STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265330	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Village Park	2041 Silva Lane Moberly, MO 65270

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff obtained a lithium level (a laboratory test to monitor the concentration of lithium (mood stabilizing medication to treat bipolar disorder (mental illness) in the blood) for Resident #24 as ordered by the psychiatric Nurse Practitioner in October 2025. Resident #24 had a physician order for lithium 600 milligrams twice daily with an order start date of 09/20/24. Review showed Resident #24 was found in his/her room unresponsive on 11/24/25. The resident had vomited and was incontinent (abnormal for this resident). The resident's color was pale (normal color pink) and yellow. The resident's heart rate was 111 beats per minute (normal 60-100) and his/her oxygen saturation (blood oxygen level) was 70 percent (%) on room air (normal 95-100%). The resident was transferred to the hospital where he/she was found to have a critically high lithium level of 3.6 (normal is 0.6 - 1.2) and required intubation (a procedure where a tube is inserted through the mouth into the trachea to secure an open airway to support breathing) and was dialyzed (a life-sustaining treatment that filters waste products from the blood) four times to lower the lithium level. Further review showed the facility failed to obtain ordered blood work, including complete blood counts (CBC) (blood cell count including measure of white blood cells (WBC), that may indicate infection) and comprehensive metabolic panels (CMP) (blood test that checks the chemical balance of the blood, including Blood Urea Nitrogen (BUN, a test to assess how well the kidneys and liver are functioning) and Creatinine (a component to test how well the kidneys are filtering waste from the body). Upon the resident's emergency medical care, he/she was found to have elevated BUN and Creatinine levels as well as an elevated WBC. Review of hospital records and interview with the physician showed the resident suffered acute kidney failure and concerns with lack of oxygen to the brain. At the time of the survey exit, the resident remained hospitalized , 19 days following admission. The facility census was 172. The administrator was notified of the Immediate Jeopardy (IJ) on 12/10/25 at 12:30 P.M. which began on 11/24/25. The IJ was removed on 12/10/25 as confirmed by the surveyor onsite. Review of the facility policy, Transcription of Orders/Following Physician's Orders, revised on 05/18/24, showed the following:-The purpose of this policy is to outline procedures in accurately transcribing physician's orders and to ensure that all physicians' orders are followed. To ensure a process is in place to monitor nurses in accurately transcribing and following physician's orders;-Upon receiving a physician's order via telephone, fax, written order, verbal order, transcribed order or other, it will be documented in residents' electronic medical record (EMR) in orders section;- After laboratory testing, diagnostic testing or other services are ordered, the nurse will document orders in the resident's EMR (electronic medical record) and will fill out the corresponding requisition for the specific services to be obtained (or follow protocol set forth by individual lab company). Review of the facility policy, Diagnostic Testing Services Policy, revised on 06/26/24, showed the following:-This facility will provide the appropriate diagnostic services (laboratory and radiology) required to maintain the overall health of its residents and in accordance with state and federal guidelines;-The facility will maintain a schedule of diagnostic tests (laboratory and radiology) in accordance with the physician's orders. Review of www.drugs.com showed the following: -Lithium is a mood stabilizing medication used to treat or control the manic (continued on next page)

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

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	episodes of bipolar disorder (brain disorder causing extreme shifts in mood, energy and activity, also known as manic depression); -Lithium toxicity can cause death. Lithium is a medicine with a narrow range of safety and toxicity can occur if you take only slightly more than a recommended dose;-Early signs of toxicity include vomiting, diarrhea, drowsiness, muscle weakness, or loss of coordination. Review of Resident #24's undated diagnoses list showed the following:-Bipolar disorder, current episodic manic without psychotic features.-Attention-deficit hyperactivity disorder (disorder that impacts attention, focus, hyperactivity and impulsivity);-Mild intellectual disabilities.-Major depressive disorder, recurrent.-Post-traumatic stress disorder (mental health condition that's caused by an extremely stressful or terrifying event). Review of the resident's Physician's Order Sheet (POS), dated 9/20/24, showed an order for lithium carbonate 600 milligrams (mg) one tablet by mouth twice daily. Review of the resident's Care Plan dated 9/20/24, showed the following: -The resident uses psychotropic medications related to behavior management;-The resident has a behavior problem related to depression;-Arrange for psychiatric consult, follow up as indicated;-Drug therapy and monitoring;-Monitor/document for side effects and effectiveness;-The plan included no specific interventions regarding monitoring for side effects of lithium, signs of toxicity, or monitoring lithium levels. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 09/26/24 showed the following:-Cognitively intact;-Diagnoses of depression, Bipolar disorder, Post Traumatic Stress, and autism (a condition related to brain development that affects how people see others and socialize with them). Review of the resident's medical record, dated 11/21/24, showed the following:-BUN 8 (normal 7-25);-Creatinine 1.0 (normal 0.7-1.3);-Lithium level 1.0 mmol/L (normal 0.6-1.3). Review of the resident's Care Plan dated 12/19/24 included no specific interventions regarding monitoring for side effects of lithium, signs of toxicity, or monitoring lithium levels. Review of the resident's medical record dated 03/20/25 showed the following:-BUN 5;-Creatinine 0.8;-Lithium level 1.0. Review of the resident's POS, dated 05/15/25, showed an order for a lithium level (laboratory test) every three months. Review of the resident's medical record showed no documentation staff attempted and obtained, or the resident refused the ordered lab work on 5/15/25. Further review showed no documentation staff notified the resident's physician the ordered lab work had not been obtained. Review of the resident's laboratory results dated [DATE] showed the following:-BUN 11;-Creatinine 0.9;-Lithium level 0.5 mmol/L (normal 0.6-1.3). Review of the resident's Care Plan, revised 09/06/25, showed the following:-Encourage adherence to prescribed medications (antidepressants, mood stabilizers, and antipsychotics as prescribed);-No specific interventions regarding monitoring for side effects of lithium, signs of toxicity, or monitoring lithium levels. Review of the resident's POS, dated 09/12/25, showed an order for a CBC monthly starting on the 13th. Review of the resident's medical record dated September 2025 showed no documentation staff obtained, or the resident refused the ordered lab work. Further review showed no documentation staff notified the resident's physician the ordered lab work had not been obtained. Review of the resident's October 2025 POS showed the following:-On 10/20/25 an order for lithium serum level and CMP;-On 10/21/25, an order for CBC;-On 10/22/25, lithium level, CMP and CBC, SENT Uncollected. Review of the resident's Medication Administration Record (MAR) dated October 2025, showed staff documented administering the resident his/her scheduled lithium carbonate 600 mg by mouth twice daily as ordered with no documentation to support the resident had been refusing the medication. Review of the resident's medical record dated October 2025 showed no documentation staff obtained, or the resident refused the 10/20/25 and 10/21/25 ordered lab work. Further review showed no documentation staff notified the resident's physician the ordered lab work had not been obtained. Review of the resident's Physician Progress Notes, dated 10/23/25, showed the following:-The resident's mental health was being actively managed with psychotropic medications;-Autistic disorder: Followed and managed by psychiatric services;-Major depressive disorder: Followed and managed by psychiatric services;-Adjustment disorder: Followed and managed by psychiatric services.-No documentation regarding the resident (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	refusing medications or experiencing side effects of lithium. Review of the resident's POS, dated November 2025, showed an order for lithium carbonate 600 mg by mouth twice daily. Review of the resident's POS, dated 11/11/25, showed an order for a CMP every three months. Review of the resident's medical record dated November 2025, showed no documentation staff obtained, or the resident refused ordered lab work of 11/11/25. Further review showed no documentation staff notified the resident's physician the ordered lab work had not been obtained. Review of the resident's MAR, dated 11/01/25 through 11/14/25, showed staff documented administering the resident his/her scheduled lithium carbonate 600 mg by mouth twice daily as ordered with no documentation to support the resident had been refusing the medication. Review of the resident's Mental Status Exam, completed by the Psychiatric Nurse Practitioner, dated 11/14/25, showed the following:-Reason for visit: Elevated lipids, valproic acid (antiseizure medication) level low, refusing medications at times;-Symptoms: resident is on six psychotropic medications;-Labs are up to date, lipids are elevated. Review of the resident's MAR, dated 11/15/25 through 11/20/25, showed staff documented administering the resident his/her scheduled lithium carbonate 600 mg by mouth twice daily as ordered with no documentation to support the resident had been refusing the medication. Review of the resident's Physician Progress Note, dated 11/20/25, showed the following:-Chief complaint: Resident evaluated for chronic psychiatric, neurologic, and gastrointestinal conditions with emphasis on acute nausea and vomiting;-Resident not doing well today;-Nursing reports he/she vomited twice and was experiencing intermittent nausea;-Appetite reduced but tolerating fluids;-The resident was already on Zofran (anti-nausea medication) four milligrams as needed, and staff will administer upon the resident's request;-Treatment: Encourage fluid intake. Continue Zofran by mouth as needed for nausea and vomiting. Monitor for dehydration and worsening gastrointestinal symptoms. Review of the resident's progress notes dated 11/20/25-11/21/25 showed no documentation regarding the resident experiencing nausea and/or vomiting. Review of the resident's MAR, dated 11/21/25 through 11/22/25, showed staff documented administering the resident his/her scheduled lithium carbonate 600 mg by mouth twice daily as ordered with no documentation to support the resident had been refusing the medication. Review of the resident's Behavior Symptoms and Cognitive Performance Assessment completed by facility staff and dated 11/22/25 showed the following:-No behavior symptom presence;-No rejection of care, including bloodwork;-Current behavior: same. Review of the resident's progress notes dated 11/22/25-11/23/25 showed no documentation regarding the resident experiencing nausea and/or vomiting. Review of the resident's MAR dated 11/23/25, showed staff documented administering the resident his/her scheduled lithium carbonate 600 mg by mouth twice daily as ordered with no documentation to support the resident had been refusing the medication. Review of the resident's Progress Notes, dated 11/24/25 at 1:45 A.M., showed the following:-Resident was found by staff after an aide heard a noise and a smell coming from the resident's room;-Upon entering the room, the resident was noted to have vomited and was incontinent;-The resident's color appeared pale and the resident was not responding to nursing staff;-Resident's pupils were noted to have poor dilation response;-Resident's lung sounds were hard to hear due to gurgling respirations (normal respiration sound is soft, low pitched);-Due to altered responsiveness, abnormal discoloration, low oxygen saturation, and significant change from baseline, Emergency Medical Services (EMS) notified;-Resident was transported to a local hospital for further evaluation and treatment. Review of the resident's emergency room record, dated 11/24/25, showed the following:-Presenting complaint: Possible aspiration of stomach contents. Received report from nurse at facility during every two hour rounds, there was a foul smell present in the resident's room. Upon turning on the lights, found resident to be covered in yellow emesis, nonreactive to painful stimuli, and having gurgling respirations. Oxygen saturation (measures the percentage of oxygen in the blood) 82 percent (%) (normal is 95 - 100%) on room air, placed on oxygen via nasal cannula (prongs placed in the nares that deliver oxygen) at facility. EMS unable to get intravenous (IV) (within the vein) or intraosseous (IO) (emergency technique for giving fluids/medications directly into the (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	bone marrow when the veins fail) access. Resident on nonrebreather mask (medical device that delivers a high concentration of supplemental oxygen) at 15 liters per minute (a high flow rate often used for severe, critical conditions). Resident became hypotensive (low blood pressure) enroute 83/43 (normal blood pressure 120/80) and tachycardic (elevated heart rate);-General: Appears distressed;-Neuro: Level of consciousness unresponsive. Pupils are sluggish;-Respiratory: Respiratory pattern is tachypnea (fast respirations). Breath sounds with crackles bilaterally (normal clear);-The resident's creatinine was greater than three, concerning for acute kidney injury, however no baseline labs are available at this time;-Resident with an elevated lithium level concerning for lithium toxicity. The lithium level is 3.6. The resident will need transfer to a Medical Intensive Care Unit (MICU) for emergent treatment of lithium toxicity;-BUN 60;-Creatinine 3.02;-WBC 19.4 (normal 4.5-11.0);-The resident was intubated upon arrival for hypoxia (low oxygen level) and altered mental status;-Transferred by EMS ground to outlying hospital. Review of the resident's Outlying Hospital admission Note, dated 11/24/25, showed the following:-Severe lithium toxicity with lethargy/coma;-Acute hypoxemia respiratory failure on mechanical ventilation (a life-supporting treatment using a machine (ventilator) to help or fully control breathing for someone unable to breathe adequately on their own);-Acute renal (kidney) failure;-Lithium at outside hospital was 3.6, now 3.2. Nonetheless, the resident continued to be minimally responsive while off sedation;-Consulted nephrology (kidney specialist) for consideration of hemodialysis (a life-sustaining treatment for kidney failure that uses a machine with a filter to clean waste and toxins from the blood) (despite level being below 4, his/her mental status was really impacted.) Review of the resident's Nephrology Consultation Note, dated 11/24/25, showed the following:-The resident's lithium dose had been reportedly stable since September 2024;-The resident's Ativan (anti-anxiety medication) dose was recently decreased due to increased somnolence;-Facility staff denies him/her having any recent illness, diarrhea, abnormal behavior or poor oral intake recently;-Assessment/Plan: Lithium level was found to be significantly elevated though it is not clear what precipitated this abrupt increase. His/Her encephalopathy (disturbance of the brain's functioning) is likely related to lithium toxicity. Review of the resident's Hospital Progress Note, dated 12/01/25, showed the following:-The resident's encephalopathy was likely related to lithium toxicity and he/she received four sessions of dialysis and lithium level within normal limits (WNL) now;-The medical intensive care unit (MICU) team will discuss with poison control and determine if more dialysis is needed for Silent Lithium Syndrome (a rare, severe complication of lithium treatment where neurological damage persists long after lithium levels normalize, causing lasting issues like tremors, balance problems, slurred speech and cognitive decline, often linked to acute toxicity episodes). During an interview on 12/08/25 at 1:16 P.M., the resident's guardian said the following:-He/She had received no communication from the facility regarding the resident refusing labs or medications;-The resident was still hospitalized and was intubated;-The resident had failed several extubating (removal of the tube in the windpipe) attempts and had been minimally responsive;-A Magnetic Resonance Imaging (MRI) (a noninvasive scan that creates detailed internal pictures of the body that helps diagnose diseases and plan treatments) was done at the hospital which showed concern for oxygen loss to the brain;-The resident required four rounds of dialysis to clear the excess lithium from his/her system. During an interview on 12/09/25 at 10:00 A.M., Nurse Aide (NA) QQ said the following:-For a few weeks prior to the resident going to the hospital, the resident was staying in bed more and was groggy when he/she woke up;-The charge nurses were aware of the resident sleeping more and thought it was one of the resident's medications. During an interview on 12/09/25 at 7:49 P.M, Certified Medication Technician (CMT) PP said the following:-Prior to the resident's hospitalization, the resident was sleeping more;-Usually the resident would take his/her medications;-Staff would have to wake the resident up for meals and he/she seemed unsteady when he/she got up out of bed. During an interview on 12/09/25 at 10:03 A.M., Licensed Practical Nurse (LPN) HH said the following:-The resident normally slept in and was groggy when staff woke him/her;-The Psychiatric Nurse Practitioner had recently (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	decreased some of the resident's medications in hopes to decrease the resident's sleepiness;-When the physician ordered lab work, Registered Nurse (RN) A took the new orders and entered them into the computer. During an interview on 12/09/25 at 11:25 A.M., RN A said the following:-The providers send a list of lab orders to the Director of Nursing (DON), and it was his/her responsibility to schedule the labs in the computer.-If the lab noted SENT uncollected there was a loss of Internet, or the resident refused. During interviews on 12/09/25 at 11:29 A.M., 1:49 P.M. and 3:30 P.M., DON #1 said the following:-Providers (physician and nurse practitioners) can enter lab orders directly into the computer but were not able to schedule labs.-Only facility staff can schedule labs. This was how the lab technician knew which residents needed blood work when they came to the facility.-RN A does rounds with the physician and enters new orders into the computer, including lab orders.-The Psychiatric Nurse Practitioner (NP) enters her new orders into the computer and sends a list of new orders to her.-The way the Psychiatric NP entered the labs into the computer did not schedule the labs to be drawn.-The providers can order labs in the computer but can't confirm the orders, only staff can confirm the orders which sends the order to the lab company.-Only facility staff can schedule resident lab work.-She was not aware of the 10/20/25 and 10/21/25 lab orders.-She gives the list of new orders to RN A to schedule in the computer.-There was no documentation in the resident's medical record the resident refused blood work in October.-The resident's last lithium level was drawn 08/19/25.-The resident had altered mental status and was sent to the hospital (on 11/24/25).-There used to be a Resident Care Coordinator (RCC) that would monitor to make sure lab orders were carried out, there had not been an RCC for a long time.-The RCC used to do a lab audit every month and if a lab was not collected, they would reorder the lab.-The resident has not had labs drawn since August.-There had been an ongoing issue with the lab company that lab orders were not being received by the lab, so they had started to double check orders for completion.-Labs should be obtained as ordered. During interview on 12/09/25 at 2:43 P.M., the resident's psychiatric NP said the following:-The resident had been on lithium for over two years, and the resident was stable.-She had recently decreased several of the resident's medications.-The resident had not had any behaviors recently.-Labs must be monitored on residents receiving multiple medications including lithium.-She placed an order for the lithium level to be drawn in October 2025 and would expect that lab to have been drawn.-She placed more than one order for the resident to receive labs and none of the labs were drawn.-When she ordered labs, she entered the order in the computer and emailed a list of new orders to the DON.-It had been an ongoing problem with the facility not getting labs as ordered.-If staff would have obtained the lithium level as ordered, the resident's critical high lithium level could have been detected sooner and addressed. During interview on 12/09/25 at 1:10 P.M., the resident's physician said the following:-Staff should follow physician's orders and obtain labs as ordered.-He examined the resident on 11/20/25 and the resident complained of nausea and vomiting but was otherwise stable.-It was very important to monitor lithium levels closely, as the range of toxicity with lithium was very small.-The resident was receiving a lot of lithium.-Lithium levels should have been obtained and monitored by psychiatry.-Sometimes it can take a person years to recover from lithium toxicity. During an interview on 12/09/25 at 4:00 P.M., the resident's hospital physician said the following:-When the resident admitted to the hospital, he/she was unresponsive.-It took four rounds of dialysis to lower the resident's lithium level.-Usually, residents are not dialyzed until the lithium level was 5.5, but the resident was persistently somnolent (a strong, continuous feeling of drowsiness or an overwhelming urge to sleep, even after getting sufficient sleep at night. It is considered a pathological condition or a symptom of an underlying medical issue) when sedation was weaned.-Hospital staff were concerned about Toxic Lithium Syndrome and had been in contact with poison control.-The resident was currently able to answer simple questions. There was concern about lack of oxygen to the resident's brain. NOTE: At the time of the recertification survey, the violation was determined to be at the immediate jeopardy level J. Based on interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). #2669559#2676987#2679510

