STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265308	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Mark Rehab and Healthcare Center	11221 North Nashua Drive Kansas City, MO 64155

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat residents with dignity and respect when staff allowed Resident #7 to scream and yell in the halls and dining room of the facility. This affected two sampled residents (Resident #2 and Resident #5). The facility census was 158. Review of the facility's policy titled, Resident Rights, dated 5/1/23, showed:-All residents have a right to a dignified existence, self-determination;-The facility must treat each resident with respect and dignity;-The facility will protect the rights of the resident.Review of the facility's policy titled, Privacy and Dignity, dated 10/24/22, showed the facility will promote resident care in a manner that maintains or enhances dignity and respect, in full recognition of each resident's individuality.1.Review of Resident #7's admission Data Set Minimum Data Set, (MDS, a federally mandated assessment tool completed by facility staff) dated 10/15/25 showed:-Severe cognitive impairment;-Dependent on staff for Activities of Daily Living (ADL)s;-Verbal behavioral symptoms directed towards others (threatening others, screaming at others, and cursing at others);-Other behavioral symptoms not directed towards others (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, and disruptive sounds);-Diagnoses included Parkinson's Disease, diabetes and anxiety.Review of the resident's care plan dated 7/24/25 showed:-The resident was at risk for a mood problem related to anxiety and depression;-Assist the resident with positive coping skills;-The resident will maintain a stable mood state.Observation on 11/18/25 at 12:13 P.M., showed:showed:-Resident #7 sat in the assisted dinging room in a wheel chair;-Resident #7 cried out and said Daddy, Daddy;-Licensed Practical Nurse (LPN) B repositioned the resident and offered him/her a cup of water;-Resident #7 continued to yell and cry out.Observation on 11/18/25 at 12:25 P.M., showed:-Resident #7 crying out loud and yelling;-Resident #1 sat across the table from Resident #7;-Nurse Aide (NA) A wheeled Resident out of the dining room;-Resident #7 yelled as he/she left the ding room.During an interview on 11/18/25 at 12:50 P.M., NA A said:-Resident #7 often yelled out loud;-Resident #7 used to live back on the rehab hall but was moved to this hall in hopes it would help the yelling;-The other residents became upset when resident #7 yells and that is why the staff took him/her back to his/room.During an interview on 11/18/25 at 12:59 P.M, Certified Nurses Aide (CNA) A said:-Resident #7 yelled and screamed often;-The staff did what they could to offer the resident food or drink and repositioning;-The staff notified the nurse if the resident does not calm down;-CNA A said he/she had not been given specific instructions on how to care for Resident #7.2.Review of Resident #2's Annual MDS dated [DATE] showed:-Mild cognitive impairment;-Impairment on one side upper and lower extremities;-Partial assistance with eating;-Dependent on staff for toileting;-Always incontinent of bowel;-Diagnosis of stroke, high blood pressure, and diabetes. Review of the resident's care plan dated 10/13/25, showed:-ADL self care deficit related to stoke;-The resident had depressive symptoms;-The resident would maintain a stable mood.During an interview on 11/18/25 at 2:22 P.M., the resident said:-Since the new company took over the care had became worse;-There is a lady that yelled constantly;-The constant yelling got on his nerves;-He/She said the staff and nurses (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Mark Rehab and Healthcare Center	11221 North Nashua Drive Kansas City, MO 64155

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	knew because the yelling happened in front of them;-He/She cannot get up and leave to get away from the noise because he/she was paralyzed;-He/She hoped the facility would do something about the yelling soon because it made him/her depressed.During an interview on 11/18/25 at 2:47 P.M., Family Member A said:-He/She could hear another resident yelling when he/she was on the phone with Resident #2;-Resident #2 told him/her the yelling agitated him/her;-Resident #2 should not have to listen to the yelling all the time.3.Review of Resident #5's Quarterly MDS dated [DATE] showed:-Mild cognitive impairment;-Partial assistance with ADLs;-Diagnoses included, diabetes, bipolar disorder and anxiety.Review of the resident's care plan dated 10/8/25 showed:-The resident is at risk for a mood problem related to depression and anxiety.During an interview on 11/18/25 at 3:07 P.M., the resident said:-There was a resident that yelled from the time they got the resident up until staff all day long and part of the evening;-The staff sat the resident in his/her wheel chair in the tv room;-The resident yells and screams until they took the resident back to his/her room;-He/She could hear the resident yell from