at 1:20 p.m., the infection control preventionist/ MDS coordinator (IC-MDS) stated that she did not have a good understanding of Trulicity and mistakenly coded it as an insulin. The IC-MDS stated she had not realized that R1 had a recent, active diagnosis of dementia, and it probably should have been added.The facility's MDS Completion and Submission Timeframe policy dated 3/2025, indicated the facility's assessment coordinator or designee was responsible for submitting the MDS assessment according to the RAI manual. The policy did not further discuss the facility's process for MDS completion before submission.

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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 record review the facility failed to ensure timeliness of person-centered care conferences for 3 of 3 residents (R2, R4, R6) and to include periodic review and revision by an interdisciplinary team along with the residents in adjusting their care plan and making decisions about their care.Findings inclide: R2's quarterly MDS dated [DATE], indicated the BIMS was completed, and R2 had a score of 15/15, indicating intact cognition. R2's quarterly MDS dated [DATE], indicated R2 was admitted to the facility on [DATE]. The MDS indicated that the BIMS and the staff assessment for mental status were not assessed. R2's medical record was reviewed, and the last care conference note was dated 8/21/25. During an interview on 3/30/26 at 6:05 p.m., the administrator confirmed the note from 8/21/25 was the most recent care conference note he could find for R2. During an interview on 4/1/26 at 1:05 p.m., R2 stated she did not recall being offered or attending a care conference in the last few months. During an interview on 4/2/26 at 10:34 a.m., the director of nursing (DON) stated she had reviewed R2's medical record and was unable to find documentation showing that a care conference had been completed for R2 since last August. The DON stated care conferences were important so things like code status, activities, dietary preferences, and pain could be discussed with the residents. R4 R4's quarterly Minimum Data Set (MDS), dated [DATE], identified R4 with intact cognition and was independent with all hygiene and dressing. In addition, R4 had diagnoses of post-traumatic stress disorder (PTSD), borderline personality disorder, diabetes, and depression. R4's electronic medical record (EMR) and paper chart were reviewed, and no care conference notes aligning with her MDS cycles for 10/31/25, 12/10/25 and 2/2/26 were identified since her admission on [DATE]. During interview with R4 on 3/30/26 at 2:38 p.m., R4 stated she had not been invited or involved in any care conference since her admission to facility 7/23/25. R6 R6's quarterly MDS dated [DATE] identified R6 with intact cognition, independent with most hygiene care and had primary diagnoses of depression with recurrent psychotic symptoms, diabetes, anxiety and PTSD. R6's EMR and paper chart were reviewed and no care conference note was identified since admission to facility on 9/29/25. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with R6 on 3/30/26 at 1:15 p.m., R6 stated he had been at facility almost a year and did not recall having an in-person care meeting or care conference to discuss his plan of care and discharge goals. I have not been invited to any meeting. No one asked. No sit-down meetings. During interview with director of nursing (DON) on 4/1/26 at 8:44 a.m., DON stated expectations of resident care conferences to be done quarterly per MDS cycle to discuss plans of care and changes that may occur. During interview with DON and the facility's MDS coordinator (IC)-MDS on 4/1/26 at 1:30 p.m., both reviewed R6's electronic medical record (EMR) and verified R6's quarterly care conference had not been done but should have been. Both DON and IC-MDS verified R4's EMR lacked evidence of a care conference corresponding to the last MDS assessment. Facility policy titled Care Conference, dated June 2018 identified All resident will have a care conference hosted a minimum of quarterly for each resident.