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain walls, flooring, resident sleeping rooms, resident restrooms, resident common areas, light fixtures, ceilings, shower and toilet rooms, plumbing fixtures, window blinds, heating/ventilation units, exhaust fans, and room fixtures such as call lights, soap dispensers, and paper towel dispensers throughout the facility to be clean and good repair. The facility census was 172. Review of the undated facility Resident Agreement (part of the admission packet) showed the facility will provide basic maintenance, replacement and repair to the resident's room as required by normal wear and tear. 1. Observation and interview on 12/08/25 at 6:18 P.M. in two of two public restrooms near the main entrance, showed a heavy buildup of fuzzy debris on both exhaust fans. The Maintenance Director said maintenance staff dusted all fans weekly. 2. Observation and interview on 12/08/25 at 3:21 P.M. in occupied resident room [ROOM NUMBER] showed two square holes in the wall next to the vanity and one hole in the blue wall. The Maintenance Director said a resident threw a chair at the wall. 3. Observation on 12/08/25 at 3:20 P.M. in occupied resident room [ROOM NUMBER] showed the ceiling light fixture was missing. 4. Observation on 12/08/25 at 2:57 P.M. in occupied resident room [ROOM NUMBER] showed the window blinds were broken with large sections missing or hanging from the window. The soap dispenser and paper towel dispenser were missing from the vanity wall. The switch plate cover was loose on the wall. 5. Observation of occupied resident room [ROOM NUMBER] on 12/07/25 at 3:20 P.M. and 12/08/25 at 3:03 P.M., showed a missing paper towel holder near the sink. The area by the bathroom sink had several screw holes and a different paint color where the towel dispenser used to be. Three ceiling tiles were discolored with areas that were black in appearance. During an interview on 12/07/25 at 3:20 P.M., the resident who resided in this room said it would be nice to have a paper towel holder in his/her room. It had been gone for quite a long time. 6. Observation on 12/07/25 at 3:42 P.M. and 12/08/25 at 3:14 P.M., showed the following:-Four holes on the wall above bed A in occupied resident room [ROOM NUMBER] where a television had previously been mounted;-Ten open holes on the white wall and four large open holes on the blue wall. The towel bar was missing from the wall. 7. Observation of occupied resident room [ROOM NUMBER] on 12/07/25 at 3:25 P.M. and 12/08/25 at 3:07 P.M. showed the following:-Multiple areas of the wall behind bed #1 repaired with dry wall mud and left unpainted with one hole approximately the size of a golf ball; -Large areas of dry wall compound on the blue wall behind the bed. The overbed light fixture was not functional and a fist-sized hole was visible on the vanity wall. The Maintenance Director said the dry wall compound had been there for quite a while, and the wall needed to be finished and painted. 8. Observation on 12/08/25 at 3:11 P.M. in occupied resident room [ROOM NUMBER] showed the overbed light was not secure to the wall and hung diagonally from the wall. 9. Observation of occupied resident room [ROOM NUMBER] on 12/07/25 at 3:25 P.M., showed the following;-The soap dispenser near the sink was taped shut to hold it together; -The bathroom door handle was loose. During an interview on 12/07/25 at 3:25 P.M., the resident who resides in this room said the following:-He/She would like the paper towel dispenser fixed; every time the bathroom door shut the cover falls open;-He/She had to tape the soap dispenser shut because every time it was used it would pop open;-The bathroom door handle was very loose and did not allow the door to shut securely;-He/She had reported his/her concerns but was not sure to who or when. 10. Observation and interview on 12/08/25 at 2:36 P.M. in the single shower room on the 200 hall showed, black areas and peeling ceiling paint inside the shower stall. The light fixture in the shower was rusty. The wall and ceiling over the toilet in the shower room had black mold-like areas and moisture. The Maintenance Director said the chiller lines had leaked over the toilet area and caused mold and wet areas. 11. Observation of occupied resident room [ROOM NUMBER] on 12/07/25 at 12:46 P.M., showed the following:-Multiple scraped areas on the wall (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	exposing previous paint above bed #1;-The shared bathroom door had a tennis ball size hole, that went completely through from one side to the other; toilet paper had been stuffed in the hole;-The toilet stool was loose and not secure to the floor; -A small amount of water was observed around the base of the toilet stool;-Multiple pieces of rubberized flooring were missing from the bathroom floor, one approximately 1 inch wide by 2-3 inches long in a half-moon shape, and 8+ cracked areas in a half-moon crescent shape; -An area on the ceiling, near the wardrobe of bed two, had a soccer ball size black mold like area on the ceiling tile with a black ring around the area;-The entry door had multiple scrapes, exposing the previous paint layers underneath the top layer, as well at the metal door. During an interview on 12/07/25 at 12:45 P.M., the resident who resided in this room said the following:-Someone hit the bathroom door and put a hole in it, and it had been that way for a while;-The toilet stool was slightly loose. 12. Observation of occupied resident room [ROOM NUMBER] on 12/07/25 at 1:03 P.M., showed the following:-Multiple bath blankets laying on the floor from the doorway across the room, in an area approximately seven feet long and four feet wide;- An area near the base trim, at the wall by the bathroom sink, had a small amount of water coming out from under the base trim; -The bathroom vent had a large amount of dust accumulation;-The bathroom ceiling had part of the tile missing around the light fixture;-Part of the wall trim entering the bathroom was missing and the strike plate for the bathroom door handle was missing. 13. Observation on 12/08/25 at 2:30 P.M. in occupied resident room [ROOM NUMBER] showed the restroom light fixture globe was cracked and ceiling tiles were missing around the light fixture. 14. Observation and interview on 12/08/25 at 2:34 P.M in the shower room across from resident room [ROOM NUMBER], showed both showers had a heavy buildup of black mold like areas on the ceilings. One water control handle for the shower was missing. Four large holes were visible in the shower room wall near the sink. The Maintenance Director said maintenance had painted Kilz on the ceilings a few months ago, but the mold returned quickly. The holes in the wall were from a previous soap dispenser. 15. Observation on 12/08/25 at 2:26 P.M. in occupied resident room [ROOM NUMBER] showed the soap dispenser was missing from the vanity wall, and a black mold-like area was visible on the ceiling tiles. 16. Observation of occupied resident room [ROOM NUMBER] on 12/07/25 at 10:16 A.M. and 12/08/25 at 1:37 P.M. showed the following:-The vented area above the closet had multiple black areas, with a mold like appearance, and previous water leaks directly below the vented area and on the ceiling tile above the door entry; -Paint missing from multiple areas on the walls and showing the white drywall beneath the paint;-The bathroom vent had a large amount of dust accumulation;-The bathroom floor was missing pieces of the flooring and had multiple cracked areas; -The light fixture cover was missing. 17. Observation of occupied room [ROOM NUMBER] on 12/07/25 at 11:50 A.M. and 12/08/25 at 2:23 P.M. showed the following:-Two large holes in the window screen on the right double window;-A ceiling tile was missing in the corner above bed two;-The exhaust fan did not work in the bathroom. -The paper towel dispenser was missing from the vanity wall. During an interview on 12/07/25 at 11:50 A.M., the resident who resided in this room said the following:-He/She did not know how long the bathroom exhaust fan had not worked;-He/She had asked staff to put in work orders for the screen, ceiling tile and bathroom fan, but was unsure who he/she told or how long ago. 18. Observation of occupied resident room [ROOM NUMBER] on 12/07/25 at 10:26 A.M. and 12:07 P.M. and 12/08/25 at 2:15 P.M., showed the following:-The paper towel dispenser was missing from the vanity wall. The area by the bathroom sink had seven screw holes and a different paint color where the towel dispenser used to be;-The bottom trim was missing around the wall between the bathroom and sink;-Two large round holes in the cream-colored wall and two large holes in the blue wall. 19. Observation and interview on 12/08/25 at 2:14 P.M. in occupied resident room [ROOM NUMBER] showed the restroom light was not functional, and there was a black mold like area on a ceiling tile in the room. The resident said the light in the restroom had not worked for two or three months. The Maintenance Director said the light in the restroom was a temporary replacement light that had been installed while waiting for the appropriate light for the restroom to come in. The bulb in (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the current light had burned out. 20. Observation on 12/8/25 at 1:55 P.M. in occupied resident room [ROOM NUMBER] showed a floor tile was missing underneath the leg of the bed by the door, and the paper towel dispenser was broken and in pieces. 21. Observation on 12/8/25 at 2:06 P.M. in occupied resident room [ROOM NUMBER] showed the wall light switch plate was broken and had jagged edges. 22. Observation on 12/8/25 at 2:02 P.M. in occupied resident room [ROOM NUMBER] showed the restroom exhaust fan was covered in heavy debris and was not functional. A fist-sized hole was visible in the blue wall near the head of the bed. 23. Observation and interview on 12/07/25 at 12:30 P.M. and 12/08/25 at 2:00 P.M. and at 3:30 P.M. in occupied resident room [ROOM NUMBER] showed the temperature in the room felt very hot. The resident said he/she was unable to adjust the temperature, and the room was always hot. The heat was either on full heat or had to be turned completely off and he/she had reported it many times to maintenance. The Maintenance Director said an HVAC vendor had already come to the facility and replaced the thermostat parts, but it still wasn't working properly. The thermostat had been installed backwards, and the vendor would need to return to fix the thermostat 24. Observation on 12/08/25 at 8:27 A.M. in the Homestead Dining Room showed the following:-Dried food spills on the wall under the window by the fire doors; -The blue paint trim around the windows had black discoloration; -There were dried brown liquid/food splatters on the wall behind the trash can; -There were gray-black scuff marks along the wall horizontally on both sides of the electrical outlet; -There were dried orange liquid stains on the tile floor behind the trash can near the windows. 25. Observation on 12/09/25 at 8:41 A.M. in the Homestead Big Shower Room showed the following:-The tile floor in the shower stall was dark and dingy;-There were scuffs in the gray paint near the light switch beside the hand sanitizer with brown paint and drywall underneath;-There was a rust color stain approximately six inches long on the wall under the electrical outlet near the hand sanitizer dispenser;-There were dried feces on the floor near the sink;-There was a rust colored discoloration on the tile near the sink;-There was dried brown debris on the wall beside and behind the toilet; -There was a brown discoloration at the base of the toilet; -There was dried fecal matter on the handrail beside the toilet; -There was chipping paint from the handrail near the toilet exposing brown and black paint underneath;-There were multiple areas of missing paint on the wall near the light switch. 26. Observation on 12/08/25 at 11:12 A.M. in occupied resident room [ROOM NUMBER] showed the heating/ventilation unit was not equipped with a vent cover. 27. Observation on 12/08/25 at 11:10 A.M in the shared restroom between occupied resident rooms [ROOM NUMBERS] showed the ceiling light fixture was not functional. 28. Observation on 12/08/25 at 11:19 A.M. in occupied resident room [ROOM NUMBER] showed the night light was not functional. The dry wall around the night light was loose, crumbling and rusted. 29. Observation and interview on 12/08/25 at 11:18 A.M. in occupied resident room [ROOM NUMBER] showed the night light was not functional. The dry wall around the night light was loose, crumbling and rusted. The Maintenance Director said the night light bulb was burned out. 30. Observation and interview on 12/08/2 at 11:20 A.M. in occupied resident room [ROOM NUMBER] showed four large holes in the dry wall (wall painted brown) and five large holes in the dry wall (wall painted white). The Maintenance Director said the holes were created from a previous wall mounting of a television and wall decor. 31. Observation on 12/07/25 at 10:51 A.M. and 12/08/25 at 11:21 A.M., in occupied resident room # 408 showed the following:-There was black discoloration on the floor tiles;-The toilet seat was loose;-There was a buildup of lint on the ceiling vent in the bathroom;-The light fixture in the bathroom was dusty and appeared dirty;-There were black scuff marks on the bathroom doors exposing bare wood;-There was dried fecal material on the wall in the bathroom;-There was a black discoloration around the base of the toilet; -There was clear liquid on the floor in front of the toilet; -There was a dried black discoloration on the wall behind the toilet;-The black kick plate was missing under the sink, exposing brown wood and drywall underneath;-There were scuff marks on the door frames exposing bare wood;-The call light at the bedside was not functional when the button was activated. During an interview on 12/07/25 at 10:53 A.M. and 12/08/25 at 11:21 A.M. with the resident who (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	resided in room [ROOM NUMBER] showed the following:-Other residents in the adjoining room leave blood and feces on the toilet seat and urinate on the floor;-He/She tells staff, but they don't clean it up;-Staff has given him/her disinfectant wipes to clean the toilet him/herself;-Housekeeping doesn't clean the room or the bathroom unless there was a problem;-The only way the call light worked was if he/she pulled it out of the wall. 32. Observation and interview on 12/08/25 at 11:37 A.M. and 12/09/25 at 12:26 P.M. in occupied resident room [ROOM NUMBER] showed the following:-Three holes in the wall. Maintenance Staff W said the wall were created by mounting a previous television on the wall;-The black strip below the built-in drawers hung loose towards the floor;-The black kick plate between the sink and the bathroom door was missing, exposing tan drywall;-There was a black discoloration on the floor tiles;-There was dried brown debris on the wall in the bathroom;-There were scrape marks on the bathroom door frame revealing brown paint. 33. Observation on 12/08/25 at 11:35 A.M. in occupied resident room [ROOM NUMBER] showed the cove base below the vanity sink lay on the floor and was not attached to the wall. 34. Observation on 12/08/25 at 10:59 A.M. in occupied resident room [ROOM NUMBER] showed a hole in the exterior wall next to the heating/ventilation unit. 35. Observation on 12/08/25 at 10:38 A.M. and 12/08/25 at 12:23 P.M. in occupied resident room [ROOM NUMBER] showed the following:-The bathroom baseboard heating unit was not equipped with a cover and the heating elements were exposed;-There were dried brown liquid spills on the floor;-There was dried brown liquid on the resident's bed frame;-There was dried brown stains on the floor below the air conditioning unit;-The paint was peeling off the windowsill exposing the wood below;-There were black scuffs in the paint along the wall in between the sink and the bathroom;-The paint was missing on the edge of the wall by the sink exposing the drywall underneath;-The floor tiles under the sink were dingy and brown;-A light bulb was missing above the sink;-There was white discoloration on the bathroom floor. 36. Observation on 12/07/25 at 9:40 A.M. in occupied resident room [ROOM NUMBER] showed the following:-The floor was sticky;-The room had a urine smell;-There was a brown stain on the bedspread (Bed A). 37. Observation on 12/07/25 at 9:38 A.M. and 12/08/25 at 10:52 A.M. in occupied resident room [ROOM NUMBER] showed the following:-The resident lay awake in bed. There was a brown discoloration on his/her pillow;-The black trim was pulled away from the wall between the sink and the bathroom. 38. Observation on 12/09/25 at 9:38 A.M. and 12:30 P.M. in occupied resident room [ROOM NUMBER] showed the following:-There was a strong urine odor in the room;-The floor in the room and bathroom was sticky;-There was fecal matter on the bedspread of occupied Bed B;-There were black marks on the tile floor near the door;-There was brown discoloration around the sink;-In the bathroom there were multiple missing standard square floor tiles. There was a gray discoloration at the base of the toilet and black discoloration near the threshold of the bathroom door. There was brown discoloration on the base of the toilet. 39. Observation on 12/07/25 at 9:31 A.M. in occupied resident room [ROOM NUMBER] showed the following:-There was a strong stale smell in the room;-There was a brown discoloration on the bed sheet (Bed A). 40. Observation and interview on 12/07/25 at 9:30 A.M. and 12/08/25 at 10:48 A.M. in occupied resident room [ROOM NUMBER] showed the following:-There was a strong urine smell;-There was a cloth incontinence pad on the floor with fecal matter on it;-The window blinds had multiple broken slats. He was aware of the broken blinds, and they needed to be replaced. 41. Observation on 12/08/25 at 9:36 A.M. in occupied resident room [ROOM NUMBER] showed the cove base was missing next to the sink. 42. Observation of occupied resident room [ROOM NUMBER] on 12/07/25 at 10:48 A.M. and 12/08/25 at 9:45 A.M. showed the following:-The four-inch, black, floor baseboard in the bathroom was pulled away from the bottom of the wall behind the toilet the entire length of the wall;-There was a hole at the bottom of the wall, measuring four-inches by two feet;-Six, twelve by twelve (12 X 12) floor tiles were loose and not affixed to the floor.-The overbed light fixture was not level and hung diagonally on the wall. During an interview on 12/07/25 at 10:48 A.M., one of the residents who resided in the adjoining room said the following:-The bathroom had been that way since he/she had resided in the room;-He/She had told maintenance (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	staff, but nothing had been done to fix the bathroom. 43. Observation and interview on 12/08/25 at 8:50 A.M. in the 700 Hall shower room on Meadowbrook showed large black mold-like areas surrounded the ceiling heating vent. The Maintenance Director said he was unaware of the mold in the shower room. 44. Observation on 12/08/25 at 8:46 A.M. in occupied resident room [ROOM NUMBER] showed the vanity hot water faucet handle spun around in circles and the hot water would not consistently run. The resident who lived in the room said the hot water knob would not stay on. He had lived at the facility for two years and this had always been a problem. 45. Observation on 12/08/25 at 8:18 A.M. in occupied resident room [ROOM NUMBER] showed the heating/ventilation unit with a broken vent cover. 46. Observation and interview on 12/08/25 at 4:38 P.M. in the social services and business office on the 800 Hall showed the ceiling light fixture was missing. The Maintenance Director said there had been a roof leak in the last year and the light fixture had not been replaced. 47. Observation on 12/08/25 at 5:21 P.M. of the 800 Hall resident telephone room showed a large round hole in the wall behind the door. 48. Observation on 12/08/25 at 5:28 P.M. of the 800 Hall snack room showed a large round hole in the wall behind the door. 49. Observation on 12/08/25 at 5:29 P.M. of the 800 Hall shower/tub room showed the knob for shower water temperature control was missing. 50. Observation on 12/08/25 at 5:07 P.M. in occupied resident room [ROOM NUMBER] showed the vent cover on the heating/ventilation unit was missing. 