his/her room;-The staff are aware because the resident yelled most of the time;-The resident yells out daddy, daddy and just screamed;-The yelling got on his/her nerves;-The yelling made him depressed.During an interview on 11/18/25 3:45 P.M., LPN B said: -The resident #7 yelled and screamed often;-The staff do what they can to offer the resident food or drink and repositioning;-He/she had not been specific instructions for how to care for Resident #7.During an interview on 11/18/25 03:57 P.M., the Director of Nursing said:-He expected staff to address the needs of resident #7;-Resident #2 and #5 have the right to be treated with dignity and respect.During an interview on 11/18/25 04:22 P.M., the Administrator said: -He expected staff to address the needs of resident #7 as well as all residents;-The facility had been in contact with the family for ideas to decrease the resident's yelling;-Resident #2 and #5 have the right to be treated with dignity and respect.2652448

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide basic Activities of Daily Living (ADLs: tasks completed in a day to care for oneself) to ensure residents were clean, dry, and free of odor. The facility failed to provide incontinence care in a timely manner for four sampled residents (Resident #10, #1, #4, and #3); failed to ensure four residents were free of offensive body odor (Resident #10, #1, #4, #3) out of 28 sampled residents. The facility census was 158. Review of the facility provided policy titled, Perineal Care, dated October 24, 2022 showed: -Purpose is to maintain cleanliness, reduce odor and prevent skin breakdown;-Perineal care is provided as part of a resident's hygienic program, a minimum of once daily and per resident need; Review of the facility provided policy titled, Care and Services, dated October 24, 2022 showed:-Purpose is to ensure that all residents receive the necessary care and services based on an individualized comprehensive assessment;-Residents are provided with the necessary care and services to maintain the highest practicable physical, mental and social well being; -Care and services are provided in a manner that consistently enhances self esteem and self worth. Review of the facility provided titled, Resident Rights, policy dated May 1, 2023 showed all residents have a right to a dignified existence. 1. Review of Resident #10's Significant Change Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 10/15/25 showed:-Brief Interview of Mental Status (BIMS) of 3 indicated significant cognitive loss;-Dependent on staff for ADL's;-Incontinent of bowel and bladder;-Diagnoses included: Dementia, heart failure, and Parkinson's disease (a disease that causes nerve cells in parts of the brain to weaken, become damaged, and die, leading to symptoms that include problems with movement, tremor, stiffness, and impaired balance). Review of the resident's Comprehensive Care Plan dated 10/22/25 showed:-He/She had an ADL self care performance deficit because of limited mobility, dementia, and amputation of fingers;-He/She required assistance with mobility;-He/She required total assistance of staff for personal hygiene and toileting; -He/She was incontinent of bowel and bladder;-He/She required full assistance with toileting and perineal care; -The staff were to keep his/her skin clean and dry. Continuous observation on 11/18/25 beginning at 11:20 A.M. through 1:50 P.M. showed:-The resident was sitting in a wheelchair in the television (TV) room, he/she was wearing grey sweatpants, and grey sweatshirt; -At 11:22 A.M. the resident was taken to the dining room by staff and placed at the dining room table; -Staff did not offer the toilet or repositioning to the resident; -He/She remained at the dining room table until 12:57 P.M. when he/she was assisted by staff to the TV room; -At 1:50 P.M. the resident remained in the TV room, he/she had a foul body odor. Observation on 11/18/25 at 4:46 P.M. showed:-The resident was removed from the TV room and assisted to his/her room by Nurse Aide (NA) A; -The resident was placed in the sit to stand lift (a mechanical device used to move residents from one surface to another, such as from a bed to a chair or chair to bed) by NA A and Certified Nurse Aide B;-The resident was raised to a standing position, NA A removed the resident's grey sweatpants; -The resident's incontinent brief was saturated and hung to his/her mid-thigh, CNA B removed the brief, the removed brief had copious amounts of fluid dripping onto the floor, multiple brown fluids rings and a small smear of red to the right side; -NA A used a wipe to cleanse the resident from front to back; -The used wipe showed yellow/brown fluid (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and a smear of red fluid wiped away from the resident; the resident said the area hurt when it was wiped; -A clean incontinent brief was applied; -The resident was returned to his/her wheelchair and assisted to the dining room. During an interview on 11/18/25 at 4:46 P.M NA A said:-He/She had not changed or cleaned up the resident since the morning of 11/18/25; -There was not enough staff to provide care to all the residents and he/she was not able to change the resident's incontinent brief when needed. During an interview on 11/18/25 at 4:46 P.M. CNA B said:-He/She had not provided cares for the resident since the morning of 11/18/25; -He/She was busy and did not have time to assist the resident with his/her cares. 