STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255244	A. Building B. Wing	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunplex Sub-Acute Center	6520 Sunscope Drive Ocean Springs, MS 39564

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident's right to a safe, clean, and comfortable environment when a resident was left with soiled linens for multiple days for one (1) of 17 sampled residents, Resident #2. Findings include:A review of the facility's policy, Resident Rights, revised 11/28/2016, revealed, . (a) Resident Rights. The resident has a right to a dignified existence, self-determination . (i) Safe environment. The resident has a right to a safe, clean, comfortable, and homelike environment . The facility must provide . (3) Clean bed and bath linens that are in good condition.On 9/29/2025 at 12:07 PM, during an observation and interview, Resident #2 was lying in bed with blood noted on the bed sheet and incontinence pad. Resident #2 explained that her legs were weeping and bleeding and that was the reason for the blood. She stated her sheets are only changed on shower days. On 9/30/2025 at 2:00 PM, during an observation and interview, Resident #2 was sitting on the side of her bed. She reported that she had removed the bloody incontinence pad herself but had not had her sheets changed. [NAME] circular areas and other dirty areas were noted on the bed sheet.On 10/1/2025 at 8:40 AM, during an observation and interview, Resident #2 confirmed her bed linens had not been changed since the prior week. [NAME] circular areas and other soiled spots were again noted on the sheet at the foot of her bed.On 10/1/2025 at 2:00 PM, during an interview with Certified Nurse Aide (CNA) #5, she stated that Resident #2 had refused her shower that morning and that she had notified the nurse. CNA #5 confirmed she did not change the resident's bed linens and acknowledged that the linens were dirty. She stated she had left clean linens in the chair in the resident's room to be placed on the bed later.On 10/2/2025 at 9:40 AM, during an observation and interview, Resident #2 was sitting on the side of the bed and stated she did not refuse her shower the previous day, but that staff often said she did. The clean linens remained on the chair where CNA #5 had left them the previous day and the dirty linens remained on the bed.On 10/2/2025 at 10:10 AM, during an interview and observation, CNA #5 confirmed that Resident #2's bed linens were still soiled and that the clean linens remained in the bedside chair.On 10/2/2025 at 3:07 PM, during an interview, the Director of Nursing (DON) confirmed that residents should never be left lying on soiled linens. She stated that linens are expected to be changed at least every other day and as needed.On 10/2/2025 at 4:45 PM, during an interview, the Administrator reported she was made aware of the dirty bed sheets not being changed. She stated her expectation is for all residents to have a safe and clean environment at all times and for staff to change linens immediately when soiled.A record review of the admission Record revealed the facility admitted Resident #2 on 12/1/2023 with diagnoses including Type 2 Diabetes Mellitus.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/19/2025 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interviews, record review, and facility policy review, the facility failed to develop a comprehensive care plan for a resident with an indwelling catheter (Resident #49) and failed to implement care plan interventions related to baths/showers as scheduled (Resident #54 and #58) for three (3) of 17 sampled residents. Findings include: A record review of the facility's policy Care Plans, Comprehensive Person-Centered dated 10/2022 revealed . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . Policy Interpretation and Implementation . 2. The comprehensive, person-centered care plan is developed within seven (7) days of completion of the required MDS (Minimum Data Set) assessment . and no more than 21 days after admission . 7. The comprehensive, person-centered care plan . b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . Resident #49 A record review of Resident #49's clinical medical record revealed there was no comprehensive care plan developed for the use and care of an indwelling catheter. A record review of Resident #49's admission Record revealed the facility admitted the resident on 09/11/2025 with the diagnoses including mechanical complication of other urinary catheter. A record review of the Comprehensive MDS with an Assessment Reference Date (ARD) of 09/23/2025 revealed Resident #49 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively impaired. A review of Section H revealed he had an indwelling catheter. A record review of the Order Summary Report revealed Resident #49 had a Physician's Order, dated 9/13/25 for catheter care. Resident #54 Record review of the Care Plan Report revealed, Focus: I have an Activities of Daily Living (ADL) self -care performance deficit .Interventions/Tasks .Bathing/Showers M, W, F x 2 with bed bath, x 1 with showers . A record review of the admission Record revealed the facility admitted Resident #54 on 1/2/24 with diagnoses including Cerebrovascular Disease affecting the Left Dominant Side. A record review of the Quarterly MDS with an ARD of 9/10/25 revealed Resident #54 had a BIMS score of 15, which indicated she was cognitively intact. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Documentation Survey Report for September 2025 revealed Resident #54 was documented as having received one (1) bath on 9/22/25, listed as Bathing/Showers M, W, F (Monday, Wednesday, Friday) X 2 (2 person assist) bed baths and X 1 (1 person assist) shower, requiring two-person assistance. There were no other documented baths for Resident #54 for the month of September 2025. This documentation represented (12) missed showers during the month of September 2025. During an interview on 9/29/2025 at 12:54 PM, Resident #54 stated she received a bath once weekly, but wanted baths more than once a week. Resident #58 A record review of the Care Plan Report revealed, Focus: I am at risk for altered ADL function . Interventions/Tasks .Bathing (TTS) (Tuesday, Thursday, Saturday) x 2 bed bath x 1 with shower . A record review of the admission Record revealed the facility admitted Resident #58 on 2/10/22 with diagnoses including Type 2 Diabetes Mellitus. A record review of the Comprehensive MDS with an ARD of 9/17/25 revealed Resident #58 had a BIMS score of 15, which indicated she was cognitively intact. A record review of the Documentation Survey Report for September 2025 revealed no documentation indicating Resident #58 received a shower or bath as scheduled on 9/4, 9/9, 9/11, 9/13, 9/23, 9/25, or 9/30/25 for a total of seven (7) missed showers during the month of September 2025. During an interview on 10/1/2025 at 7:40 AM, Resident #58 stated she did not receive her shower the previous evening, despite requesting it several times. She stated this happens often and that she was lucky to get a shower once a week. During an interview on 10/02/2025 at 3:50 PM, the Director of Nursing (DON) reported she was aware of residents complaining about not getting showers and baths as they are scheduled. This has been an ongoing problem especially with the staffing of Certified Nurse Aides (CNAs). She expects staff to honor each resident's preference of shower and to ask for assistance as needed and follow care plans. The DON confirmed that Resident #49 does have a catheter and reviewed the care plan and confirmed no care plan was implemented for a catheter. During an interview and record review on 10/02/2025 at 4:30 PM, Registered Nurse (RN)#2, she reported the purpose of the care plan is to provide the staff information on how to care for the residents and care plans are to be completed within 21 days after admission and should include all care areas. She reviewed and confirmed Resident #49 did not have a care plan developed for a catheter and reported the resident did have the catheter at the time the comprehensive care plans were completed. She explained she expects all staff to follow each individual resident's care plan to provide quality care for each resident including showers. During an interview on 10/02/2025 at 04:45 PM, the Administrator explained she was aware of staffing and residents not getting showers as scheduled. She does not expect any resident to miss a shower, and she expects showers and baths to be carried out as care planned. She reported she expects all residents to have a completed comprehensive care plan within 21 days after admission and to include all care areas.