51. Observation on 12/08/25 at 5:00 P.M. in occupied resident room [ROOM NUMBER] showed the overbed light fixture bulbs had burned out (three separate bulbs) and were not functional. The night light bulb was burned out and was not functional. 52. Observation on 12/08/25 at 4:58 P.M. in occupied resident room [ROOM NUMBER] showed the toilet paper spring bar (that holds the toilet paper roll) was missing. 53. Observation on 12/08/25 at 4:59 P.M. in occupied resident room [ROOM NUMBER] showed the light over the vanity was not equipped with a cover. 54. Observation in occupied resident room [ROOM NUMBER] on 12/07/25, at 3:22 P.M., showed the toilet tank cover was missing on the back of the toilet in the bathroom. 55. Observation in occupied resident room [ROOM NUMBER] on 12/07/25 at 1:24 P.M. and 12/08/25 at 4:50 P.M. showed the following:-A section of the corner wall below the sink had been repaired with dry wall mud and left unpainted;-An area of the corner wall was damaged. An area of the sheet rock was missing and the wall surrounding this was stained a brown color.-The night light was not functional;-The bottom to the second drawer in the resident's dresser was missing;-The resident said the light shorted out, wouldn't work and he/she would like a working light;-He/She said the dresser drawer was not useable since there was no bottom to the drawer. 56. Observation on 12/8/25 at 5:36 P.M. in occupied resident room [ROOM NUMBER] showed a large area of dry wall compound on the wall that had not been painted. 57. Observation in occupied resident room [ROOM NUMBER] on 12/7/25, at 1:15 P.M., showed multiple tiles on the bathroom floor beside and behind the toilet were discolored brown and the grout was missing between the tiles. 58. During an interview on 12/11/25 at 2:10 P.M. Housekeeper VV said the following:-Housekeeping cleans rooms daily;-Nursing staff should also check the rooms for cleanliness and address as needed;-Nursing staff have access to cleaner and disinfectant in between housekeeper visits. During an interview on 12/10/25 at 10:33 A.M., Maintenance Staff W said the facility used work orders as a way of identifying issues needing repair in the building. Staff or residents could fill out a work order. Each area in the building was a little different as to where the requested work order should go (location of a mailbox, etc.) Each hall has a designated area where staff or residents should place a work order request. Maintenance Staff W said he walked around the facility and collected work orders daily at a minimum. Once a work order was received, the repair was typically completed within a week or so. The resolution/repair was documented on the work order written form. The forms were retained for future reference. During an interview on 12/10/25 at 10:38 A.M. and 12/12/25 at 8:47 A.M., the Maintenance Director said the following:-Department heads are supposed to walk around the facility daily to identify any building issues that need correction or repair, but daily rounds don't always get completed due to emergencies, staffing, etc.;-Maintenance was usually made aware of an issue in a (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	resident's room or in the building verbally by the staff or resident;-Maintenance had asked the staff/resident to ensure a maintenance request was completed;-Maintenance requests were available on every unit;-Maintenance staff picked up the maintenance request sheets every day. During an interview on 12/10/25 at 3:27 P.M., the Administrator said daily walking rounds were conducted by department heads to identify any building issues. A work order process was already in place to address identified issues. #2630303#2640327#2664663#2646556#2652518#2686163

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, staff failed to store, prepare, and serve food in accordance with professional standards for food service safety. Staff did not securely seal, label, or date food items. Staff did not practice proper hand and glove hygiene and did not properly wear hair restraints in the kitchen. Staff did ensure personal beverages were not consumed in the food preparation areas. Staff did not maintain surfaces and equipment to be free from a buildup of grease and debris. Staff did not maintain range hood baffle filters free from an excess buildup of grease. Staff failed to ensure an air gap was present at the facility's ice machine drain to prevent possible backflow from the drain back into the ice machine. The facility census was 172. 1. Review of the facility policy, Resident Food Storage: Food from Outside Sources, revised on 11/28/24, showed the following:-Facility staff will monitor the snack refrigerators on a daily basis;-Refrigerators will be kept clean;-Food items will be dated after opening. Observation on 12/7/25 at 9:25 AM, in the facility's reach-in refrigerator in the kitchen, showed unlabeled and undated containers of pimento cheese spread, shredded cheese, cranberry juice, and pickle relish. Observation on 12/8/25 at 3:48 P.M., in the 600/700 hall snack room (located next to the nurses' station on the 700 hall side), showed the following:-In the freezer portion of the refrigerator, there was an uncovered, unlabeled, and undated clear container of a frozen pink substance and a plate of a white- and brown-colored frozen substance;-In the refrigerator, there were two undated, unlabeled boxes of pizza. There was a cottage cheese container that contained a yellowish-red substance that was undated and unlabeled to its contents;-On the shelves, there were pieces of popcorn that were scattered across the shelf surface. There was an unwrapped chocolate candy bar and had approximately 50% of the outer coating of chocolate missing from the bar. The candy bar wrapper sat approximately six inches away and there were flakes of brown chocolate from the candy bar on the shelf surface;-A sign posted on the food storage cabinet read, ?Please ensure you date/label items upon opening!!!' Observation on 12/9/25 at 9:44 A.M., in the facility's dry storage room, showed two large bags of spaghetti were unsealed and exposed to the air. A 25-pound box of food thickener had the inner plastic bag unsealed and exposed to the air. During an interview on 12/9/25 at 2:08 P.M., the Dietary Manager said she expected food items to be sealed, labeled and dated. Dietary staff did not clean or discard expired items from satellite snack rooms or refrigerators. 2. Review of the undated facility policy, Hand Washing and Glove Use, showed the following:-Hand washing is a priority for infection control;-Hands must be washed prior to beginning work, after using the restroom, after smoking, when working with different food substances such as raw chicken to fresh fruit, following contact with any unsanitary surface such as touching hair, sneezing, opening doors etc.;-Washing procedure: wet hands, apply soap, lather vigorously rubbing hands together for approximately 20 seconds, rinse hands to remove soap and debris, dry hands with a disposable paper towel, utilize paper towels to turn off the faucet, discard paper towel in a foot pedal trash can;-Gloves may be used when working with food to avoid contact with hands;-Gloves must be worn when touching any ready-to-eat food;-When gloves are used, hand washing must occur per above procedure prior to putting on gloves and whenever gloves are changed. Gloves must be changed as often as hands need to be washed. Gloves may be used for one task only;-It's important to remember that gloves can often give a false sense of security and can carry germs same as our hands. Observation on 12/8/25 at 8:01 A.M., in the kitchen, showed no hot or cold faucet handles on the handwashing sink. There were no handles just the circular metal components under where the handles should be attached - the sink could be used and water turned on by turning the circular components, making it more challenging to turn on/off the water using the metal components because they were not easy to grip. Observation on 12/8/25 from 11:53 A.M. to 12:10 P.M., in the kitchen, showed the following:-Dietary Aide Z wore gloves and prepared sandwiches at the food preparation counter;-He/She left the kitchen and returned to the kitchen with no gloves on (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	his/her hands;-Without washing his/her hands, he/she used his/her bare hands to touch and place sandwiches into individual bags;-He/She further contaminated his/her bare hands by touching/opening the reach-in refrigerator used his/her bare hands;-Without washing his/her hands, he/she put on gloves and placed unwrapped cheese slices from the preparation counter into the package of cheese (obtained from the reach-in refrigerator);-He/She placed the package of cheese back into the reach-in cooler and discarded his/her gloves;-Without washing his/her hands, he/she touched his/her face and used his/her bare hands to move clean plates from the dishwashing area to the food preparation counter. As he/she grasped the plates, he/she used his/her thumb to touch the eating surface of the plates. Observation on 12/8/25 from 12:11 P.M. to 12:18 P.M., in the kitchen, showed the following:-Dietary Aide X used a paper towel to wipe the floor around the handwashing sink; -He/She washed his/her hands at the handwashing sink, turned the faucet off with his/her clean hands, and discarded the used paper towel into the trash can by lifting the trash can lid with his/her clean hands; -He/She scooped ice from the ice machine into an open cup and drank from the cup as he/she walked across the kitchen near the steam table where staff prepared and placed food items into the steam table for the lunch meal service;-He/She sat the cup on the top shelf of the food preparation counter located near the fryer; -He/She touched his/her hair restraint, washed his/her hands at the handwashing sink, and turned the faucet off with his/her clean hands;-He/She carried the used paper towel (from washing his/her hands) across the kitchen and used it to wipe the surface of the food preparation counter located near the fryer;-He/She touched his/her hair restraint, obtained an empty pan, put parchment paper in the pan, and emptied food from the fryer basket into the pan and placed the pan of fried food into the steam table. Observation on 12/8/25 5:13 P.M., in the kitchen, showed the following:-Dietary Aide Z served food from the steam table to residents' plates during the dinner meal service;-He/She used his/her bare hands to grasp utensil handles, touch his/her hair restraint, and touch paper meal tickets;-Without washing his/her hands, he/she put on gloves and grabbed a vegan patty, bun, and handful of potato cubes and placed the food items onto a resident's plate. During an interview on 12/9/25 at 2:08 P.M., the Dietary Manager said the following:-Staff should not drink personal beverage items in the kitchen and should use the provided drink station area located at the side of the kitchen;-She expected staff to practice appropriate hand washing and gloving and not to turn the hand washing sink faucet off using clean hands;-Changing gloves did not substitute the need for staff to wash their hands;-Staff should use clean gloves when touching ready-to-eat food items;-Staff should handle clean dishes by the non-eating surfaces of those items;-The faucet handles to the hand washing sink had been missing a few months. She told the maintenance staff about the missing handles a couple of weeks ago, but the facility had started a new work order system, and she was unsure of the status of the replacement handles. 3. During an interview on 12/7/25 at 12:46 P.M., Resident #119 said he/she found a hair in his/her soup today. Observation on 12/8/25 from 11:53 A.M. to 12:10 P.M., in the kitchen, showed Dietary Aide Z prepared sandwiches at the food preparation counter. He/She wore a ballcap and one-inch long sections of uncovered hair stuck out around Dietary Aide Z's forehead. During an interview on 12/9/25 at 2:08 P.M., the Dietary Manager said she expected staff to wear hair restraints that contained all hair in the hair restraint. 4. Observation on 12/7/25 at 9:25 AM, during the initial kitchen tour of the facility, showed the following:-A used glove was in the eyewash sink and the sink was very dirty and corroded;-The walls in the dishwashing area were very dirty and splattered with debris;-There were broken and missing tiles on the wall behind the water sprayer at the dishwashing sink;-The ceiling above the dishwashing machine was patched and not painted;-There was an excess buildup of dust and debris around the door and frame of the west kitchen door (that led to the hallway near the locked men's unit and walk in cooler and freezer). This door also had chipped and missing paint on the door's metal frame;-The vent located above the preparation table next to the dishwashing area had an excess buildup of dust and debris;-The lower shelves of the food preparation tables had an excess buildup of food crumbs and debris;-There was an accumulation of debris on the can opener mounted to (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the food preparation table located by the ovens;-The six burner stove had an accumulation of grease buildup, including on the back guard of the stove and the shelf above the stove;-The fryer had a large accumulation of debris and buildup at the front and back of the unit, including in the fryer baskets;-The wall behind the clean pan storage area was patched and unpainted in some areas and had gray marks on the wall. The tape was coming off the pipe insulation located in this area. Observation on 12/8/25 from 9:27 A.M. to 11:10 A.M., in the kitchen, showed the following:-No handles on the faucet of the handwashing sink; -An approximately 3-inch by 6-foot area of ceiling, located in the top middle portion of the ceiling above the reach-in cooler, was cracked and loose in several areas;-An approximately 4-inch by 12-inch patched area of ceiling, located above the preparation tables by the stove, was cracked with flaking paint;-An approximately 3-foot by 5-foot area of ceiling, located above the dishwashing machine, had flaking paint;-An approximately 3-foot diameter fan had a moderate buildup of dust and debris on the surface of the fan guard. The fan was on the preparation counter and was blowing air on approximately 140 clean plates drying near the dishwashing area;-An approximate 2-inch by 12-inch area of tile backsplash, located above the dishwashing sink and faucet sprayer, was broken and missing tiles. There was loose caulk around the counter by the dishwashing area. Paint was flaking on the wall in this area and there were black spots visible along the edge of the caulk and trim;-The cover of the light fixture, located on the ceiling in front of and above the three-compartment sink and preparation counter, was cracked with a 1-inch by 2-inch piece of the cover missing. An approximately 0.5-inch by 2-inch piece of plastic sat loose on the top of the light fixture cover;-The floors under the cooking equipment, beverage counter, and dishwashing area had an excess buildup of black residue, debris, and pieces of food and trash;-An approximately 3-foot by 6-foot area of tile was missing under the dishwashing area and there was a heavy accumulation of debris and trash in this area;-On the top side of the reach-in cooler, there was a thick layer of dust and crusty whitish-brown buildup on the cooler's fan, piping, and other components. Observation on 12/9/25 at 9:44 A.M., in the facility's dry storage room, showed chip crumbs, food items, debris, and trash were on the floor and under the food storage shelves. During an interview on 12/9/25 at 2:08 P.M., the Dietary Manager said the following:-She expected food to be stored, prepared, and served in a safe and sanitary manner;-There were a lot of new dietary staff who were still learning expectations of cleaning and sanitation in the kitchen. 5. Review of the facility's maintenance records showed the most recent kitchen range hood cleaning was conducted on 11/3/25. The section ?Hood Filters Cleaned' showed ?Not Applicable.' Observation on 12/8/25 at 1:36 P.M. in the kitchen showed the following:-A range hood that protected a double fryer and griddle had a heavy buildup of yellow grease on three of eight baffle filters;-The other range hood protected a six-burner stove and had a moderate buildup of yellow grease on two of eight baffle filters;-A sticker on the exterior of the range hood showed the hoods were professionally cleaned in November 2025. During an interview on 12/8/25 at 1:30 P.M., the Dietary Manager said dietary staff did not regularly clean the range hood filters. She was unaware there was a buildup of yellow grease in the range hood. During an interview on 12/8/25 at 1:36 P.M., the Maintenance Director said maintenance staff were not responsible for cleaning the range hood or the filters. A professional company cleaned the range hood every six months. During an interview on 12/19/25 at 11:36 A.M., the range hood cleaning vendor said the following:-Their staff (vendor staff) clean the baffle filters each time they cleaned the range hood;-He/She was unsure why the staff who conducted the 11/3/25 cleaning marked ?not applicable' on the form;-It was possible the staff overlooked the step of cleaning the baffle filters after replacing them in the range hood. 6. Review of the Food and Drug Administration Food Code, dated 2013, showed an air gap between the water supply inlet and the flood level rim of the plumbing fixture or equipment shall be at least twice the diameter of the water supply inlet and may not be less than one inch. Observation on 12/8/25 at 2:24 P.M., of the ice machine in the kitchen, showed there was no air gap at the drain. A flexible drain hose went from the ice machine drain to an approximately 1.5-inch diameter by 10-foot long PVC pipe that went to a floor drain located under the beverage counter. The (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	end of the PVC pipe had an elbow that extended approximately 0.25-inches below the flood rim level of the floor drain. During an interview on 12/8/25 at 1:28 P.M., the Maintenance Director said he was unaware an air gap was needed for the ice machine. He thought the drainpipe was a 0.75-inch diameter pipe. During an interview on 12/9/25 at 2:08 P.M., the Dietary Manager said she expected there to be an adequate air gap at the ice machine drain. During an interview on 12/9/25 at 3:15 P.M., the Administrator said he expected there to be an air gap at the drain to prevent potential back flow from the drain back into the machine and was unaware that the ice machine in the kitchen did not contain an air gap. #2646556