2. Review of resident #1's admission MDS, dated [DATE] showed:-Severe cognitive impairment;-Incontinent of bowel and bladder;-Dependent on staff for toileting;-Substantial assistance with personal hygiene;-Diagnosis included, traumatic brain injury (a brain injury that caused by an outside force), dementia and heart failure. Review of the resident's care plan dated 10/04/25 showed:-The resident was totally dependent on staff for toileting;-The resident was incontinent of bowel and bladder;-Check the resident routinely and as needed for incontinence;-Change clothing and provide incontinence care after each incontinent episode. During an observation beginning on 11/18/25 at 09:20 A.M. - 12:22 P.M., showed:-09:32 A.M., the resident sat in the TV area in his/her wheelchair; -09:45 A.M., the resident sat in the TV area in his/her wheelchair; -10:16 A.M., Nurse Aide (NA) A took the resident to the dining room for activities and did not toilet or change the resident;-10:20 A.M., the resident sat at the table in the dining room in his/her wheelchair;-10:40 A.M., NA A took the resident back to the TV area and did not toilet or change the resident;-10:56 A.M., the resident sat in the TV area in his/her wheelchair; -11:04 A.M., there were no staff near the resident's location;-11:08 A.M., the resident sat in the TV area in his/her wheelchair; -11:18 A.M., the resident sat in the TV area in his/her wheelchair;-11:21 A.M., the resident sat in the TV area in his/her wheelchair;-11:31 A M., the resident sat in the TV area in his/her wheelchair;-11:45 A.M., NA A took the resident to the dining room;-12:02 A.M., the resident the resident sat in the dining room in his/her wheelchair;-12:18 P.M., Certified Nurses Aide (CNA) A took the resident to his/her room;-12:19 P.M., the resident had a strong smell of urine;-12:20 P.M., CNA A and NA A transferred the resident to his/her bed;-12:22 P.M., the resident's wheel chair had liquid that smelled of strong urine in it and the seat of the wheel chair was wet and smelled of strong urine;-The resident's pants were wet in the groin area and smelled of strong urine;-CNA A and NA A removed the resident's pants and brief:-The brief was saturated with urine and had a strong smell of urine. During an interview on 11/18/25 12:41 P.M., NA A said: -The resident was dependent on staff for transfers and toileting;-The resident was incontinent;-The resident should be provided incontinent care and repositioned at least every two hours;-The resident should be changed before the mechanical lift pad becomes saturated with urine;-He/She did not provide incontinent care and reposition the resident every two hours because he/she had been busy helping other residents. During an interview on 11/18/25 12:55 P.M., CNA A said: -The resident was dependent on staff for transfers and toileting;-The resident was incontinent;-The resident should be provided incontinent care and repositioned at least every two hours. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.Review of Resident #4's Quarterly MDS dated [DATE] showed:-Mild cognitive impairment;-Dependent on staff for toileting;-Dependent on staff for showers;-Substantial assistance from staff for personal hygiene; -Always incontinent of bowel and bladder;-Diagnoses included, dementia and depression. Review of the resident's care plan dated 11/07/25 showed:-The resident was totally dependent on staff for toileting;-The resident was incontinent of bowel and bladder;-Check the resident routinely and as needed for incontinence. During an observation beginning on 11/18/25 at 09:20 A.M. - 12:24 P.M., showed:-09:32 A.M., the resident sat in the TV area in his/her wheelchair; -09:45 A.M., the resident sat in the TV area in his/her wheelchair; -10:00 A.M., the NA A took the resident to the dining room for activities and did not toilet or change the resident;-10:20 A.M., the resident sat at the table in the dining room in his/her wheelchair;-10:31 A.M., CNA A took the resident back to the TV area and did not toilet or change the resident;-10:49 A.M., there were no staff near the resident's location;-10:58 A.M., the resident sat in the TV area in his/her wheelchair; -11:05 A.M., the resident sat in the TV area in his/her wheelchair; -11:13 A.M., the resident sat in the TV area in his/her wheelchair; -11:17 A.M., CNA A walked by the resident and did not toilet the resident;-11:18 A.M., the resident sat in the TV area in his/her wheelchair;-11:21 A.M., the resident sat in the TV area in his/her wheelchair;-11:27 A.M., the resident sat in the TV area in his/her wheelchair;-11:45 A.M., CNA A took the resident to the dining room;-11:46 A.M., the resident had a strong smell of