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were administered in accordance with professional standards of practice, as evidenced by nursing staff did not notify the physician or attempt to obtain medications from an alternate pharmacy source when ordered medications were unavailable for one (1) of five (5) residents observed for medication administration, Resident #9.Findings Include:A review of the facility's policy, Medication Administration - General Guidelines, dated 8/25/14, revealed, .Medications are administered as prescribed in accordance with good nursing principles and practices.On 10/1/25 at 8:37 AM, during a medication administration observation, Licensed Practical Nurse (LPN) #1 failed to administer Resident #9's Icar-C Oral Tablet 100-250 milligrams (mg), one (1) tablet by mouth daily, and Cyanocobalamin Oral Tablet, one (1) tablet by mouth daily. LPN #1 stated the medications were not in the medication cart and were on order. LPN #1 documented a 9 on the MAR, indicating the medications were on order, but failed to notify the physician or the Resident Representative that the resident had not received the ordered medications and did not attempt to obtain the medication from another pharmacy source.On 10/1/25 at 4:10 PM, during an interview, LPN #1 confirmed she did not administer Resident #9's Icar-C or Cyanocobalamin. She explained she was trained to mark 9 on the MAR for medications on order and believed the medication would eventually come in. LPN #1 stated she did not realize she was required to notify the physician when medications were not administered or attempt to obtain unavailable medications from other pharmacy sources.On 10/1/25 at 4:20 PM, during an interview, Registered Nurse (RN) #1 stated LPN #1 should have notified the physician when medications were unavailable. RN #1 stated LPN #1 could have obtained the medications from the local pharmacy as per policy.On 10/1/25 at 4:25 PM, during an interview with the Director of Nursing (DON), she stated LPN #1 should have notified her or a supervisor when the medications were not in the cart so arrangements could have been made to obtain them from the local pharmacy. The DON stated LPN #1 should have notified the physician that Resident #9 did not receive her morning medications.On 10/2/25 at 2:54 PM, during an interview with the Administrator, she stated she expected staff to follow the facility's policy. She explained that if medication was not available, the nurse should notify the DON or the Administrator so arrangements could be made to obtain it from the local pharmacy.A record review of the admission Record revealed the facility admitted Resident #9 on 3/7/25 with diagnoses including Chronic Kidney Disease.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/12/25 revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated her cognition was moderately impaired.A record review of Resident #9's electronic Medication Administration Record (eMAR) for October 2025 revealed scheduled daily medications between 7:00 AM and 10:00 AM included: Cyanocobalamin one (1) tablet by mouth daily and Icar-C 100-250 mg one (1) tablet by mouth daily had a code of 9 and was electronically initialed by LPN #1

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interviews, record review, and facility policy review, the facility failed to ensure that residents who were dependent upon staff for activities of daily living (ADL) care received assistance with bathing and personal hygiene as scheduled and in accordance with their needs and preferences for three (3) of (17) sampled residents (Residents #24, #54, and #58).Findings include: A review of the facility's policy, Bath, Shower/Tub, dated 8/25/2014, revealed, .The purposes of this procedure are to promote cleanliness, provide comfort to the resident.Documentation.The following information should be recorded on the resident's ADL record and/or in the resident's medical record: 1. The date and time the shower/tub bath was performed.5. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. Reporting.1. Notify the supervisor if the resident refuses the shower/tub bath. Resident #24A record review of the admission Record revealed the facility admitted Resident #24 on 8/11/25 with diagnoses including Encounter for Other Orthopedic Aftercare. A record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/18/25 revealed Resident #24 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Section F revealed bathing preference was coded as very important. A record review of the Documentation Survey Report for September 2025 revealed Resident #24 was documented as having received one (1) bath on 9/2/25, listed as PRN (as needed), requiring one-person physical assistance. There were no other documented baths for Resident #24 for the month of September 2025. This documentation represented (12) missed showers during the month of September 2025. On 10/1/2025 at 2:27 PM, during an interview, Resident #24 stated she preferred to receive her bath after lunch but reported that she typically only received one (1) bath per week. She explained that she wanted to receive a bath more than once a week. Resident #54A record review of the admission Record revealed the facility admitted Resident #54 on 1/2/24 with diagnoses including Cerebrovascular Disease affecting the Left Dominant Side. A record review of the Quarterly MDS with an ARD of 9/10/25 revealed Resident #54 had a BIMS score of 15, which indicated she was cognitively intact. A record review of the Documentation Survey Report for September 2025 revealed Resident #54 was documented as having received one (1) bath on 9/22/25, listed as Bathing/Showers M, W, F (Monday, Wednesday, Friday) X 2 bed baths and X 1 shower, requiring two-person assistance. There were no other documented baths for Resident #54 for the month of September 2025. On 9/29/2025 at 12:54 PM, during an interview, Resident #54 stated she received a bath once weekly, but wanted to receive them more often. On 10/1/2025 at 8:35 AM, during a phone interview, Resident #54's family member stated she was concerned about her mother's bathing care, explaining that she often found her mother's feet unclean during visits, leading her to believe the resident had not been bathed for several days. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #58A record review of the admission Record revealed the facility admitted Resident #58 on 2/10/22 with diagnoses including Type 2 Diabetes Mellitus. A record review of the Comprehensive MDS with an ARD of 9/17/25 revealed Resident #58 had a BIMS score of 15, which indicated she was cognitively intact. Section GG revealed impairment of range of motion in both lower extremities and that she required maximal assistance for bathing, showers, and personal hygiene. A record review of a handwritten Certified Nurse Aide (CNA) assignment sheet for the 2:00 PM to 10:00 PM shift dated 9/30/25 revealed Resident #58's name was written in for a shower. A record review of the Tuesday, Thursday, Saturday (TTS) shower schedule dated 9/30/25 revealed Resident #58 was not listed on the schedule. A record review of the Documentation Survey Report for September 2025 revealed no documentation indicating Resident #58 received a shower or bath as scheduled on 9/4, 9/9, 9/11, 9/13, 9/23, 9/25, or 9/30/25 for a total of seven (7) missed showers during the month of September. On 10/1/2025 at 7:40 AM, during an observation and interview, Resident #58 was observed ambulating down the hallway. She stated she did not receive her shower the previous evening, despite requesting it several times. She stated this happens often and that she was lucky to get a shower once a week. She reported the staff were always short and that there were not enough Certified Nurse Aides (CNAs) to complete all resident showers. On 10/1/2025 at 7:55 AM, during an interview, CNA #5 confirmed hearing Resident #58 complain about not receiving a shower. She stated the resident was truthful and preferred showers over bed baths. CNA #5 explained that if a resident refused a shower, the nurse should be notified, and several attempts should be made before documenting a refusal. She reviewed the resident's electronic Kardex and confirmed there was no documentation indicating Resident #58 received a shower on 9/30/25. On 10/1/2025 at 3:20 PM, during an interview, CNA #1 stated CNA #6, who typically worked part-time, had worked the prior evening but was unsure when she would return. CNA #1 stated that usually two (2) CNAs worked per hall on both day and evening shifts, and not all showers were completed. She reported that the number of showers listed on assignment sheets did not match the residents' Kardex documentation. CNA #1 stated this had been an ongoing problem. On 10/1/2025 at 3:30 PM, during an interview, CNA #4 stated she worked the evening shift on 9/30/25 on the 100 Hall and did not see Resident #58 go to the shower. She stated the resident required two-person assistance for transfers. On 10/1/2025 at 5:46 PM, during an interview, LPN #1 confirmed that the facility typically had two (2) CNAs per hall on each shift and stated, They don't have enough staff to give the residents showers like they should, and if they get a bed bath, they're doing good. On 10/2/2025 at 12:21 PM, during an interview, Licensed Practical Nurse (LPN) #5 stated the facility typically had two (2) CNAs assigned per hall, especially on weekends, making it difficult for residents to receive scheduled showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/2025 at 3:50 PM, during an interview, the Director of Nursing (DON) stated she was aware of ongoing resident complaints about missed baths and showers. She confirmed the issue was primarily related to CNA staffing shortages. The DON stated she expected staff to honor residents' bathing preferences and to request assistance when needed. She acknowledged that Resident #58 occasionally refused showers but stated staff should attempt to accommodate her preferred time rather than skip bathing entirely. On 10/1/2025 at 3:53 PM, during an interview with both the DON and the MDS Consultant, a review of documentation for Residents #24 and #54 revealed multiple days in September 2025 without recorded bathing. The MDS Consultant commented, There is something wrong with the documentation. On 10/2/2025 at 4:45 PM, during an interview, the Administrator stated she was aware of the staffing challenges and resident complaints regarding missed showers. She reported that management had discussed revising the shower schedule to better accommodate residents' needs. The Administrator stated she did not expect any resident to miss a shower and expected staff to honor resident preferences, including those who preferred showers to bed baths.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interviews, record review, and facility policy review, the facility failed to provide sufficient licensed-nurse and nurse aide coverage to meet resident needs. Specifically, the facility failed to ensure adequate licensed nurse coverage during an influenza (flu) outbreak for one (1) of two (2) resident care units (the [NAME] Unit) and failed to ensure sufficient nurse aide staffing to provide scheduled showers for three (3) of (17) sampled residents (Residents #24, #54, and #58).The facility's failure to ensure sufficient licensed-nurse coverage resulted in missed medications and lack of resident monitoring on the [NAME] Unit, which placed all 29 residents on the [NAME] Unit at risk for serious illness, serious harm, serious impairment, or death.The situation was determined to be an Immediate Jeopardy (IJ) that began on 10/12/25 when one (1) Registered Nurse (RN) was assigned responsibility for all 58 residents in the facility, including 29 residents on the [NAME] Unit and 29 residents on the Transitional Care Unit (TCU), from approximately 12 AM until 7:00 AM. The facility Administrator was notified of the IJ on 10/21/25 at 4:10 PM and was presented with the IJ Template. The facility provided an acceptable Removal Plan on 10/22/25, in which they alleged all corrective actions to remove the IJ were completed on 10/22/25, and the IJ removed on 10/23/25.The State Agency (SA) validated the Removal Plan on 10/28/25 and determined that the IJ was removed on 10/23/25, prior to exit. Therefore, the scope and severity for CFR(s) S483.35(a)(1)(2) Sufficient Staff (F725) was lowered from a K to an E while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.Findings include: A review of the facility's policy, Staffing dated 10/2022, revealed, .Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment.Policy Interpretation and Implementation.2. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. 5. Inquires or concerns relative to our facility's staffing should be directed to the administrator or his/her designee. A record review of the Facility Assessment, dated 7/1/2025 and signed by the Administrator, revealed the Goal as The goal of this assessment is to identify the resources required to provide competent care for our residents during regular operations, including nights and weekends, as well as in emergency situations. Facility Assessment and Staffing Needs a. This facility assessment will be utilized to.d. Review staffing needs for each shift (day, evening, night) .f. Aid in contingency planning for events that, while not necessitating activation of the facility's emergency plan, could impact resident care, such as the availability of direct care nurse staffing. Review of Staffing Needs as per Shift listed Ratio of Staff to Residents or #HPRD (hours per resident day) included the number of hours instead of the number of staff required per shift or per unit. Review of the Contingency Planning for Staffing revealed, In the case of an emergency event, the facility's emergency plan will be activated. If the event does not rise to the level of activation of the facility's emergency plan the facility will utilize staff, accordingly, including utilizing Administrative staff. A review of the facility's [NAME] reporting data revealed the facility triggered excessively low weekend staffing for the third (3rd) quarter, April 2025 through June 2025. A record review of a statement, undated, provided via the Administrator revealed The facility does not have a current policy for Contingency Staffing Plan/Emergency Staffing. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of a statement, undated, provided via the Administrator revealed . The facility does not have a staffing policy specific to on-call procedures for call ins. A record review of the facility's Nurse Schedule for October 2025 revealed on 10/11/2025 and 10/12/2025, two (2) nurses were scheduled for 7P-7A with one (1) nurse call-in for both days. Further review revealed the facility consistently scheduled two (2) licensed nurses for the 7P to 7A shift. A record review of the facility's Daily PPD (Per Patient Day) for 10/11/2025 revealed . Census 58 . Day Shift Actual RN (Registered Nurse) :0, LPN (Licensed Practical Nurse): 3, CNA (Certified Nurse Aide): 4 . Evening Shift Actual: RN: 0.5, LPN: 1.5, CNA: 5 . Night Shift Actual RN:1, LPN: 0, and CNA:4 . For 10/12/2025, the Daily PPD revealed . Census 58 . Day Shift Actual RN:0, LPN: 3, CNA:5 . Evening Shift Actual: RN: 0.5, LPN: 2, CNA: 3.75 . Night Shift Actual RN:1, LPN: 1, and CNA:4 . A record review of the facility's daily assignment sheet for 10/11/2025 for 10P-6:30A revealed RN #3 was listed as the TCU Nurse and there was no nurse assigned as West Nurse. A record review of the facility's Employee Time-Cards for 10/11/2025 revealed RN #3 was the only licensed nurse at the facility from approximately 11:00 PM until 7:00 AM. A record review of the facility's On-Call Log revealed the nurse scheduled for the 7:00 PM to 7:00 AM shift reported illness and called out at 12:00 PM on 10/11/25, providing the facility with approximately seven (7) hours to secure replacement coverage before the shift began. The facility was unable to provide written documentation that leadership attempted to find replacement coverage. A record review of the facility's Daily Census for 10/11/2025 and 10/12/2025 revealed there were 58 active residents at the facility. On 10/19/25 at 3:25 PM, during an interview with RN #2, she stated she was assigned on-call duty for the weekend and was working the medication cart that evening for four (4) hours. She stated she heard there was no nurse on duty for the night shift on Saturday, 10/11/25, but confirmed she was not on call and did not work that weekend. She stated the facility's wound care nurse had the on-call phone that weekend, but she was not sure what occurred. She explained the Director of Nursing (DON) is responsible for on-call coverage Monday through Friday until 4:30 PM, and staff nurses rotate on-call duty during weekends. She stated the nurse assigned to on-call duty is required to answer the on-call phone, attempt to find coverage for any call-ins, and, if no coverage is available, report to the facility to work the shift. (continued on next page)