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow current infection control standards for two residents (Residents #14 and #4), in a review of 47 sampled and five additional residents (Resident #23, #110, #180, #172 and #72). The facility failed to follow infection control practices while performing blood glucose monitoring (also known as accu check, a procedure where a drop of blood is obtained to test the amount of sugar in the blood) for two residents (Resident #23 and #110) when staff failed to appropriately sanitize the glucometer (a machine that tests a drop of blood for sugar it contains) after use to protect against contamination. The facility failed to review their Legionella risk assessment, follow interventions, test residents diagnosed with pneumonia for Legionnaire's Disease, and retest water samples when an outside laboratory found Legionella pneumophila in water samples provided by the facility. The facility failed to follow infection control practices for Enhanced Barrier Precaution (EBP) when staff did not wear personal protective equipment (PPE) during personal care for two residents (#180 and #4) who required EBP use, failed to ensure staff washed their hands and changed their gloves after they became soiled during direct care and before touching the resident and/or clean items for one resident (Resident #4), failed to ensure catheter (a tube used to drain urine from the bladder) bags (a bag attached to the catheter, used to collect urine) and catheter tubing (tube used to drain urine from the bladder into a collection bag) did not lay on the floor for two residents (Resident #180 and #172) and failed to ensure a blood glucose monitor was not sat directly on a surface without a barrier while in use for one resident (Resident #72). Additionally, the facility failed to follow infection control practices for storage of oxygen tubing when not in use for one resident (Resident #14). The facility census was 172. Review of the Centers for Disease Control (CDC), Considerations for Blood Glucose Monitoring, showed the following:-Assign blood glucose meters to a person unless the device is designed for use in professional settings and is cleaned and disinfected after every use;-Clean and disinfect blood glucose meters after every use per the manufacturer's instructions, to prevent the spread of blood and infectious agents. Review of the facility policy, Glucometer Disinfection, revised 4/30/24, showed the following:-The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use;-Glucometers will be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against HIV, hepatitis B and hepatitis C;-Glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions regardless of whether they are intended for single resident or multiple resident use;-Obtain needed equipment and supplies (gloves, glucometer, alcohol pads, gauze pads, single-use lancet, blood glucose testing strips and disinfecting wipes);-Wash hands, explain procedure to the resident, provide privacy, put on gloves and obtain blood glucose sampling according to facility policy;-Remove and discard gloves, perform hand hygiene prior to exiting room;-Reapply gloves if there is visible contamination of the device or if the resident is HIV or hepatitis B or C positive;-Retrieve disinfectant wipes from container, using first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer;-After cleaning, use second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufacturer's instructions;-Allow the glucometer to air dry;-Discard wipes and perform hand hygiene. Review of the [NAME] True Metrix Blood Glucose Monitoring System user manual, showed the following:-Wash hands thoroughly with soap and water;-Wear a clean pair of gloves;-To clean the meter, use a Super Sani Cloth wipe or any disinfectant product with EPA* reg.no. of 9480-4;-Rub the entire outside of the meter with the cloth using three circular wiping motions with moderate pressure on the front, back, left, right, side, top and bottom of the meter;-Repeat as needed until all surfaces are visibly clean;-Discard used wipes;-To disinfect the meter, use a fresh wipe and make sure all outside surfaces of the meter remain wet for two minutes;-Let the meter air dry thoroughly before using to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	placed the resident's personal glucometer on the resident's countertop without a barrier while he/she washed his/her hands; -He/She applied gloves, picked up the glucometer and held it in his/her gloved hand. He/She obtained blood from the resident's finger using a lancet and applied the resident's blood to the test strip in the glucometer; -He/She left the room wearing soiled gloves, carrying the blood glucometer and used test strip still in the glucometer. He/She placed the glucometer directly on the medication cart with no barrier;-CMT II removed his/her gloves and used hand sanitizer for hand hygiene;-He/She gathered the resident's insulin from the medication cart, prepared the resident's insulin dose, entered the resident's room, washed his/her hands with soap and water and applied gloves. He/She administered the resident's insulin, removed his/her gloves, washed his/her hands with soap and water and then returned to the medication cart; -He/She documented the blood sugar reading and the insulin administration into the resident's electronic health record;-He/She put on gloves, picked up the glucometer, removed the blood filled test strip from the glucometer and put the soiled test strip into the sharp's container;-He/She cleaned the blood glucometer with a Sani wipe, waited until the glucometer was dry and put it back into the medication cart.;-He/She then removed his/her gloves and used hand sanitizer. During an interview on 12/19/25 at 8:31 A.M., CMT II said the following:-Each resident has their own glucometer;-He/She sat the glucometer on the counter by the sink and on the medication cart without a barrier;-The glucometer should be placed on a surface with a barrier;-He/She should not have left the glucometer on the cart without a barrier and the soiled test strip in the machine;-Hands should be washed with soap and water after the removal of gloves. During interview on 12/12/25 at 3:42 P.M., Licensed Practical Nurse (LPN) HH said the following:-Glucometers should not sit directly on a surface without a barrier;-A glucometer should not be left sitting directly on the medication cart with the blood-filled test strip in the machine. As soon as a blood sugar was read, staff should document the reading in the computer and the strip should be discarded and the glucometer cleaned and put back into the medication cart. During an interview on 12/12/2025 3:39 P.M., Corporate Registered Nurse/Interim DON #2 said the following: -She expected staff to have disinfecting wipes and to set up a clean field (barrier) when performing Accu checks; -She expected staff to clean glucometers with an acceptable product before and after use and before they stored the glucometers;-Staff should not clean the glucometers with alcohol wipes;-She expected staff to wash their hands before and after providing any care or performing a procedure;-She expected staff to wash their hands before and after they use a glucometer;-Staff should wash their hands with soap and water after the removal of gloves; just using hand sanitizer was not appropriate, especially after performing a procedure where blood was collected; -She expected staff to place a barrier between the surface and glucometer when checking a blood sugar. 4. Review of the Centers for Medicare and Medicaid Services (CMS) Survey and Certification (S&C) letter 17-30, dated 06/02/17 and revised on 06/09/17, showed the following:-The bacterium Legionella can cause a serious type of pneumonia called Legionnaire'sDisease (LD) in persons at risk. Those at risk include persons who are at least [AGE] years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as shower heads, cooking towers, hot tubs, and decorative fountains;-Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water;-CMS expects Medicare certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. An industry standard calling for the development and implementation of water management programs in large or complex building water systems to reduce the risk of legionellosis was published in 2015 by American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE). In 2016, the CDC and its partners developed a toolkit to facilitate implementation of this ASHRAE Standard (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	sample collection, hauling, and testing;-Examine equipment to confirm that systems in good working order and functioning as intended;-Review records to confirm that the Water Management Plan was implemented as designed (verification);-Review assumptions about operating conditions, such as physical and chemical characteristics of incoming water;-Re-evaluate the Water Management Plan, including analysis of:-Chemical treatment;-Cleaning;-Hazardous conditions;-Maintenance procedures; -Adjust Water Management Program as necessary to address any deficiencies identified; -Consider whether remedial treatment is needed only after completing prior steps; -Re-test: After performing any remediation, wait at least 48 hours after the system returns to normal operating conditions. Then test representative samples to confirm the response's effectiveness. 7. Review of the facility's Infection Control Log, dated 8/1/25 through 8/31/25, showed the following:-Resident #50 developed pneumonia; the infection control log and the resident's medical record did not contain any testing for Legionella;-Resident #59 developed pneumonia; the infection control log and the resident's medical record did not contain any testing for Legionella. 8. Review of the facility's Infection Control Log, dated 9/1/25 through 9/30/25, showed the following:-Resident #142 developed pneumonia; the infection control log and the resident's medical record did not contain any testing for Legionella;-Resident #157 developed pneumonia; the infection control log and the resident's medical record did not contain any testing for Legionella. 9. Review of the facility's analytical results for 22 samples received by the contracted laboratory for Legionella testing, dated 9/5/25, showed the following:-Sample obtained at the 700 Hall Nurse Station had 4,920 MPN (most probable number)/100 milliliters (ml) of Legionella pneumophila (type of bacteria that causes Legionnaires' disease, a severe pneumonia, and a milder flu-like illness called Pontiac fever, thriving in warm water systems like cooling towers and hot tubs);-Sample obtained at the Meadow [NAME] Dining Room had greater than 2,272.6 MPN/100 ml of Legionella pneumophila;-Sample obtained from room [ROOM NUMBER] had 854 MPN/100 ml;-Sample obtained from room [ROOM NUMBER] had 19,200 MPN/100 ml;-Sample obtained from room [ROOM NUMBER] had 534 MPN/100 ml. 10. Review of the facility's Infection Control Log, dated 10/1/25 through 10/31/25, showed the following:-Resident #8 developed pneumonia; the infection control log and the resident's medical record did not contain any testing for Legionella;-Resident #116 developed pneumonia; the infection control log and the resident's medical record did not contain any testing for Legionella. During an interview on 12/18/25 at 3:39 P.M., the Director of Nursing (DON #1) said the facility did not test any residents with pneumonia for Legionella. 11. Observation on 12/12/25 at 12:25 P.M. through 1:20 P.M., showed the following:-In the Meadowbrook dining room, the temperature of the hot water at the handwashing/drinking water sink was 107.8 degrees Fahrenheit (F); -In occupied resident room [ROOM NUMBER], the temperature of the hot water at the handwashing/drinking water sink was 100.2 degrees F; -In occupied resident room [ROOM NUMBER], the temperature of the hot water at the handwashing/drinking water sink was 110. 4 degrees F;-During the temperature checks, the water pressure fluctuated from strong to weak pressure. During an interview on 12/12/25 at 8:28 A.M. and 9:34 A.M., the Maintenance Director said the following:-The temperature parameters for hot water were 105 to 120 degrees F and cold water temperatures not over 80 degrees F;-He checked water temperatures in four rooms per day and documented it on a log;-He visually inspected faucet aerators for calcium build up once a month;-There was no process in place to ensure there was no sediment or biofilm in the water system or appropriate chlorine levels as the water coming in from the city was already chlorinated;-If the temperatures were not within range, then he checked the hot water heaters and if not functioning correctly called a plumber. He also tried to adjust the temperature valve;-He was not part of the infection control committee and didn't know if there was a Water Maintenance Committee;-The facility had water softeners for incoming water, but they didn't work;-He emailed the Legionella pneumophila microbiology report to the Corporate Maintenance Director as soon as it was received;-The Corporate Maintenance Director determined the corrective measures from the report;-He was told to check the faucet aerators throughout the facility and change out the ones that had a calcium build up, then use (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the ordered water testing kits when they arrived;-He didn't know how to perform the water tests, so he requested assistance from the Corporate Maintenance Director, who assigned the Regional Maintenance Director to show the facility's Maintenance Director how to use the tests;-The Regional Maintenance Director came to the facility two months ago to pick up a kit and left. The Regional Maintenance Director was in the facility once since that time and still didn't show him how to perform the tests, so the tests were not completed. During an interview on 12/12/25 at 9:25 A.M., the Corporate Maintenance Director said the following:-Once he received the microbiology report on 9/8/25, he ordered eleven water testing kits for the facility;-He told the Maintenance Director to flush the lines and aerators, change aerators on the affected faucets as needed, then use the new kits to retest the water;-The facility's Maintenance Director was supposed to use five test kits on the hot water samples and five test kits on the cold water samples, then use one on the sprinkler system;-He didn't have the results from the retesting the facility's Maintenance Director was supposed to complete, so he couldn't show it was completed. During an interview on 12/12/25 at 1:19 P.M., the Corporate Registered Nurse/Interim (DON #2) and Administrator said the following:-The Maintenance Director along with the Administrator were part of the Infection Control Committee;-The Maintenance Director, Administrator and Corporate Maintenance Director were the Water Management Committee;-Neither one knew about the Legionella pneumophila testing results in August 2025 or what the interventions were put in place following the test;-The Administrator said the facility sent out water samples yearly. Record review showed the facility did not have a policy in place for flushing and descaling the faucets on a regular basis. The Maintenance Director did not have documentation showing at least once weekly and descaling monthly. There was no documentation for monitoring chlorine levels or development of a protocol for when levels were too low and no documentation of specific actions to take in response to a Legionella positive water sample. The policy did not address backflow prevention device inspection frequency. A schedule of preventative maintenance for all potable water fixtures was not described in the water management plan. 12. Review of the Center for Disease Control website, Guidelines for Prevention of Catheter- Associated Urinary Tract Infections last updated 06/06/2019, showed proper techniques for urinary catheter maintenance included not resting the urine collection bag or catheter on the floor. 13. Review of the facility policy, Enhanced Barrier Precautions, reviewed and revised on 05/18/24, showed the following:-It is the policy of this facility to implement enhanced barrier precautions (EBP) for the prevention of transmission of multidrug-resistant organisms;-Enhanced Barrier Precautions (EBP) is a strategy to decrease transmission of Centers for Disease Control and Prevention (CDC) -targeted and epidemiologically important multidrug-resistant organisms (MDROs) when contact precautions do not apply. EBP uses personal protective equipment (PPE) and recommends gown and glove use for certain residents during specific high contact resident care activities associated with MDRO transmission. EBP expands the use of PPE beyond situations in which exposure to blood and body fluids is anticipated. EBP uses gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing:-EBP (gown and gloves) must be used for high-contact resident care activities for residents (dressing, bathing/ showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, indwelling device care or use, or wound care) with any of the following: -Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO;- Indwelling Medical Device: Indwelling medical devices include, but are not limited to, central lines, urinary catheters, feeding tubes, and tracheotomies;- The facility should ensure that all staff and other health care providers know which residents require EBP. 14. Review of Resident #180's face sheet showed diagnoses that included neuromuscular dysfunction of the bladder (when nerve damage to the brain disrupts the signals controlling bladder function, causing problems holding or releasing urine, leading to issues like incontinence, retention, or frequent urination). Review of the resident's physician orders, dated 11/19/25, showed the following:-Change catheter for leakage, blockage or becoming (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dislodged as needed;-Monitor catheter for signs and symptoms of infection, adequate output and empty every shift;-Check and secure urinary catheter with tube holder. Review of the resident's care plan, dated 11/20/25, showed the following:-The resident had a catheter related to neuromuscular dysfunction of bladder;-No documentation shown for EBP. Observation on 12/07/25 at 10:29 A.M., showed the following:-The resident lay in bed with the bed in the low position;-The resident's catheter bag and tubing lay directly on the floor; the urine collection bag was not in a dignity bag. The urine in the bag was dark in color (normal urine color is clear, pale yellow to amber in color). Observation on 12/09/25 at 8:38 A.M and 11:03 A.M., showed the following:-The resident lay in bed;-His/Her catheter tubing lay directly on the floor;-The urine in the tube was dark yellow in color. Observation on 12/09/25 at 11:08 A.M., showed the following:-The resident lay in bed;-There was an EBP sign on the resident's door; -Certified Nurse Aide (CNA) FF entered the resident's room, washed his/her hands with soap and water and donned gloves;-CNA FF did not put on a gown;-CNA GG entered the resident's room, washed his/her hands with soap and water and donned gloves;-CNA GG did not put on a gown; -CNA FF performed peri-care and catheter care for the resident. During interview on 12/11/25 at 3:02 P.M., CNA FF said the following:-He/She did not wear EBP while providing peri care and catheter care for the resident;-He/She did not realize EBP should be worn if a resident had a urinary catheter;-He/She thought EBP should be worn if a resident required wound care or had a roommate that required wound care;-He/She had been educated on EBP, but did not wear EPB while helping with peri care. During interview on 12/12/25 at 3:36 P.M., CNA GG said the following:-He/She did not wear EBP while providing peri care and catheter care for the resident;-He/She thought EBP had to be worn in the rooms with residents who had wounds;-He/She had been educated on when to wear EBP, but had not had a lot of residents with catheters to care for in the past;-He/She should have worn EBP while providing peri care and catheter care for the resident;-Catheter bags and tubing should not be directly on the floor. It could increase the risk of infection. During interview on 12/12/25 at 3:42 P.M., LPN HH said the following:-All staff should wear EBP when providing cares for a resident who had a urinary catheter;-All urinary catheter bags and tubing should be off the floor to prevent the risk of infection. During an interview on 12/09/25 at 8:57 P.M., the Resident Care Coordinator said the following:-EBP was not new to the facility;-Staff had been trained on when to use EBP;-If there was an EBP sign on the door, staff were to use EBP for both residents in the room. During an interview on 12/12/25 at 3:39 P.M., the Corporate Registered Nurse/Interim DON #2, said the following:-She expected staff to use EBP when any resident has an artificial opening in their body;-Staff should wear gloves and gowns when providing cares and face shields if needed;-Catheter bags and tubing should not be on the floor. 15. Review of Resident #172's face sheet showed on 11/12/25 the resident was diagnosed with a closed fracture of the left femur (break in the thigh bone but the skin over the break remains intact). Review of the resident's physician order summary, dated December 2025, showed an order to change the resident's urinary catheter as needed, start date 11/17/25. Observation on 12/07/25 at 11:54 and 3:17 P.M., showed the following:-The resident sat in a wheelchair in the dining room;-His/Her catheter bag and tubing sat directly on the floor under the wheelchair; the urine collection bag was not in a privacy bag; staff were in the dining room assisting residents; -There was dark yellow urine in the catheter bag. Observation on 12/07/25 at 4:54 P.M. showed the following:-The resident sat in a wheelchair and self-propelled down the hallway; -The resident's catheter bag and tubing dragged the[TRUNCATED]