urine; -12:02 P.M., the resident sat in the dining room in his/her wheelchair;-12:18 P.M., the resident the resident sat in the dining room in his/her wheelchair;-12:22 P.M., the resident sat in the dining room in his her/wheel chair;-12:24 P.M., the facility staff did not offer to toilet the resident during this continuous observation. During an interview on 11/18/25 12:41 P.M., NA A said: -The resident was dependent on staff for transfers and toileting;-The resident was incontinent;-He/She had not provided incontinent care since breakfast;-The resident should be provided incontinent care and repositioned at least every two hours;-He/She did not provide incontinent care and reposition the resident every two hours because he/she had been busy helping other residents. During an interview on 11/18/25 at 12:55 P.M., CNA A said: -The resident was dependent on staff for transfers and toileting;-The resident was incontinent;-He/She had not provided incontinent care or repositioned since breakfast;-The resident should be provided incontinent care and repositioned at least every two hours;-He/She did not provide incontinent care and reposition the resident every two hours because he/she had been busy helping other residents. 4. Review of Resident #3's Five Day MDS dated [DATE] showed:-Severe cognitive impairment;-Occasionally incontinent of bowel and bladder;-Substantial assistance for toileting;-Diagnoses included, anemia, dementia and respiratory failure. Review of the resident's care plan dated 10/18/25 showed:-The resident was totally dependent on staff for toileting;-The resident was incontinent of bowel and bladder;-Check the resident routinely and as needed for incontinence. During an observation beginning on 11/18/25 at 09:20 A.M. - 12:02 P.M., showed:-09:32 A.M., the resident sat in the TV area in his/her wheelchair; -09:45 A.M., the resident sat in the TV area in his/her wheelchair; -10:16 A.M., CNA A took the resident to the dining room for activities and did not toilet or change the resident;-10:20 A.M., the resident sat at the table in the dining room in his/her (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wheelchair;-10:40 A.M., Certified Nurses Aide CNA A took the resident back to the TV area and did not toilet or change the resident;-10:56 A.M., the resident sat in the TV area in his/her wheelchair; -11:12 A.M., the resident sat in the TV area in his/her wheelchair;-11:22 A.M., the resident sat in the TV area in his/her wheelchair;-11:35 A.M., the resident sat in the TV area in his/her wheelchair;-11:45 A.M., NA A took the resident to the dining room;-12:02 P.M., the resident the resident sat in the dining room in his/her wheelchair. During an interview on 11/18/25 12:41 P.M., CNA A said: -The resident was dependent on staff for transfers and toileting;-The resident was incontinent;-The resident should be provided incontinent care and repositioned at least every two hours. During an interview on 11/18/25 12:55 P.M., LPN B said: -The resident was dependent on staff for transfers and toileting;-The resident was incontinent;-He/She would expect the resident be provided incontinent care and repositioned at least every two hours;-All dependent residents who are incontinent should be provided incontinent care at least every two hours. During an interview on 11/18/25 03:17 P.M., the Director of Nursing said he expected staff to check and change incontinent residents at least every two hours and as needed. During an interview on 11/18/25 04:22 P.M., the Administrator said: -All dependent residents who are incontinent should be provided incontinent at least every two hours;-He expected staff to check and change incontinent residents at least every two hours and as needed. Intakes 2672337, 2672247, 2672338, 2652454

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to ensure one resident with potential for skin breakdown was free of preventable pressure ulcers when Resident #10 was not provided timely incontinent care and had open area to his/her buttocks. The facility census was 158. Review of the facility provided policy titled, Perineal Care, dated 10/24/2022 showed the purpose was to maintain cleanliness and prevent skin breakdown.Review of the facility provided policy titled, Care and Services, dated 10/24/2022 showed the facility will have sufficient staff to provide services to residents, to provide nursing and related services to assure resident's attain or maintain highest practicable physical well being.Review of the facility provided policy titeled, Wound Management, dated 10/24/2022 showed:- Residents will receive necessary services to promote healing, prevent infection and prevent new pressure ulcers from developing;- Upon identification of a new wound the licensed nurse wil measure the wound, initiate a Wound Monitoring Record Sheet and implement a wound treatment per physician's order.1. Review of Resident #10's Significant Change Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 10/15/25 showed:-Brief Interview of Mental Status (BIMS) of 3 indicated significant cognitive