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	255244	A. Building B. Wing	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/20/25 at 8:45 AM, during an interview with the Administrator, she stated that on Saturday, 10/11/25, the nurse scheduled for the 7:00 PM to 7:00 AM shift called in sick around 1:00 PM, reporting a fever. She stated the on-call nurse was also ill that day and was unable to find coverage or report to work. She stated she attempted to obtain coverage from the facility's sister facilities but was told no nurses were available. She stated the day-shift nurses agreed to remain until 11:00 PM, leaving one (1) Registered Nurse (RN) in the building from approximately 11:00 PM until 7:00 AM. She stated the day-shift nurses actually left around 12:00 AM, and because no additional nurse was found for the [NAME] Unit, she went to the nurses' station to monitor activity and notify the RN if assistance was needed. She stated she is not a nurse and was unaware of which medications or treatments were completed. She stated the RN came to the [NAME] Unit twice during the shift, once to administer an as needed (PRN) pain medication and once to perform a PRN blood glucose check. She stated she did not observe the nurse complete any medication pass around 5:00 AM or 6:00 AM. She stated she attempted to review the Medication Administration Records (MARs) to see which medications were scheduled but did not think about the 5:00 AM and 6:00 AM medication pass. She confirmed she did not maintain any written documentation of the efforts made to secure shift coverage. A record review of the admission Record revealed the facility admitted Resident #28 on 10/12/2023 with current diagnoses including Unspecified Injury at Unspecified Level of Cervical Spinal Cord, Sequela. A record review of the Quarterly MDS with an ARD of 8/6/25, revealed Resident #28 had a BIMS Summary Score of 15, which indicated he was cognitively intact. On 10/20/25 at 9:40 AM, during an interview and observation, Resident #28 resided on the [NAME] Unit and was observed lying in bed. Resident #28 stated he did not receive his morning medications, including his prescribed pain medication, on Sunday morning, 10/12/25. He stated he informed the nurse when she later brought his medications, but she told him it was too late to administer the missed doses. A record review of the admission Record revealed the facility admitted Resident #12 on 07/21/2023 with current diagnoses including Other Intervertebral Disc Degeneration, Lumbar Region with Discogenic Back Pain Only. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/23/25 revealed Resident #12 had a Brief Interview for Mental Status (BIMS) Summary Score of 14, which indicated he was cognitively intact. On 10/20/25 at 10:00 AM, during an interview and observation, Resident #12 resided on the [NAME] Unit and was observed sitting upright in a recliner. Resident #12 stated he did not receive his morning medications, including his prescribed pain medications, on 10/12/25. He stated he informed the daytime nurse when she arrived for her shift, but by that time, it was too late for the missed medications to be administered. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/20/25 at 10:45 AM, during an interview with Licensed Practical Nurse (LPN) #5, she stated she worked the 7:00 AM to 7:00 PM shift on 10/11/25 and was assigned to the split medication cart for both the Transitional Care Unit (TCU) and the [NAME] Unit. She stated the nurse scheduled for the [NAME] Unit called in sick around 1:30 PM. She stated there was no supervisor or Registered Nurse (RN) in the facility during the day shift that weekend, and there were critical issues because multiple residents were ill with flu-like symptoms. She stated two (2) residents were transferred to the hospital that day. She stated the other LPN on duty attempted to contact multiple staff for coverage by text and phone but received no response until approximately 5:00 PM. She stated the on-call nurse arrived at the facility around 5:00 PM, handed her and the other LPN the on-call phone, stated she quit, and left the facility because she was sick and unable to work. She stated the Administrator was notified, but no replacement nurse arrived. She stated she and the other LPN remained on duty and were informed that the TCU nurse would count off with them at 11:00 PM. She stated no one specifically asked them to stay, but they stayed voluntarily because no relief arrived, and residents required care. She stated both nurses remained until 11:00 PM after working sixteen (16) consecutive hours and completed all scheduled medication passes through that time. She stated she arrived late on the morning of 10/12/25 after oversleeping and came in at approximately 8:30 AM. She stated the other day-shift nurse called out, and the medical records nurse came in to assist with coverage. She stated that when she arrived, she counted the medication cart with the TCU nurse, and no mention was made of the 5:00 AM medications not being given; however, when she passed her own medications later that morning, several residents told her they had not received their morning medications. On 10/20/25 at 11:30 AM, during an interview with the Director of Nursing (DON), she stated she was on vacation the weekend of 10/11/25 and 10/12/25 and was not available to provide coverage for the nurse who called in sick. On 10/20/25 at 1:50 PM, during an interview with Licensed Practical Nurse (LPN) #7, she stated she was the nurse assigned to on-call duty for the weekend of 10/11/25 and 10/12/25. She stated that around Wednesday, 10/08/25, she began feeling ill and went to the doctor, who ruled out COVID-19 and influenza, so she continued to work while wearing a mask. She stated that on 10/11/25, the scheduled night nurse called in sick, and she notified the Administrator, and both attempted to find coverage. She stated the on-call phone rang throughout the day, and at one point she brought the phone into the facility and told the Administrator she was quitting, but they discussed it, and she agreed to continue to work. She stated the day-shift nurses wanted to be relieved, but no replacement could be found, and to her knowledge, they were asked to stay until 11:00 PM so the night nurse could take over the building. She stated she was unsure if the night nurse was ever told she would be responsible for both units. She stated she knew the Administrator came in that night and sat at the nurses' station on the [NAME] Unit. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/20/25 at 5:00 PM, during a phone interview with RN #3, she stated she worked the night shift from 7:00 PM to 7:00 AM on 10/11/25 and 10/12/25. She stated that when she arrived, she was informed another nurse scheduled for the [NAME] Unit had called in sick. She stated she counted off with the nurses on the [NAME] Unit and was told the Administrator would be at the nurses' station and would notify her if any residents on that unit needed medication. She stated she was never informed that she would be responsible for administering medications to residents on both units or completing the morning medication pass for the entire facility. She stated all staff were aware that she could not manage both units because she had multiple residents on the TCU who were ill and required her attention. She stated she went to the [NAME] Unit twice during her shift to administer a PRN pain medication and to perform a PRN blood glucose check for a resident who requested to have her blood sugar checked. On 10/20/25 at 5:30 PM, during a phone interview with Certified Nurse Aide (CNA) #10, she stated she worked on 10/11/25 from 10:00 PM to 6:30 AM on the [NAME] Unit. She stated there was no nurse present on the unit after midnight. She stated several residents were complaining of flu-like signs and symptoms during that weekend. On 10/20/25 at 5:45 PM, during a phone interview with CNA #11, she stated she worked on 10/11/25 from 10:00 PM to 6:30 AM on the TCU. She stated there was only one nurse, a Registered Nurse (RN), in the facility after midnight. On 10/21/2025 at 12:30 PM, during a phone interview with the facility's Medical Director/Physician, he reported he was not aware that only one (1) nurse was on duty overnight during the outbreak but stated that additional staff should have been provided, especially during an increase in resident acuity. He stated that staffing adequacy and infection control are discussed in QAPI meetings and that he relies on facility leadership to ensure appropriate staffing coverage. He explained that he believes the facility should have adequate staff and resources to meet resident needs during an outbreak, but that staffing continues to be an ongoing concern. On 10/21/25 at 1:30 PM, during an interview with the Administrator and DON, the Administrator explained on 10/11/25 she was notified at approximately 1:00 PM that the night nurse had called in sick. She stated that additional attempts were made to contact all nurses, including those at sister facilities, but they were unable to find coverage. The Administrator stated she arrived at the facility around midnight and remained at the [NAME] nursing station to assist the night nurse by answering call lights and notifying the nurse when residents requested medications. She confirmed she reviewed the Medication Administration Record (MAR) for evening medications but did not address the 5:00 AM medication pass. She stated she did not direct the night nurse to complete the morning medication pass and was unaware that some residents did not receive scheduled medications. The Administrator reported that she notified the Regional Director of Operations of the staffing shortage and that administrative staff assisted as needed. She confirmed the facility's contingency plan allowed administrative staff to assist during emergencies but acknowledged no agency staff were used, and no updates were made to the contingency plan following the incident. The DON confirmed she was aware only one nurse was on duty overnight for approximately sixty (60) residents but stated that one nurse should have been able to complete all medication passes. She stated she was not aware medications were missed until notified by the State Agency. Both the Administrator and DON described the incident as isolated and confirmed no changes had been made to the contingency plan or facility assessment. Resident #24 (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of the admission Record revealed the facility admitted Resident #24 on 8/11/25 with diagnoses including Encounter for Other Orthopedic Aftercare. A record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/18/25 revealed Resident #24 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Section F revealed bathing preference was coded as very important. A record review of the Documentation Survey Report for September 2025 revealed Resident #24 was documented as having received one (1) bath on 9/2/25, listed as PRN (as needed), requiring one-person physical assistance. There were no other documented baths for Resident #24 for the month of September 2025. This documentation represented (12) missed showers during the month of September 2025. Resident #54 A record review of the admission Record revealed the facility admitted Resident #54 on 1/2/24 with diagnoses including Cerebrovascular Disease affecting the Left Dominant Side. A record review of the Quarterly MDS with an ARD of 9/10/25 revealed Resident #54 had a BIMS score of 15, which indicated she was cognitively intact. A record review of the Documentation Survey Report for September 2025 revealed Resident #54 was documented as having received one (1) bath on 9/22/25, listed as Bathing/Showers M, W, F (Monday, Wednesday, Friday) X (times) 2 bed baths and X 1 shower, requiring two-person assistance. There were no other documented baths for Resident #54 for the month of September 2025. During an interview on 9/29/2025, Resident #54 stated she received a bath once weekly but wanted to be bathed more often. During a phone interview on 10/1/2025 at 8:35 AM, Resident #54's family member stated she was concerned about her mother's bathing care because the resident's feet were unclean during visits. Resident #58 A record review of the admission Record revealed the facility admitted Resident #58 on 2/10/22 with diagnoses including Type 2 Diabetes Mellitus. A record review of the Comprehensive MDS with an ARD of 9/17/25 revealed Resident #58 had a BIMS score of 15, which indicated she was cognitively intact. Section GG revealed impairment of range of motion in both lower extremities and that she required maximal assistance for bathing, showers, and personal hygiene. A record review of the Documentation Survey Report for September 2025 revealed no documentation indicating Resident #58 received a shower or bath as scheduled on 9/4, 9/9, 9/11, 9/13, 9/23, 9/25, or 9/30/25 for a total of seven (7) missed showers during the month of September 2025. During an interview on 10/1/2025 at 7:40 AM, Resident #58 stated she did not receive her shower the previous evening, despite requesting it several times. She reported the staff were always short and that there were not enough Certified Nurse Aides (CNAs) to complete all resident showers. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 10/1/2025 at 7:55 AM, CNA #5 confirmed hearing Resident #58 complain about not receiving a shower and stated the resident was truthful. She confirmed there was no documentation in the electronic Kardex indicating Resident #58 received a shower on 9/30/25. During an interview on 10/1/25 at 10:37 AM, CNA #2 stated she was scheduled for three (3) baths that day but had only completed one (1) due to workload. During an interview on 10/1/25 at 11:12 AM, CNA #3 reported there were more residents scheduled on shower days than staff could handle, and she did not feel the facility had enough CNAs to meet resident needs. During an interview on 10/1/2025 at 3:20 PM, CNA #1 stated that usually two (2) CNAs worked per hall on both day and evening shifts, and not all showers were completed. CNA #1 stated staffing levels did not allow all scheduled showers to be completed and that management was aware of the problem. During an interview on 10/1/25 at 5:46 PM, LPN #1 reported staffing levels did not allow staff to provide showers consistently and residents often received bed baths instead. During an interview on 10/2/25 at 3:50 PM, the Director of Nursing (DON) confirmed residents complained of not receiving showers as scheduled. She stated CNA staffing shortages were an ongoing issue. During an interview on 10/2/25 at 4:15 PM, RN #2 stated that staffing shortages were ongoing. During an interview on 10/2/25 at 4:30 PM, the Administrator confirmed the facility did not have sufficient staff to meet resident needs. She stated resident acuity was high, CNA turnover was significant, and staff call-offs were frequent on weekends. The facility submitted the following acceptable Removal Plan on 10/22/25: On 10/21/2025 at 4: 10 PM, the State Agency presented Immediate Jeopardy (IJ) Templates for five failures of the facility. The facility failed to provide the necessary care and services to protect residents from neglect. Residents did not receive prescribed medications; the physician was not notified of missed medications and supervision was inadequate on 10/12/25. The facility failed to provide sufficient licensed-nurse coverage to meet resident needs during an influenza outbreak resulting in one (1) nurse being assigned responsibility for 58 residents from approximately 12 AM until 7 AM on 10/12/25, resulting in missed medications and lack of monitoring for residents on one unit. The facility failed to identify an influenza (flu} outbreak when three residents tested positive for flu from 10/8/25 through 1 0/12/25. The facility did not initiate droplet precautions, notify health department, provide timely antiviral treatment, maintain outbreak surveillance or staff illness tracking during outbreak. The facility failed to ensure the facility assessment had required detail on staffing needs by shift and by unit, and the contingency plan for staffing emergencies had no actionable process which resulted in insufficient staffing during an influenza outbreak. The facility failed to use its Quality Assurance and Performance Improvement (QAPI) program to identify and correct system failures in infection control and staffing during an influenza outbreak. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. On 10/21/2025 at 6:15 PM, the Administrator held an emergency Quality Assurance and Performance Improvement meeting with the Medical Director, Director of Nursing, Infection Preventionist, Medical Records nurse, Life Connections Coordinator, Wound Care nurse and others as part of the Interdisciplinary team to discuss findings from the State Agency, discuss immediate actions, and further interventions. Immediate actions were decided as in-servicing all staff on Abuse and Neglect, in-servicing nurses on medication administration and medication errors, in-servicing all staff on flu outbreak and isolation precautions. The Administrator would review policy for Quality Assurance and Performance Improvement for any changes needed and as re-education in policy. The Administrator would review and update facility assessment to identify updated needs to staff per unit and the contingency plan for emergencies. Administrative nurses would complete a 100 percent audit on all medication carts compared to medication orders to ensure all medications were accessible in the building. The Infection Preventionist would be in-serviced on the roles and responsibilities of an Infection Preventionist. Policies on Abuse and Neglect, medication administration, medication errors, QAPI, flu outbreak, isolation precautions, and the expectations of the Infection Preventionist were all reviewed and updated. Staff were in-serviced with new policies. 2. On 10/21/2025 at 6: 15 PM, the Administrator notified Medical Director of missed medications during QAPI meeting. All missed medications were reviewed with Medical Director during this meeting. No new orders were given. No adverse reactions were noted due to missed medications. 3. On 10/21/2025 at 8:00 PM, the Director of Nursing began an in-service for all staff on the policies and procedures of Abuse and Neglect. No employee was permitted to return to work until they completed the in-service. 4. On 10/21/2025 at 8:00 PM, the Director of Nursing began an in-service on medication administration and medication errors to educate all nursing staff. This in-service included procedures for when medication cannot be located anywhere in the facility. If medication is not available, staff should contact pharmacy and pull medication from emergency kit. Any missed medications are to be reported to the Director of Nursing and Medical Director immediately, an incident report is to be completed, the resident observed for any adverse reactions, and the family/resident representative is to be notified. Any tasks left undone are to be reported to relief during report for oncoming shift. No employee was permitted to return to work until they completed the in-service. 5. On 10/21/2025 at 8:00 PM, Administrator and Director of Nursing reviewed Flu outbreak and Isolation precautions policy and procedures. The Director of Nursing began an inservice for flu outbreak and isolation precautions to educate all staff. All staff are to continue to monitor residents and staff for flu-like symptoms and report any findings to the immediate supervisor. No employee was permitted to return to work until they completed the in-service. 6. On 10/21/2025 at B: 15 PM, the Administrator reviewed policy on Quality Assurance and Performance Improvement plan and policy for re-education purposes and to review new policy. The Quality Assurance and Performance Improvement plan and policy was reviewed with the facility's Interdisciplinary Team including the Administrator, Medical Director, Director of Nursing, Infection Preventionist, Medical Records nurse, Life Connections Coordinator, Wound Care nurse and others in a follow up Quality Assurance and Performance Improvement meeting held on 10/22/2025 at 4:00 PM. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interviews, record review, and facility policy review, the facility failed to ensure medications were stored securely and in accordance with professional standards of practice by allowing a resident to have medications stored at the bedside without an assessment for safe self-administration for one (1) of (17) sampled residents (Resident #2).Findings include:A review of the facility's policy, Self-Administration of Medication, revised February 2021, revealed, .Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so.Policy Interpretation and Implementation.9. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge.On 9/29/2025 at 12:07 PM, during an observation and interview, Resident #2 was observed with an inhaler on the bedside table in plain view. Resident #2 explained she used the inhaler as needed.On 9/30/2025 at 2:00 PM, during an observation, Resident #2 was sitting up on the side of the bed. The inhaler remained on the bedside table in plain view, and an empty inhaler box was observed inside the water basin on a shelf in the room.On 10/1/2025 at 8:40 AM, during an observation and interview, Resident #2 was again observed sitting on the side of the bed. The inhaler remained on the bedside table in plain view, and the box was still located in a basin in the room. Resident #2 stated she knew the inhaler was to be used as needed every four (4) to six (6) hours. She explained that staff previously brought her the inhaler, but since she did not always need it when they offered, it was left in her room. She stated she uses it when she feels it is needed and does not notify staff.On 10/1/2025 at 3:30 PM, during an observation and interview with Licensed Practical Nurse (LPN) #4, she stated she was not aware that Resident #2 had an inhaler at the bedside and confirmed the resident had never requested one. LPN #4 observed and confirmed the inhaler was on the bedside table in plain view. She stated Resident #2 had an order for an inhaler, two (2) puffs every four (4) hours as needed for shortness of breath. LPN #4 stated the resident was cognitively intact and capable of self-administering medications but acknowledged she was not aware if an assessment had been completed.On 10/2/2025 at 3:15 PM, during an interview, the Director of Nursing (DON) acknowledged that the facility had not assessed Resident #2 for safe self-administration of medications and that there was not a physician's order authorizing the medication to be kept at the bedside. The DON stated it was her expectation that all medications be stored securely and that medications should not be kept at the bedside unless specifically authorized and assessed.A record review of the admission Record revealed the facility admitted Resident #2 on 12/1/2023 with diagnoses including Simple Chronic Bronchitis and Unspecified Asthma, Uncomplicated.A record review of the Order Summary Report revealed Resident #2 had a physician's order, dated 4/12/24 for .Proventil HFA Inhalation Aerosol Solution.2) puff inhale orally every 4 hours as needed for SOB (shortness of breath). There was no order authorizing the medication to be kept at the bedside.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/19/2025 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.