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure checking account fees deducted from the resident trust account were replaced by the facility. This affected 127 residents for which the facility managed funds. Further review showed the facility failed to ensure residents had reasonable access to their personal funds. Residents were unable to gain access to their funds unless it was between the hours of 10:30 A.M. and 2:00 P.M. Monday-Friday. The facility census was 172. Review of the facility's policy, titled Resident Trust, last revised 09/21/2025 showed the following:-The facility shall allow the residents access to their personal possessions and funds during regular business hours, Monday through Friday; (there were no specific hours listed, and Saturday availability was not mentioned)-The facility shall keep an accurate and maintained accounting system for the residents that choose to have their personal funds managed. These funds shall be safeguarded by the facility, using complete accounting principles;-The facility shall reimburse the resident trust account for any service charges or new check order charges;-The management accountant will fill out a check request to the trust account for any items that are to be funded by the facility. Review of the facility's undated Resident Agreement (part of the admission packet) showed the following:-1. Management of Resident Funds:-Funds may be deposited or withdrawn by the resident to meet the resident's personal needs upon written request and in accordance with the facility's procedures;-The facility will ensure that the resident's funds are accessible, at a minimum, during regular business hours, Monday through Friday, excluding banking holidays (Saturday availability was not mentioned). 1. Review of the facility monthly reconciliations of the resident trust fund showed the following:Month Amount Description11/2024 $103.52 September (Sept) Deposit Slip Order 11/2024 $48.00 Sept Check Order12/2024 $103.52 Sept Deposit Slip Order12/2024 $48.00 Sept Check Order01/2025 $103.52 Sept Deposit Slip Order01/2025 $48.00 Sept Check Order02/2025 $103.52 Sept Deposit Slip Order02/2025 $48.00 Sept Check Order03/2025 $103.52 Sept Deposit Slip Order03/2025 $48.00 Sept Check Order04/2025 $103.52 Sept Deposit Slip Order04/2025 $48.00 Sept Check Order05/2025 $103.52 Sept Deposit Slip Order05/2025 $48.00 Sept Check Order06/2025 $103.52 Sept Deposit Slip Order06/2025 $48.00 Sept Check Order07/2025 $103.52 Sept Deposit Slip Order07/2025 $48.00 Sept Check Order08/2025 $103.52 Sept Deposit Slip Order08/2025 $48.00 Sept Check Order09/2025 $103.52 Sept Deposit Slip Order09/2025 $48.00 Sept Check Order10/2025 $103.52 Sept Deposit Slip Order10/2025 $48.00 Sept Check Order The facility was not able to provide any documentation to show the resident trust fund had been reimbursed for the September deposit slip order or the September check order. During an interview on 12/09/25 at 11:00 A.M., the Business Office Manager, (BOM), also the Resident Trust Clerk, said the following: -She was in charge of the resident trust account;-She did not know why the resident trust reconciliations listed September Deposit Slip order and September Check Order to be reimbursed. The Corporate Accounts Payable (AP) staff documented that. During an interview on 12/09/25 at 2:00P.M., the Corporate Business Office Manager said the following: -The entries on the Resident Trust Reconciliation form showing the September Deposit Slip order and September Check Order were on the form as a reminder that this money was due to be reimbursed to the resident trust account. The staff member who documented that on that form was the Corporate AP, who was the management company accountant;-There were several factors as to why the resident trust reimbursements were not done timely;-The Corporate AP was terminated, and emails were still going to her email that no one had access to; -The deposit slip and check orders automatically come out of the resident trust account, then the facility reimburses the resident trust account; -It would have been the Corporate AP's responsibility to fill out a check request for reimbursement to the resident trust; -They started using new software in October 2024, and they got behind;-She was unaware that these amounts to be reimbursed had not been reimbursed. During an interview on 12/12/25 at 3:48 P.M., the administrator said there should not be any operating (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expenses, like deposit slips and check orders, in the resident trust fund. 2. Review of the facility Resident Trust-Current Account Balance dated 12/7/25 showed the following:-Resident #167 had a balance of $100.94;-Resident #132 had a balance of $1367.67. Review of Resident #167's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/8/25 showed the resident was cognitively intact. During an interview on 12/11/25 at 12:22 P.M., the resident said the following:-He/She had funds in the resident trust account;-Monday-Friday, the BOM brings around the list of residents with money in the trust account and the Certified Nurse Aides (CNAs) must go to each resident and ask if they want to withdraw money;-Often the list of residents with money doesn't come to his/her unit until around 10:30 A.M. and was picked up around 11:00 A.M. This was the only opportunity to request money each day;-If your request was not in during this specific time, you could not request money until the next day;-The BOM was only available from 10:30 A.M. to 2:00 P.M. Monday-Friday;-He/She was upset because he/she could not access his/her funds on the same business day. Review of Resident #132's Quarterly MDS dated [DATE] showed the resident was cognitively intact. During an interview on 12/11/25 at 2:25 P.M., the resident said the following:-He/She had money in the resident trust account;-He/She must tell the aide by 10:00 or 10:30 A.M. in the morning if he/she wanted money from his/her account or he/she could not get money until the next day;-Sometimes he/she needs money on the same day and can't get his/her money. During an interview on 12/11/25 at 12:30 P.M., Nurse Aide (NA) UU said the following:-Staff only have the list of residents with money in the trust account for a short period of time each day and then the list was picked up;-If money was not requested during this time, a resident could not request money until the next day. During an interview on 12/11/25 at 1:35 P.M., the BOM said the following:-She only worked Monday through Friday, from 8:00 A.M. to 4:00 P.M.; resident funds were only accessible from 10:30 A.M. to 2:00 P.M.;-At 10:30 A.M., she sent a list of residents to each unit showing the resident's balance in the trust account;-CNA staff were responsible for taking the list around to the residents on the unit and asking if they wanted to withdraw money. During an interview on 12/11/25 at 1:35 P.M., the Administrator said resident funds should be available per facility policy. #2655329

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on record review and interview, the facility failed to maintain a system to ensure the resident trust fund account was managed in accordance with proper accounting principles by not maintaining an accurate accounting of all monies held in the resident trust fund account and by not reconciling each month. The facility managed funds for 127 residents. The facility census was 172. Review of the facility's policy, titled Resident Trust, last revised 09/21/2025 showed the following:-The facility shall keep an accurate and maintained accounting system for the residents that choose to have their personal funds managed. These funds shall be safeguarded by the facility, using complete accounting principles;-A reconciliation of the bank statement, checkbook, and the Point Click Care (PCC) Trust Funds module must be completed monthly. This will be completed by the management company staff accountant responsible for the facility's financials. The reconciliation must be done by someone other than the Resident Trust Clerk;-On the first day of every month, the Resident Trust Clerk must reconcile a list of all checks that were written from the resident trust account during the prior month. The list should include the date, check number, payee and amount of the check. This list should be kept on the Public P drive under your facility named folder in a trust folder. An email will be sent to the management company staff accountant responsible for your facility's reconciliation once it is updated. The bank statement should be sent as soon as it is received to account as soon as it is received;-As the management accountant finds errors, he/she will email the Resident Trust Clerk on or before the 5th of each month to obtain information on the discrepancies to make accurate corrections. The Administrator should be copied on the email. The Resident Trust Clerk must respond the same day to ensure a timely reconciliation of the trust funds. For any issues preventing this the Resident Trust Clerk must reach out to the Regional Business Office team for assistance and get it resolved no later than the 7th of each month;-When the reconciliation is complete, the management accountant will send to the Resident Trust Clerk a copy of the completed reconciliation and bank statement, which should be filed in the monthly resident trust folder or Binder. 1. Review of the facility monthly reconciliation of the resident trust fund showed the following:Month Amount Description11/2024 $2829.56 Reconciled difference to be reimbursed 12/2024 $2829.56 Reconciled difference to be reimbursed01/2025 $2829.56 Reconciled difference to be reimbursed02/2025 $2829.56 Reconciled difference to be reimbursed03/2025 $350.00 September (Sept) shortage to be reimbursed 04/2025 $350.00 Sept shortage to be reimbursed05/2025 $350.00 Sept shortage to be reimbursed05/2025 $650.00 Reconciled difference to be reimbursed06/2025 $350.00 Sept shortage to be reimbursed06/2025 $650.00 Reconciled difference to be reimbursed07/2025 $350.00 Sept shortage to be reimbursed07/2025 $650.00 Reconciled difference to be reimbursed08/2025 $350.00 Sept shortage to be reimbursed08/2025 $650.00 Reconciled difference to be reimbursed09/2025 $350.00 Sept shortage to be reimbursed09/2025 $650.00 Reconciled difference to be reimbursed10/2025 $350.00 Sept shortage to be reimbursed10/2025 $650.00 Reconciled difference to be reimbursed 2. Review of the facility maintained attempted reconciliation forms, for the period 11/01/24 through 10/31/25, showed the attempted reconciliations did not reconcile to the residents' current balance at the time of reconciliation by inserting an amount with Reconciled difference to be reimbursed and/or Sept shortage to be reimbursed.3. During an interview on 12/09/25 at 11:00 A.M., the Business Office Manager, who is the Resident Trust Clerk, said the following: -She was in charge of the resident trust account;-She did not know why the resident trust reconciliations listed September shortage to be reimbursed or reconciling difference to be reimbursed. The Corporate Accounts Payable (AP) staff documented that. During an interview on 12/09/25 at 2:00P.M., the Corporate Business Office Manager said the following:-The entries on the Resident Trust Reconciliation form stating Sept shortage to be reimbursed and reconciled difference to be reimbursed were on the form as a reminder that this money was due to be reimbursed to the resident trust account;-The reconciled difference to (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be reimbursed and September shortage to be reimbursed were due to the previous business office manager having some posting errors, and not keeping track of purchases correctly;-The previous Corporate Accounts Payable (AP) staff, who was the management company staff accountant, should have addressed this, but there were several factors as to why it had not been;-The corporate AP was terminated, and emails were still going to her email that nobody had access to; -They started using new software in October 2024, and they got behind;-She was unaware these amounts to be reimbursed had not been reimbursed. During an interview on 12/12/25 at 3:48 P.M., the administrator said the resident trust fund statements should be reconciled accurately monthly.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview and record review, the facility failed to ensure residents (Resident #131 and #178) who participated in group interview, received mail on regular mail delivery days as identified by the United States Postal Service, including Saturdays. The facility census was 172. Review of the facility's policy, Resident Rights, revised 09/21/25, showed the resident has the right to privacy in written communications, including the right to send and promptly receive mail that was unopened. Request was made for, but the facility did not provide a policy regarding mail delivery at the facility. 1. Resident council/group interview on 12/09/25 at 9:59 A.M. showed the following: -Residents said mail comes on Saturday, but was not delivered that day because there was no mail delivery on weekends;-Resident #131 said he/she would like to receive his/her mail on Saturday;-Resident #178 said he/she would like to receive his/her mail on Saturday. During an interview on 12/12/25 at 2:45 P.M, the activity director said the following:-Activity staff are responsible for delivering mail to the residents;-Mail gets delivered to the residents on Saturday if it was picked up by 5:30 P.M.; -If staff pick the mail up later than that, the mail was not delivered until Monday. During an interview on 12/12/25 at 1:08 P.M., the administrator said the following:-Mail was picked up on Saturday by whatever department manager was on duty;-He would expect mail to be delivered to the residents on Saturday by the department manager on duty.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to review the Nurse Aide Registry for a Federal Indicator (this indicator disqualifies an individual from working in the facility) for three of ten newly hired employees (Maintenance Assistant I, Certified Nurse Aide (CNA) J and Dietary Aide L) reviewed. The facility also failed to check the Employee Disqualification List (EDL) for three of ten newly hired employees (Maintenance Assistant I, Dietary Aide L and Licensed Practical Nurse (LPN H) reviewed. The facility census was 172. Review of the facility's policy, Screening-Applicant, Employee, Volunteer and Vendor, revised 06/12/25 showed the following:-Human Resources (HR) department will conduct pre-employment screens on applicants to determine whether the applicant has committed a disqualifying crime, is an excluded provider of any Federal or State health care programs, is eligible to work in the United States, and, if applicable, is duly licensed or certified to perform the duties of the position for which they applied;-Applicant shall complete a Request for Criminal Records Check and Request for Consent to EmployeeDisqualification Check Form. Human Resources Staff will conduct the following screens on potential employees prior to hire;-The results of each background check must be maintained in the applicant's file;-Family Care Safety Registry (FCSR) - this screening will check the sex offender, employee disqualification list, and other Missouri databases automatically. Enter the applicant Social Security Number, and print, date and initial the results. If the applicant's Social Security Number is not found in the database, then the applicant needs to be registered with the FCSR. The company should ensure that the applicant submits the paperwork and the fee to the FCSR. For the convenience of the applicant, the fee can be paid by the company and deducted from the applicant's first paycheck. Registration can be done online or mailed to the Department of Health and Senior Services (DHSS). Registration and background check must be completed within fifteen days of the first date of employment and a copy placed in the employee's file;-The Missouri Employee Disqualification List (EDL) must be checked for every applicant. Log in to the EDL at http://health.mo.gov/safety/edl/index.php. If a record is found, the applicant is on the EDL and may not be hired. A copy of that information must be put in the employee's file. If no record is found, the applicant may be hired. The results must be placed in the employee's file;-The CNA Registry must be checked for all applicants regardless of the position for which they are applying. Any applicant listed with background problems, or a federal indicator may not be hired for any position;-Any applicant being hired for a CNA or Certified Medication Technician (CMT) position must have an active (not inactive or suspended) certification before beginning employment. The results must be placed in the Employee File. 1.Review of Maintenance Assistant I's employee file showed the following:-Date of hire 08/12/25;-No documentation the facility completed a Nurse Aide Registry check;-No documentation the facility completed an EDL check;-A Family Care Safety Registry letter dated 12/09/25, 120 days after the employee's date of hire. 2.Review of CNA J's employee file showed the following.-Date of hire 11/19/25;-No documentation the facility completed a Nurse Aide Registry check. 3.Review of Dietary Aide L's employee file showed the following:-Date of hire 08/11/25;-No documentation the facility completed a Nurse Aide Registry check;-No documentation the facility completed an EDL check;-A Family Care Safety Registry letter dated 12/09/25, 121 days after the employee's date of hire. 4.Review of LPN H's employee file showed the following:-Date of hire 10/23/25;-No documentation the facility completed an EDL check;-No documentation of a Family Care Safety Registry check. During an interview on 12/10/25 at 1:30 P.M., Human Resources (HR) staff said the following-He/She had been in this position since September 8, 2025 and had been trained to obtain the background checks, EDLs, and the Nurse Aide Registry and was told this was part of his/her job;-The previous administrator took care of human resource duties including checking the Family Care Safety Registry, EDL, and Nurse Aide Registry prior to September when she started the HR position; -Corporate HR was in charge of running the background checks, EDL and Nurse Aide Registry on all new hires;-The background checks and Nurse Aid Registry checks were all uploaded to (continued on next page)

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North Village Park	2041 Silva Lane Moberly, MO 65270

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a computer program by corporate and HR was to print the results of the background checks and Nurse Aide Registry checks and put them in the employee files;-With so many changes in HR personnel, the results of the background checks and Nurse Aide Registry checks did not get printed off and put in the employee file and the facility no longer had access to the computer program;-He/She said he/she had recently been doing an audit and caught a few missing pieces but had not finished the audit yet. During an interview on 12/12/25 at 3:48 P.M., the administrator said Nurse Aide Registry check and EDL check should be completed upon hire, before actual starting work and before resident contact.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written notice of transfer discharge to seven residents (Resident #85, #113, #30, #38, #5, #6, #75) or the resident representatives, in a sample of 47 residents reviewed, that included the reason for discharge/transfer, location being discharged to, resident's appeal rights and who to contact for an appeal hearing request, the contact information for the Ombudsman, the contact information for the advocacy agency for residents with intellectual and developmental disabilities or the contact information for the agency that is an advocacy for residents with mental illness. Further review showed the facility did not provide a bed hold policy to one resident (Resident # 113) or their representative at the time of their transfer. The facility census was 172. Review of the facility policy, Resident Transfer/Discharge, Immediate Discharge, and Therapeutic Leave Policy, revised 4/28/25, showed the following:-With the exception of ceasing to operate, the resident's medical record must be documented with the reasons for any transfer or discharge;-When a resident is discharged or transferred, the Interdisciplinary Discharge Summary (recapitulation) must be completed in Point Click Care;-Before any resident is transferred or discharged , the facility must notify the resident and the resident representative of the reason for the transfer or discharge in writing in a manner they understand;-The written notice shall include the following information:-Reason for the transfer or discharge;-Effective date of the transfer or discharge;-Location to which the resident is being transferred or discharged , including specific address;-Resident's right to appeal the transfer or discharge notice within 30 days of the receipt of the notice and the address to which the request shall be sent;-That if the resident files an appeal, they can remain in the facility unless and until a hearing official finds otherwise;-The name, address, e-mail, and telephone number of the designated regional long-term care Ombudsman office;-For residents with development disabilities, the mailing address, e-mail, and telephone number of tile agency responsible for the protection and advocacy of individuals with developmental disabilities;-For residents with a mental disorder or related disabilities, the mailing address, e-mail, and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder;-If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available;-In the case of an emergency or immediate transfer or discharge, the notice shall be as soon as practicable before the transfer/discharge;-Emergency or immediate discharge is permitted if it specifically alleged in the notice that:-Immediate transfer or discharge is required by resident's urgent medical needs; or-The administrator, social service manager or their designee is responsible for drafting the transfer/ discharge letter;-This letter shall be sent to the facility Chief Compliance Officer for view;-The legal review will ensure that the letter meets all the legal requirements, but the decision to discharge the resident and where to discharge the resident is fully the facility's decision. Review of the facility policy, Notice of Bed Hold Policy, revised 04/28/25, showed the following:-When a resident is transferred to the hospital or other location or when the resident goes on therapeutic leave, the facility must provide to the resident or their legal representative, a written copy of the bed hold policy;-This notice must be given at the time of transfer or therapeutic leave. For emergency transfers, the notice must be given within 24 hours of transfer:-If the emergency transfer was to a hospital, the facility may send copy of bed hold policy to the resident in the hospital if a hospital representative such as a social worker, agrees and will confirm resident received the copy in an e-mail that will be kept in the medical record;-In the case of an emergency transfer, if the resident returns to facility within 24 hours, the facility may document in the medical record that the notice was not issued due to resident returning within 24 hours;-If the Facility is unable to provide a copy to the resident's legal representative, the facility should document the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	multiple attempts to reach the resident's representative;-Documentation that the bed hold policy was provided must be put in the resident's medical record. This documentation shall include how and when the notice was issued;-The bed hold policy must provide information to the resident that explains the duration of bed hold, if any, and the reserve bed payment policy. It also addresses permitting the return of residents to the next available bed. 1. Review of Resident #85's face sheet showed the resident had a guardian. Review of the resident's progress note, dated 11/20/25 at 5:31 P.M., showed the following:-The resident was in pain related to could not urinate since yesterday at 1:00 P.M.;-The resident was yelling and kicking doors and said he/she was in pain;-Physician contacted and order received to send to the hospital;-Transported by facility van. Review of the resident's progress note, dated 11/22/25 at 3:58 P.M., showed the social services director (SSD) sent the bed hold to the guardian via email for signature. There was no documentation staff provided a written notice of transfer. Review of the resident's progress note, dated 11/24/25 at 3:19 P.M., showed the resident arrived back to the facility from the hospital via facility van. Review of the resident's electronic health record (EHR) showed no documentation the facility gave the resident, or the resident's representative, a written notice of transfer to the hospital when the resident was transferred to the hospital on [DATE]. 