loss;-Dependent on staff for Activities of Daily Living (ADLs');-Incontinent of bowel and bladder;-At risk for pressure ulcers;-He/She had no wounds;- Diagnoses included: Dementia, heart failure, and Parkinson's disease (a disease that causes nerve cells in parts of the brain to weaken, become damaged, and die, leading to symptoms that include problems with movement, tremor, stiffness, and impaired balance). Review of the resident's Comprehensive Care Plan date 10/22/25 showed:-He/She had an ADL self care performance deficit because of limited mobility, dementia, and amputation of fingers;-He/She required assistance with mobility;-He/She required complete assistance from staff for personal hygiene and toileting; -He/She was incontinent of bowel and bladder;-He/She had an actual impairment of skin integrity as evidenced by bowel and bladder incontinence; -He/She required full assistance with toileting and perineal care; -Staff were to keep his/her skin clean and dry.Review of the resident's Physician Order Sheets (POS) for November 2025 showed no orders for treatment to open area on buttocks.Review of the resident's Nurse Progress Notes dated 11/18/25 at 6:10 P.M. by Unit Manager A showed:-Reported the resident had loose stools and an area to the right buttocks; -Nurse Practitioner A was notified of the loose stools and moisture breakdown to his/her buttocks; -Orders received for Imodium and moisture barrier to buttocks. Review of Nurse Practitioner A Progress Notes for the resident dated 11/19/2025 at 5:40 P.M. showed:- The patient experienced loose stools on 11/19/25;- Imodium ordered and barrier cream to be applied to buttocks each shift and as needed.Continuous observation on 11/18/25 beginning at 11:20 A.M. through 1:50 P.M. showed:-The resident was sitting in a wheelchair in the television (TV) room, he/she was wearing grey sweatpants, and grey sweatshirt;-At 11:22 A.M. the resident was taken to the dining room by staff and placed at the dining room table; -Staff did not offer the toilet or repositioning to the resident; -He/She remained at the dining room table until 12:57 P.M. when he/she was assisted by staff to the TV room; -At 1:50 P.M. the resident remained in the TV room, he/she had a foul body odor.Observation on 11/18/25 at 4:46 P.M. showed:-The resident was removed from the TV room and assisted to his/her room by Nurse Aide (NA) A;-The resident was placed in the sit to stand lift (a mechanical device used to move residents from one surface to another, such as from a bed to a chair or chair to bed) by NA A and Certified Nurse Aide (CNA) B;-The resident was raised to a standing position, NA A removed the resident's grey sweatpants; -The resident's incontinent brief was saturated and hung to his/her mid-thigh, CNA B removed the brief;-The removed brief had copious amounts of fluid dripping onto the floor, multiple brown fluids rings and a small smear of red to the right side; -NA A used a wipe to cleanse the resident from front to back; -The used wipe showed yellow/brown fluid and a smear of red fluid wiped away from the resident; -The resident said the area hurt when it was wiped; -The resident had a pencil eraser sized open area, with pink tinged drainage to the right buttock; -The (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	skin surrounding the open wound was red and inflamed; -A clean incontinent brief was applied; -The sweatpants were repositioned and the resident was returned to his/her wheelchair;-The resident was assisted to the dining room. During an interview on 11/18/25 at 4:46 P.M NA A said:-He/She was not aware of any open areas to the resident;-He/She noticed some red bloody drainage on the wipe when he/she cleaned up the resident the morning of 11/18/25; -He/She had not changed or cleaned up the resident since the morning of 11/18/25; -There was not enough staff to provide care to all the residents and he/she was not able to change the resident's incontinent brief as needed.During an interview on 11/18/25 at 4:46 P.M. CNA B said:-He/She had not provided cares for the resident since the morning of 11/18/25; -He/She was busy and did not have time to assist the resident.During an interview on 11/18/25 at 5:20 P.M. Licensed Practical Nurse (LPN) A said;-He/She was not aware of any open areas on the resident; -He/She could not evaluate the resident as the resident was in the dining room;-The resident has a history of open areas and wounds.During an interview on 11/18/25 03:17 P.M., the Director of Nursing said:-He expected staff to check and change incontinent residents at least every two hours and as needed, and report open areas immediately;-Resident #10 did not have an open area he was aware of.During a follow up interview on 11/18/25 04:22 P.M., the Administrator said: -All dependent residents who are incontinent should be provided incontinent at least every two hours;-He expected staff to check and change incontinent residents at least every two hours and as needed and report open areas to the nurse.-Resident #10 did not have an open area he was aware of. Intake 2672337