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	255244	A. Building B. Wing	10/28/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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, staff interview, and facility policy review, the facility failed to ensure food items were stored and maintained in a safe and sanitary manner as evidenced by not discarding expired products and spoiled food and not refrigerating items according to manufacturer's instructions for one (1) of four (4) survey days.Findings include:A review of the facility's policy, Food Receiving and Storage, reviewed 7/24/23, revealed, .Foods shall be stored in a manner that complies with safe food handling practices .On 9/29/25, at 10:28 AM, during an observation and interview, there were (10) loaves of wheat bread that had an expiration date of 9/23/25. In the dry goods room, there were five (5) quarts of nectar-consistency Thick & Easy milk with a use-by date of 8/1/25, and five (5) quarts of moderately Thick & Easy with a use-by date of 5/31/25. Additionally, there was (1) gallon of opened Sweet Baby Ray's teriyaki sauce that was stored on a dry goods shelf despite manufacturer instructions requiring refrigeration after opening. In Refrigerator #1, there was peanut butter pudding with an expiration date of 9/2/25, as well as three (3) bell peppers that were deteriorating and macerated. The Head [NAME] acknowledged and confirmed the findings and stated that the dietary staff who stock the food items were responsible for ensuring they were not expired, refrigerated appropriately, and were not overly ripe.On 10/2/25, at 11:47 AM, during an interview with the Administrator, she stated her expectation is for dietary staff to receive regular in-service training, perform routine checks of dry goods and refrigerator areas, ensure food items are labeled and dated, and consistently follow established procedures. She explained that the dietary staff had been employed at the facility for an extended period and should know how to perform those tasks.

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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 0838 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. (continued on next page)

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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 0838 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Based on staff interview and record review, the facility failed to ensure the facility assessment contained required details regarding staffing needs by shift and by unit and failed to maintain an actionable contingency plan for staffing emergencies for (59) of (59) residents in the facility during the influenza outbreak from 10/8/25 through 10/12/25.The facility's failure of not specifying in the facility assessment the number of licensed nurses and Certified Nurse Aides (CNAs) needed per shift and per unit to meet resident needs and the contingency plan not containing clear procedures for securing coverage during emergencies or staff call-offs, resulted in the facility being unprepared for staff absences during the influenza outbreak, which placed all residents at risk for serious illness, serious harm, serious impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) that began on 10/12/25 when there was insufficient staffing during the influenza outbreak. The facility Administrator was notified of the IJ on 10/21/25 at 4:10 PM and was presented with the IJ Template. The facility provided an acceptable Removal Plan on 10/22/25, in which they alleged all corrective actions to remove the IJ were completed on 10/22/25, and the IJ removed on 10/23/25.The State Agency (SA) validated the Removal Plan on 10/28/25 and determined that the IJ was removed on 10/23/25, prior to exit. Therefore, the scope and severity for CFR(s) S483.71(c)(2)(3) and (5) - Facility Assessment (F838) was lowered from a L to a F while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.Findings include:Record review of the Facility Assessment, dated 7/1/2025 and signed by the Administrator, revealed the Goal as The goal of this assessment is to identify the resources required to provide competent care for our residents during regular operations, including nights and weekends, as well as in emergency situations.Facility Assessment and Staffing Needs a. This facility assessment will be utilized to.d. Review staffing needs for each shift (day, evening, night).f. Aid in contingency planning for events that, while not necessitating activation of the facility's emergency plan, could impact resident care, such as the availability of direct care nurse staffing. Review of Staffing Needs as per Shift listed Ratio of Staff to Residents or #HPRD (hours per resident day) included the number of hours instead of the number of staff required per shift or per unit. Review of the Contingency Planning for Staffing revealed, In the case of an emergency event, the facility's emergency plan will be activated. IF the event does not rise to the level of activation of the facility's emergency plan the facility will utilize staff, accordingly, including utilizing Administrative staff .On 10/20/2025 at 5:00 PM, during a phone interview with Registered Nurse (RN) #3, she confirmed that the facility usually had two licensed nurses, including an RN and a Licensed Practical Nurse (LPN), that works on the 7 PM to 7 AM shift. On 10/21/25 at 1:30 PM, during an interview with the Administrator and Director of Nursing (DON), the Administrator explained she was notified on 10/11/25 at approximately 1:00 PM that the night nurse had called in sick during the influenza outbreak. She stated that additional attempts were made to contact all nurses, including those at sister facilities, but no coverage was found. The Administrator stated she arrived at the facility around midnight and remained at the [NAME] nursing station to assist the night nurse by answering call lights and notifying the nurse when residents requested medications. The Administrator reported that she notified the Regional Director of Operations of the staffing shortage and that administrative staff assisted as needed. She confirmed the facility's contingency plan allowed administrative staff to assist during emergencies but acknowledged no agency staff were used, and no updates were made to the contingency plan following the incident. The Administrator and DON both stated that only three (3) residents tested positive for influenza, and they did not consider the event an emergency requiring activation of the emergency plan. The Administrator stated the facility assessment used was carried over from the prior Administrator and did not contain a breakdown of the number of licensed nurses and Certified Nurse Aides (CNAs) required per shift or unit. She acknowledged she was unaware the assessment required this detail. She confirmed the assessment had not been revised following the outbreak and that staffing adjustments were made only as needed. Both the Administrator and DON described the incident as isolated and confirmed no changes had been made to the contingency plan or the facility assessment as a result.The facility submitted the following acceptable Removal Plan on 10/22/25:On 10/21/2025 at 4: 10 PM, the State Agency presented Immediate Jeopardy (IJ) Templates for five failures of the facility. The facility failed to provide the necessary care and services to protect residents from neglect. Residents did not receive prescribed medications; the physician was not notified of missed medications and supervision was inadequate on 10/12/25. The facility failed to provide sufficient