2.Review of Resident #113's face sheet showed the resident had a guardian. Review of the progress note, dated 12/7/25 at 7:28 P.M., showed the following:-The resident complained of right upper abdominal pain;-PRN (as needed) pain medication given per orders, and the resident reported it was not effective;-Physician notified and order received to send the resident out for evaluation and treatment. Review of the resident's progress note, dated 12/7/25 at 7:32 P.M., showed the resident left the facility to go to the hospital. Review of the resident's progress note, dated 12/8/25 at 6:21 A.M., showed the resident returned to the facility on [DATE] at 10:40 P.M. Review of the resident's EHR showed no documentation the facility provided the resident, or the resident's representative, a written notice of transfer to the hospital or the bed hold policy for the resident's 12/7/25 transfer. 3. Review of Resident #30's face sheet showed he/she had a guardian. Review of the resident's census list showed the resident transferred to the hospital and was hospitalized from [DATE] through 09/10/25 and again on 12/10/25. The resident remained hospitalized on [DATE]. Review of facility documentation from the SSD showed a bed hold notice had been emailed to the resident's guardian on 08/15/25 and 12/10/25. There was no documentation the facility provided a written notice of transfer. Review of the resident's EHR showed no documentation the facility issued the resident, or the resident's representative, a written notice of transfer to the hospital for his/her 08/12/25 or 12/10/25 transfer. 4. Review of Resident #38's face sheet showed he/she had a guardian. Review of the resident's census list showed the resident transferred to the hospital and was hospitalized from [DATE] through 10/21/25. Review of documentation from the SSD showed a bed hold notice had been emailed to the resident's guardian on 10/13/25. There was no documentation the facility provided a written notice of transfer. Review of the resident's EHR showed no documentation the facility issued the resident, or the resident's representative, a written notice of transfer to the hospital for his/her 10/12/25 transfer. 5. Review of Resident #6 face sheet showed the resident was his/her own responsible party. Review of the resident's nurse's notes, dated 10/13/25 at 6:28 P.M., showed the resident admitted to the Intensive Care Unit (ICU) at the hospital for shortness of breath. Review of the resident's medical record showed no documentation staff informed the resident in writing of the transfer notice prior to transfer to the hospital on [DATE]. Review of the resident's nurse's notes, dated 10/24/25 at 6:46 P.M., showed the resident readmitted to the facility (from the hospital). Review of the resident's nurse's notes, dated 11/12/25 at 1:20 P.M., showed the resident was sent to the emergency room for evaluation and treatment for shortness of breath. Review of the resident's medical record showed no documentation staff informed the resident in writing of the transfer notice prior to transfer to the hospital on [DATE]. Review of the resident's nurse's notes, dated 11/14/25 at 8:18 P.M., showed the resident was readmitted to the facility (from the hospital). 6. Review of Resident #75 face sheet showed the resident had a guardian (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(power of attorney). Review of the resident's nurse's notes, dated 07/13/25 at 2:36 P.M., showed the following:-The resident was delusional;-He/She was throwing things and trying to hit staff;-The psych hospital called, and the resident could be admitted on [DATE];-The resident's guardian had been notified. Review of the resident's nurse's notes, dated 07/14/25 at 1:12 P.M., showed the resident was sent to the hospital for evaluation. Review of the resident's medical record showed no evidence facility staff informed the resident's guardian (POA) in writing of the transfer and the reason for transfer to the hospital on [DATE]. 7. Review of Resident #5 face sheet showed the resident had a guardian (POA). Review of the resident's nurse's notes, dated 10/09/25 at 5:22 P.M., showed the following:-The resident was being seen by the physician;-He/She was pale in color and unable to transfer himself/herself;-His/Her blood sugar was elevated, and he/she had altered mental status;-The physician ordered staff to send the resident to the hospital for evaluation and treatment. Review of the resident's medical record showed no evidence facility staff informed the resident's guardian (POA) in writing of the transfer and the reason for transfer to the hospital on [DATE]. Review of the resident's nurse's notes, dated 10/12/25 at 11:45 A.M., showed the resident was readmitted to the facility (from the hospital). 8. During an interview on 12/11/25, at 1:30 P.M., the SSD said the following:-She sends the bed hold notice to the resident's responsible party/guardian on each transfer to the emergency room, but she does not send the discharge/transfer notice and has not sent it in the past on any transfer;-She was unaware that a written transfer notice needed to be sent. During an interview on 12/11/25, at 1:30 P.M., Director of Nursing (DON) #2 said the following:-A written transfer notice was required to be given to the resident/resident's responsible party with every hospital transfer and has very specific information required on the transfer notice;-The admitting nurse starts the packet, but the SSD was responsible for ensuring the written transfer agreement and bed hold notice was given to the resident/resident's representative;-The written transfer notice and bed hold notice was part of a packet to be completed with each transfer.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS), a federally mandated assessment completed by staff, according to the Resident Assessment Instrument (RAI) manual for six residents (Residents #11, #20, #103, #179, #45, and #167), in a review of 47 sampled residents. The facility census was 172. Review of the facility policy, MDS 3.0, care assessment summary and individualized care plans, revised on 11/6/23, showed the following:-The purpose is to understand the changes presented by CMS for the MDS 3.0;-To define the intent of each section of the MDS 3.0;-To ensure that MDS 3.0 sections are completed accurately and in a timely manner by the assigned responsible parties;-The MDS 3.0 with the Care Area Assessment Summaries is a much more user-friendly assessment tool that addresses the wholistic person, including functional status, quality of life and individual plan of care to address and meet the needs of the individual resident;-Section K is to be completed by Dietary Manager. This section addresses nutritional and swallowing status;-Used to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration;-Monitors for triggered weight gains or losses;-Triggered gains or losses are: 5% in 30 days, 7.5% in 90 days or 10% in 180 days;-Section N is to be completed by nursing staff;-This section focuses on the medications the resident has received in the last 7 days or since admission or re-entry if less than 7 days;-Used to record the number of days that the resident receives any type of injection, insulin and/ or specific oral medications;-MDSs must be kept current and up to date. Review of the Resident Assessment Instrument (RAI) Manual, dated October 2025, showed the following:-Swallowing/Nutritional status: Diminished nutritional and hydration status can lead to debility that can adversely affect health and safety as well as quality of life;-Height and weight measurements assist staff with assessing the resident's nutrition and hydration status by providing a mechanism for monitoring stability of weight over a period of time;-The measurement of weight is one guide for determining nutritional status;-Base weight on the most recent measure in the last 30 days;-If the resident's weight was taken more than once during the preceding month, record the most recent weight;-If significant weight loss is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need, change in medications or changed fluid volume status;-Weight loss should be assessed at the time of detection and not delayed until the next MDS assessment;-Medications: High Risk Drug Classes: Residents taking medications in these medication categories and pharmacologic classes are at risk of side effects that can adversely affect health, safety and quality of life;-Code question N0415E2, Anticoagulant: Check is there is an indication noted for all anticoagulant medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than seven days);-Anticoagulants must be monitored with dosage frequency determined by clinical circumstances and duration of use;-Certain anticoagulants require monitoring via laboratory results. 1.Review of Resident #45's Weights and Vitals dated 05/12/25 showed the resident weighed 161 pounds. Review of the resident's Care Plan dated /13/25 showed the following:-The resident was on a regular diet;-Dietary department will monitor diet monthly to ensure proper dietary recommendations;-Dietician will review chart quarterly to ensure regular diet is still proper diet for resident. Review of the resident's admission MDS, dated [DATE], showed the following:-Short and long term memory problems;-Diagnoses of dementia and psychotic disorder;-Weight 161 pounds. Review of the resident's facility Weights and Vitals Record showed staff documented the resident's weight as the following:-06/4/25, 153.8 pounds; -07/9/25, 151 pounds.-08/5/25, 149 pounds. Review of the resident's facility Quality Assurance (QA)/Weight Note, dated 08/13/25, showed the resident's weight was 149 pounds. This was down two pounds in one month and down 12 pounds in three months. Review of the resident's Quarterly MDS, dated [DATE], showed the following:-Severely impaired cognition;-Weight 149 pounds; (loss of 12 pounds or 7% in three months). -No weight loss. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(This was not an accurate assessment as the resident had weight loss.) Review of the resident's facility Weights and Vitals Record, dated 09/04/25, showed the resident weighed 148 pounds. Review of the resident's Weight Note (completed by the Registered Dietitian), dated 10/13/25, showed the resident's weight was 141 pounds on 10/08/25, this was down seven pounds in one month, down nine pounds in three months, and down 20 pounds in five months. Review of the resident's facility Weights and Vitals Record showed the following:-10/14/25, the resident weighed 140 pounds;-11/05/25, the resident weighed 138 pounds (23 pound weight loss or 14.2% in six months). Review of the resident's QA/Weight Note, dated 11/10/25, showed the resident's weight was 138 pounds on 11/05/25, this was down three pounds in one month, down 11 pounds in three months, and down 23 pounds in six months (14.2% loss). Review of the resident's Significant Change MDS, dated [DATE], showed the following:-Severely impaired cognition;-Weight 149 pounds recorded by staff. (The resident's Weights and Vitals Record showed the resident weighed 138 pounds on 11/05/25);-No weight loss recorded by staff (Review of the RD notes and review of the resident's Weight and Vitals Record showed a loss of 23 pounds in 6 months or 14.2%);-Review of the resident's Significant Change MDS showed inaccurate documentation regarding the resident's current weight and weight loss. 2. Review of Resident #103's care plan, revised 11/04/24, showed the following:-He/She had a communication problem related to difficulty hearing;-He/She was independent with activities of daily living (ADLs). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact;-Section B, staff documented the resident's hearing was adequate, no difficulty in normal conversation, social interaction, listening to TV;-Ability to understand others, understands-clear comprehension;-Section GG, staff documented the resident needed supervision or touching assistance - helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completed activity. Assistance may be provided throughout the activity or intermittently for eating, oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing including putting on and taking off footwear, personal hygiene, roll left and right in bed, sitting on side of bed to lying flat in bed, lying in bed to sitting on side of bed, sitting to standing, chair/bed-to-chair transfers, toilet transfer, tub/shower transfer, walking 10 feet, walking 50 feet with two turns and walking 150 feet. Observation and interview on 12/07/25 at 12:30 P.M., showed the following:-Music was playing loudly in the resident's room;-The resident apologized for his/her music being loud and said he/she was hard of hearing and turns the music up to hear it;-He/She was independent in all his/her ADLs (items referenced in section GG);-He/She takes his/her own shower, gets dressed without cues, transfers to and from bed/chairs independently and walked to and from all areas in the building unassisted;-He/She did not need assistance from staff to complete any tasks except getting medication and cigarettes during smoking times. During an interview on 12/10/25 at 10:30 A.M., Nurse Aide (NA) M said the resident was independent and if he/she needed something, the resident would ask staff. 3. Review of Resident #179's quarterly MDS, dated [DATE], showed the following: -Cognitively intact;-Section GG, staff documented the resident needed supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completed activity. Assistance may be provided throughout the activity or intermittently for eating, oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing including putting on and taking off footwear, roll left and right in bed, sitting on side of bed to lying flat in bed, lying in bed to sitting on side of bed, sitting to standing, chair/bed-to-chair transfers, toilet transfer, tub/shower transfer, walking 10 feet, walking 50 feet with two turns and walking 150 feet;-Independent with personal hygiene;-Indwelling catheter (a tube inserted directly into the bladder to drain urine) present. During an interview on 12/09/25 at 8:39 A.M., the resident said the following:-He/She has a suprapubic catheter (a hollow flexible tube that is used to drain urine from the bladder) he/she plugs because the physician wanted to try to stretch his/her bladder;-He/She does all his/her catheter care independently and has been doing so for years;-He/She was independent in all his/her ADLs and only needed staff assistance to take him/her to the dining room (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as he/she needed supervision for meals;-He/She walked independently and will ask staff for any needs. Staff administer his/her medications, otherwise staff does not do anything to help him/her. During an interview on 12/10/25 at 10:30 A.M., NA M said the resident was independent and if he/she needed something, the resident would ask staff. 4. Review of Resident #20's Care Plan, revised 10/27/24, showed the following:-The resident had an ADL self-care performance deficit related to activity intolerance. He/She did need assistance with ADLs;-No direction towards staff regarding assistance required for hygiene, transfers and ambulation. Review of the resident's Quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Diagnosis of depression;-Required staff supervision or touch assistance for oral hygiene, toileting hygiene, dressing and personal hygiene;-He/She also required staff supervision or touch assistance for rolling left to right, sit to lying transfers, sit to stand, chair/bed-to-chair transfers and walk 10 feet. During an interview on 12/09/25 at 9:39 A.M., the resident said he/she can do all his/her own self-care except for trimming his/her nails and shaving as that was done with staff supervision. During an interview on 12/11/25 at 12:30 P.M., NA UU said the resident is independent with all cares. 5. Review of Resident #167's Care Plan, revised 07/02/25, showed the following:-The resident displayed impaired thought processes related to delusions/hallucinations/poor insight/judgment;-The resident had a legal guardian who assisted with decision making;-The resident was independent with ADLs and required set-up help only for all meals and prompting for personal hygiene;-Provide assist and supervision as needed/requested. Encourage resident to do as much for him/herself as possible. Review of the resident's Quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Diagnosis of schizophrenia (mental illness);-Required supervision or touch assistance for oral hygiene, toileting hygiene, shower/bathing and upper and lower body dressing;-The resident also required supervision or touch assistance for rolling left to right, sitting to lying, sit to stand, chair/bed-to-chair transfer, toilet transfer, walk 50 feet with two turns and walk 150 feet. During an interview on 12/11/25 at 12:22 P.M., the resident said the following:-He/She received no ADL assistance from staff;-He/She walked independently, dressed him/herself and takes him/herself to the bathroom without any prompting or assistance from staff. During an interview on 12/11/25 at 12:30 P.M., NA UU said the resident was independent with all cares. 6. Review of Resident #11's Physician's Orders, dated 8/15/25, showed Apixaban (a blood thinner medication used to prevent and treat blood clots) was discontinued on this date. Review of the resident's Physician's Orders, dated October 2025, showed no order for an anticoagulant. Review of the resident's quarterly MDS, dated [DATE], showed the resident received an anticoagulant in the last seven days. Review of the resident's current care plan, initiated date of 8/21/24 and last revised on 7/2/25, showed the resident received an anticoagulant. During an interview on 12/11/25 at 11:30 A.M., Registered Nurse A said the following:-The resident was on the blood thinner from 9/20/24 to 8/15/25;-The anticoagulant should not be marked on the MDS after the end date. 7. During an interview on 12/19/25 11:48 A.M., the Nurse Assessment Coordinator said the following:-She completed the nursing assessment for the MDS;-She talked to the resident in-person and does section GG;-She does not enter anything into the MDS specifically; -She only does the assessments and passes them on to the MDS coordinator;-She was made aware of the current condition of a resident related to how they bathe, ambulate, transfer and what medications are ordered by laying eyes on the residents and doing the assessment for section GG;-Supervision in section GG means verbal cues, eyes on the resident, cues for them to complete tasks or any cues or assistance provided;-No staff assistance or cueing would be considered independent;-She did not feel like anyone at the facility would be coded as independent as cues are given daily as well as supervision daily;-Everything about the resident should be on the MDS. During an interview on 12/19/25 11:38 A.M., the facility MDS Coordinator said the following:-She expected assessments to be accurate regarding current medications such as anticoagulants, weights, catheters and level of care provided in section GG;-The nurse assessment coordinator went into facilities and completed the hands-on assessment for the completion of portions of the MDS;-Medications were reviewed on the MAR/treatment administration (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	record (TARs);-Supervision in section GG meant the resident was only able to complete tasks with cues;-Touch assistance would be supervision;-Independent was when the resident did not have any staff assistance provided;-She used the RAI manual for MDS completions. During an interview on 12/12/25 at 3:39 P.M., Director of Nursing #2 said the MDS should be accurate and reflect the most current level of care for a resident. During an interview on 12/18/25 at 1:08 P.M., the Corporate MDS Coordinator said the following:-She had been the facility MDS coordinator until about September of this year, and now she was the corporate MDS coordinator; -She expected assessments to be accurate regarding current diet orders, medications such as anticoagulants, weights, catheters and level of care provided in section GG;-When she completed the MDS for the facility, she spoke to the nurse managers to get the assessment of current condition to complete the MDS;-The nurse assessment coordinator went into the facilities and completed the hands-on assessment for the completion of portions of the MDS;-The medication administration record (MAR) was reviewed for the medication section; -Supervision in section GG meant verbal cues, eyes on the resident and cues for them to complete the tasks;-No staff assistance or cueing would be considered independent;-She used the RAI manual for MDS completions.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to update care plans to reflect current care needs for six residents (Resident #45, #4, #172, #14, #87 and #10), in a review of 47 sampled residents. The facility census was 172. Review of the Resident Assessment Instrument (RAI) Manual dated October 2025 showed the following:-4.7 The RAI and Care Planning as required at 42 CFR 483.21(b), the comprehensive care plan is an interdisciplinary communication tool;-It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being;-The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. 