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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 observation, interview, and document review the facility failed to provide routine dental services to 2 of 2 residents (R3, R4) reviewed for dental services. Findings include: R3R3's face sheet identified R3 admitted to facility on 4/10/2020.R3's quarterly Minimum Data Set (MDS) dated [DATE], identified R3 with intact cognition, did not reject care, was independent with personal and oral hygiene, and diagnoses of schizoaffective disorder, bipolar, diabetes, anxiety, and epilepsy.R3's Care Area Assessment (CAA) dated 3/21/25 identified R3, Teeth show obvious cavities and missing most of upper teeth and triggered a dental care plan due to medications, unstable diabetes,R3's care plan (CP) dated 4/18/20, identified, PERSONAL HYGIENE/ORAL CARE: The resident requires supervision to assistance of 1 PRN to complete hygiene cares and The resident has potential for oral/dental health problems r/t Poor oral hygiene. In addition, CP intervention state, Coordinate arrangements for dental care, transportation as needed/as ordered.R3's electronic medical record (EMR) and paper chart failed to identify when R3 was offered and provided a routine dental appointment. R4R4's quarterly MDS dated [DATE] identified R4 with intact cognition, independent with all hygiene, and diagnoses of diabetes, post-traumatic stress disorder (PTSD), depression, and borderline personality disorder.R4's CAA dated 8/4/25, identified R4 as not being assessed for Dental Care-Care Planning Decision.R4's CP dated 10/28/25 state, Encourage resident to practice good general health practices: lose weight if overweight, stop smoking, compliance with dietary restrictions, compliance with treatment regimen, adequate sleep and exercise, good hygiene and oral care.During interview with R4 on 3/30/26 at 2:38 p.m., R4 stated she had been a resident at facility for two years coming up and had never been offered or provided a routine dental appointment. I should go at least every year.Review of R4's EMR and paper chart failed to identify documentation of R4 being offered and provided a routine dental appointment.During interview with administrator on 4/1/26 at 1:21 p.m., the administrator verified R3 did not have a dental visit scheduled or completed. The administrator stated expectation of (DON) to keep [dental] appointments on [facility] appointment calendar.During interview with DON on 4/1/26 at 1:24 p.m., DON verified R3 and R4 EMR and paper charts failed to have documentation of routine dental appointments. DON stated dental appointments were necessary for all residents every 6-12 months. In addition, DON stated, I don't have a system to monitor and follow up on making sure the residents have had their dentist appointments and I do not have documentation that they refused or where they go for their appointments.Facility assessment dated [DATE], identified Services and care offered based on Residents' Needs with dental services.Facility policy titled Routine and Emergency Dental Services and Dentures, updated 01/28/2024 identifies, [facility] coordinates with each of the residents' dentist to ensure regular visits with a licensed dentist and, dental appointment will be scheduled for each resident a minimum of annually by a licensed dentist, where the resident's teeth will be evaluated for the condition of oral cavity, teeth and tooth-supporting structures, presence or absence of natural teeth or dentures, dentist or dental hygienist documents all resident exams for resident medical record which will include the name of licensed dentist, date of service, specific service provided, follow up orders or follow-up appointments, findings of dental status and oral health assessment, and the resident has the right to choose their dentist.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and document review, the facility failed to ensure the required nurse staffing information was posted daily and contained required information, such as the daily census and total number of licensed nursing staff working. This had the potential to affect all 13 residents residing in the facility and/or visitors who may wish to view the information.Findings include:During an observation and record review on 4/1/26 at 8:08 a.m., the nurse staff posting was observed in a hallway between the dining room and the kitchen, attached to a bulletin board. The posting had five columns, including days of the week, shift, registered nurse (RN) hours, licensed practical nurse (LPN) hours, and the date. The posting did not include a daily census or the total number of licensed staff working every shift. The posting showed the following information:-on Monday 3/29/26: 16 hours worked during the day shift, no hours recorded for the PM shift, and 8 hours recorded for LPN hours for the night shift.-on Tuesday, 3/30/26: eight RN hours for the day shift, eight LPN hours for the evening shift, eight LPN hours for the night shift.-on Wednesday, 3/31/26: no hours were recorded.-on Thursday, 4/1/26: no hours were recordedDuring an interview on 4/1/26 at 1:10 p.m., the director of nursing (DON) stated she oversaw the staff posting. The DON stated she usually waited until the end of the week, on Saturday, to fully fill out the staff posting as sometimes staff would call in and then the staff posting would not be accurate. The DON stated that she was not aware that the census or the number of staff members needed to be on the staff posting so it had not been included.The facility's Posting Direct Care Daily Staffing Numbers policy dated 8/2022, indicated the nurse staffing information would be posted daily at the beginning of each shift and would include resident census and the total number of licensed nurses.