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on staff interview and record review, the facility failed to accurately document a resident's weight in the medical record for one (1) of 17 sampled residents. Resident #10 Findings include:A record review of the Weights and Vitals Summary for Resident #10 revealed that on 9/5/25 a weight of 76.7 pounds was recorded in the clinical record. However, two (2) days earlier, on 9/3/25, his weight was recorded as 167.2 pounds. Also, on 6/6/25, Resident #10's weight was recorded as 159.5 pounds and five (5) days later, on 6/11/25, the resident's weight was documented as 189 lbs.On 10/1/25 at 3:30 PM, during an interview, the Director of Nursing (DON) identified that weights dated 9/5/25 and 6/11/25 for Resident #10 were entered incorrectly in the electronic medical record.On 10/1/25 at 4:44 PM, during an interview with Registered Nurse (RN) #1 (Nurse Supervisor), she confirmed that the weights documented on 9/5/25 and 6/11/25 were inaccurate and caused the resident's record to incorrectly trigger weight alerts. RN #1 explained that Licensed Practical Nurse (LPN) #2 entered the resident's weight as 76 pounds rather than 76.7 kilograms on 9/5/25, which resulted in the system calculating and triggering a 5% weight loss over a 180-day period. She further stated that LPN #3 entered the weights documented on 6/11/25, which were also inaccurate. RN #1 acknowledged these errors created inconsistencies between the resident's actual clinical status and the weights recorded in the medical record. On 10/2/25 at 11:50 AM, during an interview, the Administrator stated that resident weights are reviewed monthly during quality meetings to identify and correct potential errors. The Administrator stated her expectation is that when more than one staff member inputs weight, there should be a monitoring and follow-up review process to ensure accuracy of documented weights.A record review of the admission Record revealed the facility admitted Resident #10 on 9/16/24 has current diagnoses including Heart Failure.A record Review of Quarterly Minimum Data (MDS) with the Assessment Review Date (ARD) date of 6/18/25, Section K, revealed Resident #10 had a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review, staff interview, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to sustain corrective actions to prevent recurrence of a previously cited deficiency, specifically, the facility was cited for failing to ensure food items were stored and maintained in a safe and sanitary manner by not discarding expired products and spoiled food, and not refrigerating items according to manufacturer's instructions and was cited again for the same deficiency during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for one (1) of (13) deficiencies cited. F812.Findings Include:Record review of the facility's policy, Quality Assessment and Performance Improvement QAPI Program, dated 10/2022, revealed, .This facility shall.maintain an ongoing, facility-wide, data-drive QAPI program.Policy Interpretation and Implementation The objectives of the QAPI program are to.4. Establish system through which to monitor and evaluate corrective actions.Implementation.2. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include.f. monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed.Record review of the Provider History Profile revealed the facility received a citation for F812 - Food Procurement, Store/Prepare/Serve-Sanitary for the annual survey dated 7/17/24. Record review of the CMS-2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), with a survey date of 7/17/2024, revealed the facility received a citation for F812, .Based on observation, staff interviews, and facility policy review, the facility failed to ensure spoiled food items were discarded, food items such as seasonings and spices were not open and exposed, and the food prep area was free from contamination for two (2) of (2) kitchen observations. During the current recertification survey, the facility failed to ensure food items were stored and maintained in a safe and sanitary manner as evidenced by not discarding expired products and spoiled food and not refrigerating items according to manufacturer's instructions for one (1) of four (4) survey days. On 10/02/2025 at 4:45 PM, during an interview, the Administrator stated the facility conducts monthly QAPI meetings addressing high-risk concerns. The Administrator stated she was not the active Administrator during the July 2024 survey but was aware of the previous deficiencies.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and facility policy review, the facility failed to implement appropriate infection prevention and control practices to prevent and contain the spread of influenza (flu) when three (3) residents (Residents #1, #53, and #63) tested positive between 10/8/25 and 10/12/25 for (59) of (59) residents in the facility. Additionally, the facility failed to implement Enhanced Barrier Precautions (EBP) during catheter care (a high contact care activity) for Resident #49.The facility's failure to identify the presence of an outbreak, initiate droplet precautions, post appropriate signage, notify the local health department, provide staff and family education regarding the outbreak, ensure the Infection Preventionist and clinical leadership verified isolation orders and monitored staff illness and infection-control compliance, and ensure antiviral medications were administered as prescribed resulted in the continued exposure of residents and the potential for transmission of flu throughout the facility, placing all residents at risk for serious illness, serious harm, serious impairment, or death The situation was determined to be an Immediate Jeopardy (IJ) that began on 10/8/25 when the facility had its first laboratory-confirmed case of flu. The facility Administrator was notified of the IJ on 10/21/25 at 4:10 PM and was presented with the IJ Template. The facility provided an acceptable Removal Plan on 10/22/25, in which they alleged all corrective actions to remove the IJ were completed on 10/22/25, and the IJ removed on 10/23/25.The State Agency (SA) validated the Removal Plan on 10/28/25 and determined that the IJ was removed on 10/23/25, prior to exit. Therefore, the scope and severity for CFR(s) S483.80(a)(1) - Infection Control (F880) was lowered from a L to a F while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.Findings include:A record review of the facility's policy Influenza, Prevention and Control of Seasonal, revised 01/12/2024 revealed . This facility follows current CDC (Center for Disease Control and Prevention) and State and Federal guidelines and recommendations for the prevention and control of seasonal influenza. Policy Interpretation and Implementation.Surveillance 1. When there is influenza activity in the local community, or one laboratory-confirmed influenza case is identified in the facility, active daily surveillance for influenza illness is conducted among all new and current residents, healthcare personnel, and visitors . Influenza Control Symptomatic Residents and Visitors 1. Residents and visitors are asked to inform staff if they have symptoms of any respiratory infections (. cough, runny nose, fever) . 3. Residents and visitors are reminded to report signs and symptoms of respiratory infection through the posting of signs at the entrance to and in public areas of the facility. 4. Staff are trained in recognizing and reporting signs of respiratory illness observed in residents. 7. Visual alerts (. signs, posters) are posted at the entrance to and in common areas of the facility to provide residents, visitors, and staff with instructions about respiratory hygiene and cough etiquette. 12. Wear a facemask upon entering room of influenza positive or suspected resident. Remove and dispose of facemask when leaving the room. Symptomatic Healthcare Workers 1. The infection preventionist and/or designee monitors and manages ill healthcare personnel. Laboratory Testing for Influenza 1. Laboratory testing for influenza is considered for residents (whether or not it is influenza season): a. with signs and symptoms of influenza; OR b. for high-risk residents who have atypical signs and symptoms, AND c. for residents in which test results will influence clinical management. 2. Confirmation of influenza by laboratory testing is not required in order to prescribe antiviral medication, and antiviral treatment is not delayed while awaiting test results.Infection Precautions 1. Contact and droplet precautions are implemented for residents with suspected or confirmed influenza for seven (7) days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer. Precautions may be applied for longer periods based on clinical judgement.6. Report influenza outbreak to local health department. Two cases is considered an outbreak. 7. Follow CDC guidance for influenza outbreak management. 8. Notify medical director for guidance on administering antiviral treatment during an outbreak.A review of the facility's policy, Enhanced Barrier Precautions, undated, revealed, .Enhanced barrier precautions (EBP)s are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. Policy Interpretation and Implementation.2. EBPs employ targeted gown and glove use during high contact resident care . 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include: . g. device care or use . urinary catheter .A record review of the CDC Interim Guidance for Influenza Outbreak Management in Long-Term Care and Post-Acute Care Facilities, dated 9/17/2024, revealed , Residents of long-term care facilities can