1. Review of Resident #45's Care Plan, dated 05/13/25, showed the following:-The resident was on a regular diet;-Dietary department will monitor diet monthly to ensure proper dietary recommendations;-Dietician will review chart quarterly to ensure regular diet is still proper diet for resident. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 05/18/25, showed the following:-Short and long term memory problems;-Diagnoses of dementia and psychotic disorder;-Weight 161 pounds;-Required partial to moderate assistance for eating. Review of the resident's facility, Weights and Vitals Record, showed staff documented the resident's weight as the following:-06/04/25, 153.8 pounds;-07/09/25, 151 pounds;-08/05/25, 149 pounds. Review of the resident's Quality Assurance (QA)/Weight Note, dated 08/13/25, showed the following:-Resident currently on a regular diet with thin liquids, health shake (nutritional supplement) and Magic Cup (nutritional supplement) three times daily;-Weight 149 pounds. This is down two pounds in one month and down 12 pounds in three months;-Continue current plan of care, monitor intake on current diet and weight for significant changes. Review of the resident's Quarterly MDS, dated [DATE], showed the following:-Severely impaired cognition;-Required supervision or touch assist for eating;-Weight 149 pounds; -No weight loss. Review of the resident's facility, Weights and Vitals Record, dated 09/04/25 showed the resident weighed 148 pounds. Review of the resident's Weight Note (completed by the Registered Dietitian), dated 10/13/25, showed the following:-Weight 141 pounds on 10/08/25, this is down seven pounds in one month, down nine pounds in three months, and down 20 pounds in five months;-Continue current plan of care, monitor intake on current diet and weight for significant changes. Review of the resident's facility, Weights and Vitals Record, dated 10/14/25, showed the resident weighed 140 pounds. Review of the resident's Physician Progress Note, dated 10/23/25, showed the following:-Staff report the resident needs reminders and assistance during meals;-Appetite appears fair but needs monitoring;-Ensure resident is eating adequately and receiving nutritional support. Review of the resident's facility, Weights and Vitals Record, dated 11/05/25, showed the resident weighed 138 pounds. (23 pound weight loss or 14% in six months). Review of the resident's QA/Weight Note, dated 11/10/25, showed the following:-Weight 138 pounds on 11/05/25, this is down three pounds in one month, down 11 pounds in three months, and down 23 pounds in six months (14.2% loss);-Continue current plan of care encouraging intake especially of supplements. Review of the resident's Significant Change MDS, which staff said was done because the resident had been placed on hospice, dated 11/10/25, showed the following: -Severely impaired cognition;-Required supervision or touch assist for eating;-Weight 149 pounds; (incorrect weight)-No weight loss. Review of the resident's Care Plan showed no documentation regarding continued weight loss since admission or interventions in place to prevent weight loss. 2. Review of Resident #4's face sheet showed the following:-His/Her diagnoses included dependence on renal dialysis (a person's kidneys have permanently failed (End-Stage Renal Disease or ESRD), requiring regular dialysis sessions to filter waste and fluid from their blood, essentially (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	replacing kidney function to sustain life), and cerebral palsy (a group of neurological disorders affecting movement, posture, and muscle coordination). Review of the resident's care plan, dated 07/26/24, showed the following:-Problem: the resident needed dialysis related to his/her renal failure;-No documentation to show the resident had a central line (a long, flexible tube inserted into a large vein, typically in the neck, chest, arm, or groin, that ends near the heart, providing longer-term access for fluids, treatments like dialysis);-Problem: The resident requires a mechanical lift for transfers, used a wheelchair for ambulation and required assistance;-Intervention: Staff provide supportive care and assistance with mobility as needed. Review of the resident's informed consent for use of restraints, dated 02/12/25, showed the following:-Recommended device: seat belt;-Purpose for device: Safety per resident's request;-The resident signed the consent on 02/12/25. Review of the resident's physician orders, dated February 2025, showed an order for a central line dressing change every seven days and as needed by a Registered Nurse (RN), one time a day every seven days for central line care, start date 02/26/25. Review of the resident's comprehensive Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 07/07/25, showed the following:-Active diagnoses included: end stage renal disease and cerebral palsy; -He/She was frequently incontinent of urine;-He/She was frequently incontinent of bowel;-He/She had functional limitation in range of motion in both lower extremities;-He/She was dependent on staff assistance with toileting hygiene, shower/bathe self, oral hygiene, upper and lower body dressing and putting on/taking off footwear, rolling left and right, sit to lying, lying to sitting on bed side, chair/bed-to-chair transfers, shower transfers and toilet transfers;-He/She needed partial to moderate assistance from staff with eating;-He/She needed supervision or touching assistance for personal hygiene;-He/She used a wheelchair for mobility;-No documentation showing the resident used a seatbelt in his/her wheelchair for safety;-He/She received dialysis;-No documentation showing the resident had a central line. Review of the resident's nurses' notes, dated 11/19/25 at 3:41, showed the following:-The resident returned from dialysis;- No complications noted. Review of the resident's physician orders, dated December 2025, showed the resident may have seat belt for safety start date 12/08/25. Review of the resident's quarterly MDS, dated [DATE], showed the following:-He/She was always incontinent of urine;-He/She was frequently incontinent of bowel;-He/She was dependent on staff assistance with toileting and hygiene;-No documentation showing the resident received dialysis;-No documentation showing the resident had a central line;-No documentation showing the resident used a seatbelt in his/her wheelchair for safety. Observation on 12/07/25 at 3:18 P.M., showed the resident sat in a wheelchair with a seat belt buckled. The resident unbuckled his/her seat belt on his/her wheelchair. The resident showed he/she had a central line on his/her left upper chest. Observation on 12/09/25 at 8:33 P.M., showed the following:-The resident's call light was on;-Certified Nurse Aide (CNA) KK entered the room, and the resident told him/her he/she had a bowel movement;-The resident was incontinent of bowel and had soiled his/her under pad;-CNA KK performed peri care for the resident;-CNA KK repositioned the resident to his/her right side;-CNA KK took both residents' hands in his/her hands and rolled the resident to his/her left side.During an interview on 12/07/25 at 3:18 P.M., the resident said the following:-He/She had requested to have a seat belt on his/her wheelchair;-The seatbelt on his/her wheelchair helps him/her feel safe;-He/She had a central line that was being used during dialysis treatments. Review of the resident's care plan showed no documentation the care plan was updated to include the resident's central line, need for assistance with activities of daily living, including bowel and bladder incontinence, or the use of a seat belt while in his/her wheelchair for safety. 3. Review of Resident #172's face sheet showed diagnoses included fracture of left femur, onset date 11/12/25 (break in the thigh bone). Review of the resident's care plan, dated 11/07/25, showed the following:-Problem: The resident sustained a significant injury (fracture to left femur (large leg bone, one of two leg bones, also known as the thigh bone, a bone that supports body weight) during a routine, appropriate transfer;-The resident was transferred to the hospital;-The hospital gave a diagnosis of transverse (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	distal femur fracture (a break in the lower part of the thigh bone, right above the knee, where the fracture line runs straight across the bone, perpendicular to its length) and urinary tract infection (UTI). Review of the resident's physician order summary, dated November 2025, showed an order to change urinary catheter (a tube used to drain urine from the bladder) as needed, start date 11/17/25. Observation on 12/07/25 at 11:54 and 3:17 P.M., showed the following:-The resident sat in a wheelchair;-A catheter bag was present under the wheelchair. Observation on 12/08/25 at 8:04 A.M., showed the following:-The resident was sitting in a wheelchair;-A catheter bag was present under the wheelchair. Review of the resident's physician order summary, dated December 2025, showed an order to change the catheter once a month and as needed, start date 12/10/25. Review showed no documentation the resident's care plan was updated to include catheter care and maintenance of the catheter. 4. Review of Resident #14's care plan, revised on 07/02/25, showed the following:-He/She requires encouragement, reminders, supervision, and set up assistance with activities of daily living (ADL), grooming, eating and hygiene initiated on 09/02/23;-The resident has an ADL self-care performance deficit and requires minimum supervision with all ADL's initiated on 04/21/25;-He/She was currently prescribed a low concentrated sugar/controlled carbohydrate diet with a goal to maintain current nutritional status through next review, initiated on 09/02/23. Review of the resident's December 2025 physician order sheets (POS) showed an order for a regular diet, regular texture, thin/regular consistency. Observation on 12/08/25, at 12:32 P.M., showed staff served the resident a regular diet with regular consistency. The resident independently ate his/her meal with no prompting or cues from staff. During an interview on 12/09/25 at 12:27 P.M., the resident said he/she does everything on his/her own and does not need staff assistance to complete any activities of daily living (ADLs). Review of the resident's comprehensive care plan showed the care plan did not resolve or update problems, outcomes or interventions related to the resident's ADL assistance required or diet order changes. 5. Review of Resident #87's care plan, dated 6/13/25, showed the following:-The resident was on a regular diet;-The dietary department will monitor the resident's diet monthly to ensure proper dietary recommendations. Review of the resident's POS dated 11/21/25, showed an order for regular diet, mechanical soft texture, thin/regular consistency, diabetic precautions. Review of the resident's progress notes, dated 11/25/25 at 5:26 P.M., showed the resident readmitted to the facility with esophageal mass biopsy, awaiting biopsy results, gastrointestinal (GI) consult for a stent placement to keep esophageal open and mechanical soft diet. Review showed no documentation the resident's care plan was updated to include the mechanical soft diet. 6. Review of Resident #10's physician progress note, dated 9/26/25, showed the following:-Resident reports tolerating Zepbound (medicine used for weight loss) dose but continues to seek additional weight loss support;-Resident wants the dose increased;-Agreed with the plan;-Plan to increase Zepbound dose;-Monitor for nausea or side effects; -Encourage continued diet and exercise;-Follow up in one to two months for dose reassessment and progress. Review of resident's November 2025 Physician Orders showed an order for Zepbound. Review of the resident's current nutritional care plan, initiated on 11/14/23, with no revision date, showed no documentation the resident was on a prescribed weight loss program, including approaches identified by the resident's physician to monitor for nausea and side effects of the weight loss medication and to encourage exercise. 7. During an interview on 12/11/25 at 3:26 P.M., the care plan coordinator said the following:-The care plans should be resident specific, person-centered up-to-date and accurate;-She has been working to get all the care plans updated. During an interview on 12/12/2025 3:39 P.M., Director of Nursing #2 said the following:-She expected care plans to be person-centered and up to date;-Any nurse, interdisciplinary team member or care plan coordinator could review the care plans. #2674083

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow professional standards of practice for seven residents (Resident #24, #47, #118, #127, #113, #77 and #4) in review of 47 sampled residents. The facility failed to follow physician orders and obtain ordered bloodwork related to therapeutic medication level monitoring and bloodwork for five residents (Residents #24, #47, #113, #118 and #127). Further review showed no documentation the resident's physicians were notified when bloodwork was not obtained and/or documented as uncollected. Facility staff failed to obtain a blood pressure or pulse prior to administering a medication for high blood pressure, with ordered parameters on when to give the medication and when the medication should be held and not given for one resident (Resident #77). Resident #77 also had orders for an Accu Check (finger stick procedure to determine the amount of sugar in the blood) and insulin (injectable medication to treat diabetes and control blood sugars) administration. The facility failed to administer one resident (Resident #4) his/her nutritional supplement as ordered, and failed to follow professional standards of practice when nursing staff documented administration of the supplement, when the supplement had not been available for administration for some time. The facility census was 172. Review of the facility policy, Transcription of Orders/Following Physician's Orders, revised on 05/18/24, showed the following: -The purpose of this policy is to outline procedures in accurately transcribing physician orders and to ensure that all physician orders are followed. To ensure a process is in place to monitor nurses in accurately transcribing and following physician orders;-Upon receiving a physician's order via telephone, fax, written order, verbal order, transcribed order or other, it will be documented in the residents' electronic medical record (EMR) under the orders section;-After laboratory testing, diagnostic testing or other services are ordered, the nurse will document orders in the residents EMR and fill out the corresponding requisition for the specific services to be obtained (or follow protocol set forth by individual lab company);-The Licensed Nurse will review electronic Medication Administration Records (MARs) & electronic Treatment Administration Records (TARs) on a routine basis to monitor for medications that were not administered to the resident due to unavailability, refusal, omission, etc.;-The Nurse or Certified Medication Technician (CMT) in charge of medication administration must review all their designated MARs and TARs prior to the end of their shift to ensure that all medications/treatments scheduled to be given on their shift were administered according to the physician order and that all necessary interventions were taken in the event of an omission. Review of the facility policy, Diagnostic Testing Services Policy, revised on 06/26/24, showed the following:-This facility will provide the appropriate diagnostic services (laboratory and radiology) required to maintain the overall health of its residents and in accordance with state and federal guidelines;-The facility will maintain a schedule of diagnostic tests (laboratory and radiology) in accordance with the physician's orders. 1. Review of Resident #24's undated Diagnosis List showed the following:-Bipolar disorder (mental illness), current episodic manic without psychotic features;-Attention-deficit hyperactivity disorder (disorder that impacts attention, focus, hyperactivity and impulsivity);-Mild intellectual disabilities;-Major depressive disorder, recurrent;-Post-traumatic stress disorder (mental health condition that's caused by an extremely stressful or terrifying event). Review of the resident's Care Plan, dated 9/20/24, showed the following:-The resident has a guardian to assist in decision making due to mental illness;-Arrange for psychiatric consult, follow up as indicated;-Drug therapy and monitoring;-Monitor/document for side effects and effectiveness. Review of the resident's physician order sheets (POS), dated 05/15/25, showed an order for lipid level (blood test to measure various fats in the blood), magnesium (blood test to measure the level of the mineral crucial for muscle/brain function, energy and blood pressure), thyroid stimulating hormone (TSH) and Vitamin D level every three months. Review of the resident's medical record showed no documentation staff obtained, or the resident refused ordered lab work on 05/15/25. Further review (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed no documentation staff notified the physician the blood work was not obtained as ordered. Review of the resident's POS, dated 09/12/25, showed an order for complete blood count (CBC) monthly starting on the 13th. Review of the resident's medical record dated September 2025 showed no documentation staff obtained, or the resident refused the ordered lab work. Further review showed no documentation staff notified the physician the blood work was not obtained as ordered. Review of the resident's October 2025 POS showed the following:-Levothyroxine (thyroid medication) 25 micrograms (mcg) 0.5 tablet by mouth once daily;-Clozapine (antipsychotic) 25 milligrams (mg) give three tablets by mouth twice daily;-Depakote (a medication used to treat mental health disorders)500 mg by mouth three times daily;-Depakote 250 mg by mouth three times daily;-On 10/20/25 an order for Depakote serum, ammonia level (blood test that measures the amount of toxic waste product ammonia in the blood), Hemoglobin A1c (HgbA1C) (a blood test measuring average blood sugar over the past two to three months), fasting lipid level (a blood test that determines the amount of fats in the blood), and clozapine serum (a blood test to measure the levels of the medication in the blood to ensure efficacy and minimize side effects);-On 10/21/25 an order for a CBC and urine drug screen (UDS) (a test of urine for illegal substances and some prescription medications, detecting recent use) monthly;-On 10/22/25 Depakote serum, ammonia level, HgbA1C, lipase (a blood test to determine the amount of fat-digesting enzymes in the blood) and clozapine serum. Review of the resident's Medical Record dated October 2025 showed no documentation staff obtained, or the resident refused the 10/20/25 and 10/21/25 ordered lab work. Further review showed no documentation staff notified the physician the blood work was not obtained as ordered. Review of the resident's Physician Progress Notes, dated 10/23/25, showed the following:-The resident's mental health is being actively managed with psychotropic medications;-Autistic disorder (a condition that affects social skills, communication and behavior): Followed and managed by psychiatric services;-Major depressive disorder: Followed and managed by psychiatric services;-Adjustment disorder: Followed and managed by psychiatric services. Review of the resident's POS, dated 11/11/25, showed an order for a CMP and valproic acid (Depakote) level every three months. Review of the resident's medical record dated November 2025 showed no documentation staff obtained, or the resident refused the ordered lab work of 11/11/25. Further review showed no documentation staff notified the physician blood work was not obtained as ordered. Review of the resident's Mental Status Exam, completed by the Psychiatric Nurse Practitioner, dated 11/14/25, showed the following:-Reason for visit: Elevated lipids, valproic acid level low, refusing medications at times;-Symptoms: resident is on six psychotropic medications;-Lipids are elevated. Review of the resident's Behavior Symptoms and Cognitive Performance Assessment completed by facility staff and dated 11/22/25 showed the following:-No behavior symptom presence;-No rejection of care, including bloodwork;-Current behavior: same. During an interview on 12/08/25 at 1:16 P.M., the resident's guardian said he/she had received no communication from the facility regarding the resident refusing labs. During interview on 12/09/25 at 10:03 A.M., Licensed Practical Nurse (LPN) HH said when the physician orders lab work, Registered Nurse (RN) A takes the new orders and enters them into the computer. During an interview on 12/09/25 at 11:25 A.M., RN A said the following:-Providers send a list of lab orders to the Director of Nursing (DON) and it was her responsibility to schedule the labs in the computer;-If the lab noted SENT uncollected there was a loss of Internet, or the resident refused. During an interview on 12/09/25 at 11:29 A.M., 1:49 P.M. and 3:30 P.M., Director of Nursing #1 said the following:-Providers (physician and nurse practitioners) can enter lab orders directly into the computer but are not able to schedule the labs;-Only facility staff can schedule labs; this was how the lab technician knows which residents need blood work when they come to the facility;-RN A does rounds with the physician and enters the new orders into the computer, including lab orders;-The Psychiatric Nurse Practitioner (NP) enters her new orders into the computer and sends a list of new orders to her;-The way the Psychiatric NP entered labs into the computer did not schedule the labs to be drawn;-Only facility staff can schedule resident lab work;-She gives the list of new orders to RN A to schedule in the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	computer;-There was no documentation in the resident's medical record that he/she refused blood work in October;-She was not aware of the 10/20/25 and 10/21/25 lab orders;-There used to be a Resident Care Coordinator (RCC) that would monitor to make sure lab orders were carried out but there had not been an RCC for a long time;-The RCC used to do a lab audit every month and if a lab was not collected, they would reorder the lab;-There had been an ongoing issue with the lab company that lab orders were not being received by the lab, so they had started to double check orders for completion;-Labs should be obtained as ordered. During interview on 12/09/25 at 2:43 P.M., the resident's psychiatric NP said the following:-The resident had not had any behaviors recently;-Labs must be monitored on residents receiving multiple medications including Depakote;-For residents receiving Depakote, both Depakote levels and ammonia levels must be obtained routinely;-She placed more than one order for the resident to receive labs in October 2025 and none of the labs were drawn;-When she ordered labs, she enters the order in the computer and emails a list of new orders to the DON;-It has been an ongoing problem with the facility not getting labs as ordered. During interview on 12/09/25 at 1:10 P.M., the resident's Physician said staff should follow physician orders and obtain labs. 2. Review of Resident #47's face sheet showed a diagnosis of bipolar disorder (a mental health condition that causes extreme mood swings) and schizoaffective disorder (a mental health condition marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression). Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 10/28/25, showed the following:-Cognitively intact;-No behaviors or rejection of cares. Review of the resident's medical record, laboratory results, showed a Depakote level was obtained on 04/25/25 and 07/25/25. Review of the resident's December 2025 POS showed the following:-Divalproex sodium (the generic form of Depakote) 500 milligrams, give two tablets two times a day for schizoaffective disorder, bipolar type, with an order start date of 04/15/25;-Depakote level every three months with an order start date of 04/16/25;-11/26/25, Depakote and ammonia level (Depakote can cause high ammonia levels) uncollected;-11/30/25, Depakote and ammonia level uncollected;-12/04/25, Depakote and ammonia level uncollected. Review of the resident's medical record showed the resident did not have a Depakote level obtained in the month of October as would have been due and no documentation to explain why the level was uncollected on 11/26/25, 11/30/25 and 12/04/25. Further review showed no documentation staff notified the resident's physician bloodwork had not been obtained as ordered. 3. Review of Resident #118's face sheet showed a diagnosis of bipolar disorder, anxiety disorder (a mental health condition marked by excessive, persistent, and uncontrollable work or fear that significantly impairs daily life) and major depressive disorder (a mental health condition causing persistent sadness, loss of interest, and impaired daily functioning). Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-No behaviors or rejection of cares. Review of the resident's September 2025 POS showed the following:-Depakote 250 milligrams, give one tablet three times a day for major depressive disorder with an order start date of 11/19/24;-Depakote and ammonia level (measures the level of ammonia in the blood to check liver function) every three months with an order start date of 09/10/25. Review of the resident's medical record, laboratory results, showed no documentation of a Depakote and ammonia level obtained or refused in September 2025. Further review showed no documentation staff notified the resident's physician bloodwork had not been obtained as ordered. Review of the resident's October 2025 POS showed the following:-Depakote 250 milligrams, give one tablet three times a day for major depressive disorder with an order start date of 11/19/24;-An additional order for Depakote serum (level) and ammonia level on 10/20/25;-10/22/25 ammonia and Depakote uncollected. Review of the resident's medical record, laboratory results, showed no documentation of why the resident's ordered Depakote and ammonia levels were not collected on 10/22/25. Further review showed no documentation staff notified the resident's physician bloodwork had not been obtained as ordered. 4. Review of Resident #127's face sheet showed a diagnosis of anxiety disorder and schizoaffective (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disorder. Review of the resident's June 2025 POS showed an order for an ammonia and Depakote level, ordered on 06/24/25 and scheduled to be obtained on 07/14/25, one time only. Review of the resident's July 2025 POS showed ammonia and Depakote level ordered on 06/24/25 and scheduled to be obtained on 07/14/25, one time only. Review of the resident's medical record, laboratory results, showed no documentation the ordered Depakote and ammonia level were obtained or refused on 07/14/25. Further review showed no documentation staff notified the resident's physician the bloodwork had not been obtained as ordered. Review of the resident's August 2025 POS showed an order for Depakote sprinkles 125 milligrams, give eight capsules two times a day related to schizophrenia with an order start date of 08/04/25. Review of the resident's December 2025 POS showed an order for a valproic acid level and ammonia level with an order date of 10/03/25 as a one-time order. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-No behaviors or rejection of cares. Review of the resident's December 2025 POS showed valproic acid and ammonia level scheduled for 10/09/25. Review of the resident's medical record, laboratory results, showed no documentation the valproic acid or ammonia levels staff obtained, or the resident refused on 10/09/25. Further review showed no documentation staff notified the resident's physician the bloodwork had not been obtained as ordered. 5. Review of Resident #113's undated face sheet showed a diagnosis of bipolar disorder and anxiety disorder. Review of resident's physician orders, dated 6/3/25, showed a new order for ammonia levels to be drawn every six months. Review of resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-No behaviors or rejection of cares;-Diagnosis of bipolar, anxiety and depression;-Is taking an antipsychotic, anti-anxiety and anti-depressant medication. Review of the resident's laboratory results showed no documentation the facility obtained the ordered ammonia levels from June 2025 through 12/12/25. 6. Review of Resident #77's undated face sheet showed a diagnosis of essential hypertension (high blood pressure) and diabetes mellitus (too much sugar in the blood stream). Review of the resident's November 2025 Physicians Order Sheet (POS) showed the following: -Accu checks (a blood sample obtained by a finger stick to check the level of sugar in the blood stream) in the morning, every two days, related to diabetes mellitus;-Lisinopril (a medication used to treat high blood pressure) 10 milligrams once a day, related to essential hypertension. Hold if systolic (top number) blood pressure is less than 100, diastolic (bottom number) blood pressure is less than 60 or heart rate less than 60 and notify the physician. Review of the resident's November 2025 MAR showed the following: -On 11/02/25, the Accu-Check box was documented with staff initials and a check mark where results should be documented, a code of 13 was marked which indicated the blood sugar was outside of parameters; there was no documented result of the blood sugar obtained; -On 11/04/25, 11/06/25, 11/08/25, 11/10/25, 11/12/25, 11/14/25, 11/16/25, 11/18/25, 11/20/25, 11/22/25, 11/24/25, 11/26/25, 11/28/25 and 11/30/25, the Accu-Check box was documented with staff initials and a check mark where the results should be documented; there was no documented result of the blood sugar obtained;-Certified Medication Technician (CMT) R and D, administered lisinopril daily from 11/01/25 through 11/30/25, with no indication of a blood pressure or pulse obtained prior to administration. Review of the resident's December 2025 POS showed the following: -Accu Checks in the morning, every two days, related to diabetes mellitus;-Lisinopril 10 milligrams once a day related to essential hypertension. Hold if systolic blood pressure is less than 100, diastolic blood pressure is less than 60 or heart rate less than 60 and notify the physician. Review of the resident's December 2025 MAR showed the following: -On 12/02/25, 12/04/25, 12/06/25 and 12/08/25, the Accu Check box was documented with staff initials and a check mark where the results should be documented; there was no documented result of the blood sugar obtained;-On 12/10/25 blood sugar obtained with a result of 154;-On 12/12/25 blood sugar obtained with a result of 136;-Lisinopril 10 milligrams administered daily from 12/01/25 through 12/09/25 with no indication of a blood pressure or pulse being obtained prior to administration;-On 12/10/25 blood pressure obtained with a result of 138/76; no pulse documented; -On 12/11/25 a (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blood pressure obtained with a result of 136/70; no pulse documented;-On 12/12/25 a blood pressure obtained with a result of 130/69; no pulse documented. During an interview on 12/09/25 at 9:14 A.M., the resident said the following:-He/She had high blood pressure and staff had not checked his/her blood pressure for months;-Staff were supposed to check it daily before his/her medications;-He/She also has diabetes and was supposed to have his/her blood sugar checked twice a week and that had not occurred for four or five weeks now. During an interview on 12/09/25 at 2:15 P.M., CMT R said the following:-He/She has not obtained a blood sugar for the resident for quite some time;-He/She thought the resident's blood sugar check order had been discontinued;-The resident did not need his/her blood pressure or pulse checked in the morning before medications. During an interview on 12/11/25 at 2:15 P.M., CMT D said the following: -Staff take the resident's blood sugar two times a week, but until December 10th, there was no place to document the results on the MAR; -There was no way to see prior results of blood sugar checks; the MAR was just check marked to show the procedure was done; -The blood sugar results are only documented on the MAR and not on the vital sign record in the electronic health record;-The resident did not get his/her blood pressure or pulse taken before medication administration. During an interview on 12/12/25 at 3:39 P.M., Director of Nursing (DON) #2 said the following: -She would expect orders to be followed as written;-She would expect a blood sugar to be obtained if ordered;-She would expect staff to obtain a blood pressure and pulse prior to medication administration if there were ordered parameters to follow. 7. Review of Resident #4's face sheet showed the following:-His/Her diagnoses included dependence on renal dialysis (a person's kidneys have permanently failed requiring regular dialysis sessions to filter waste and fluid from their blood, essentially replacing kidney function to sustain life), dysphagia (difficulty swallowing), and muscle weakness. Review of the resident's December 2025 physician order sheet showed an order for Magic Cup (frozen dessert used for adding calories and protein for those experiencing involuntary weight loss) two times daily at 7:00 A.M. and 4:00 P.M. with an order start date of 08/06/25. Review of the resident's MAR, dated December 2025, showed staff documented the resident received a Magic Cup on 12/01/25 through 12/09/25 at 7:00 A.M. and 4:00 P.M. Review of the resident's MAR, dated December 2025, showed the following:-On 12/10/25, CMT OO documented providing a Magic Cup to the resident at 7:00 A.M. and 4:00 P.M.;-On 12/11/25, CMT OO documented providing the resident a Magic Cup at 7:00 A.M. Observation on 12/11/25 at 8:18 A.M., in the assisted dining room during the breakfast meal showed staff did not provide a Magic Cup to the resident with his/her meal. During an interview on 12/11/25 at 8:18 A.M., the resident said he/she was supposed to have a Magic Cup two times a day. He/She could not remember the last time staff provided a Magic Cup. He/She was supposed to get a Magic Cup as a supplement, because he/she could not have Boost (drinkable nutritional supplement) due to dialysis. Observations of the kitchen, including the walk-in freezer, during the survey process on 12/08/25 and 12/09/25, showed no evidence the facility had a supply of Magic Cups available for residents. During an interview on 12/09/25 at 8:30 A.M. Certified Nurse Aide (CNA) WW said the following:-The only supplement served in the dining room was Boost (drinkable nutritional supplement);-He/She had never seen Magic Cups served by dietary or nursing. During an interview on 12/08/25 at 5:31 P.M. CMT II said the following:-The kitchen was responsible for the Magic Cups;-Nursing staff does not have access to the Magic Cups. During an interview on 12/11/25 at 12:20 P.M., CMT C said dietary gives Magic Cups as nursing does not have access to those supplements. During an interview on 12/11/25 at 2:45 P.M., CMT OO said the following:-Magic Cups are given to the resident's during meals by dietary staff;-He/She asked Dietary Aide AA if Resident #4 had a Magic Cup and Dietary Aide AA said yes;-He/She documented on the MAR the resident received a Magic Cup if dietary staff say they served the resident a Magic Cup;-He/She did not go into the dining room and confirm the resident received a Magic Cup. During interviews on 12/11/25 at 12:25 P.M. and 2:49 P.M., Dietary Aide AA, said a lot of residents received Magic Cups for weight loss and it was dietary's responsibility to give them to the residents. Resident #4 did not have an order for a Magic Cup. He/She did not serve Magic Cups today or yesterday (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(12/10/25). He/She did not tell CMT OO Magic Cups were served to any resident. During an interview on 12/11/25 at 12:27 P.M. and 1:06 P.M., the dietary manager said the following:-She received a list from nursing with the residents who were supposed to get a Magic Cup; -She could also see the order in the dashboard of the electronic health record system;-They had been out of Magic Cups for some time:-She knew Resident #4 was supposed to be served a Magic Cup; -It was dietary staffs responsibility to give residents Magic Cups;-She did not know the last time Resident #4 was served a Magic Cup. During an interview on 12/18/25 at 2:25 P.M. the Registered Dietitian said if a resident has orders for nutritional supplements such as Magic Cups, she expected staff to give the supplements as ordered; During interview on 12/09/25 at 1:10 P.M. the resident's Physician said he would expect staff to follow physician's orders. #2646556#2669559#2655329#2675728#2679510

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, the facility failed to ensure five nurse aides (NA) (NA T, NA U, NA MM, NA QQ and NA UU), who performed resident care, completed a nurse aide training program within four months of their employment in the facility. The facility census was 172. Review of the facility policy titled, Nurse Aide Training Program Policy, dated 05/18/24 showed the following:-The facility, with oversight from the Director of Nursing, shall be responsible for the coordination and/or provision of nurse aide education;-The policy did not include nurse aides completing a nurse aide training program within four months of hire. 1. Review of the employee roster provided by the facility showed NA T was hired on 07/19/23. During interview on 12/8/25 at 10:20 A.M., NA T said the following:-He/She has worked at the facility for two years;-He/She worked as a NA and provided care to residents.-He/She was currently in a CNA class. 2. Review of the employee roster provided by the facility showed NA U was hired on 10/18/23. During interview on 12/8/25 at 10:25 A.M., NA U said the following:-He/She started working at the facility in October 2023;-He/She worked as a NA and provided care to residents.-He/She was not a CNA and was currently in a CNA class. 3. Review of the employee roster provided by the facility showed transporter/NA MM was hired on 09/08/2020. Review of NA MM's employee files showed no documentation of CNA training or certification. During an interview on 12/11/25 at 9:35 A.M., transporter/NA MM said the following:-He/She had been working at the facility for about five years;-He/She was not in a CNA class yet;-He/She worked as a NA, providing cares as needed;-No one had every told him/her he/she had four months to obtain a CNA certification;-He/She had been waiting on corporate to sign him/her up for his/her classes. 4. Review of the employee roster provided by the facility showed NA QQ was hired on 11/03/22. During an interview on 12/8/25 at 12:10 P.M., NA QQ said the following:-He/She has worked at the facility as a NA for three years;-He/She provides resident care and has for more than 4 months;-He/She recently finished the CNA class online and was ready to take the CNA test but had not yet. 5. Review of the employee roster provided by the facility showed NA UU was hired on 12/04/24. During an interview on 12/11/25 at 12:30 P.M., NA UU said the following:-He/She was currently in a CNA class;-He/She provides resident care;-He/She has worked for the facility as an NA for one year and he/she was not certified. 6. During an interview on 12/16/25 at 1:00 P.M., Human Resources said the following:-She has only been in her current position for three months and the facility had identified there were multiple NAs past the four month certification period;-She was aware that NAs had to be enrolled/and or certified as a Certified Nurse Aide within four months of date of hire;-Before she started, it had been almost a year since any NAs were enrolled in CNA classes;-She can only enroll a certain number of NAs in CNA class at the same time. During an interview on 12/12/25 at 3:39 P.M., Director of Nursing (DON) #2 said she was aware that NAs had to be certified within 120 days, or they should be removed from the schedule.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to serve food items to residents at a safe and appetizing temperature. The facility census was 172. Review of the undated facility policy, Food Temperatures, showed the following: -Foods will be served at proper temperature to ensure food safety; -Record temperature reading on Food Temperature Chart form at beginning of tray line and during the tray line. Take the temperature of each pan of product before serving; -Acceptable serving temperatures include: -Greater than 135 degrees Fahrenheit (F), but preferably between 160 to 175 degrees F, for the following food items: gravy, casseroles, meat, entrees, potatoes, pasta, soup, pureed foods, hot pureed foods, vegetables; -Less than 41 degrees F: hazardous salads, milk, juice, and desserts; -If temperatures are not at acceptable levels and cannot be corrected in time for meal service, make an appropriate menu substitution and discard out of temperature range foods;-Cold foods need to be put in the freezer half hour to three quarter hour prior to meal service. Bring only one tray at a time out on the tray line. Put on ice. Ice down all cold foods on the tray line. Chill dishes to be used for cold food. 1. During an interview on 12/07/25, at 3:51 P.M., Resident #53 said staff served eggs every day for breakfast, and the eggs were always cold. During an interview on 12/08/25, at 8:29 A.M., Resident #67 said the food was always cold, and breakfast was cold again today. During an interview on 12/7/25 at 10:53 A.M., Resident #123 said the food was served cold. 2. Review of the Diet Orders, printed 12/7/25, showed the following: -147 residents with a physician-ordered regular diet; -18 residents with a physician-ordered mechanical soft diet. Review of the facility's diet spreadsheet menu for the lunch meal served on 12/8/25 (Day 9 of menu cycle) showed the following: -Staff were to serve smothered chicken, stuffing, and garlic green beans to residents on a regular diet; -Staff were to serve ground smothered chicken with gravy, stuffing with gravy, and garlic green beans to residents on a mechanical soft diet. Observation on 12/8/25 from 12:22 P.M. to 12:46 P.M., in the kitchen at the steam table, showed the following:-Dietary Aide X prepared plates for residents on regular and mechanical soft diets, added a plate cover to each plate, and placed the trays of food items into insulated tray carts for the 100, 200, 300, 800, and 900 hall dining areas;-At 12:47 P.M., Dietary Aide X plated a test tray containing regular and mechanical soft food items and placed the test tray on the cart staff took to the 900 hall dining room. Observation on 12/08/25, at 12:32 P.M., of the dining cart served with residents' meals on the 100/200 hall, showed ice cream was served in cups on the same tray as the hot food. The ice cream was melted when served to the residents. Multiple residents opened the cup of ice cream and drank it instead of using a spoon because it had melted. Observation on 12/8/25 from 12:49 P.M. to 1:13 P.M., in the 900 hall dining room, showed Certified Nurse Aide (CNA) EE served trays off the meal cart (that arrived from the kitchen) to residents with regular and mechanical soft diets. Observation on 12/8/25 at 1:13 P.M., of the temperature of the food items on the test tray, taken with a calibrated probe-style thermometer, after the last residents in the 900 hall dining room were served showed the following: -The smothered chicken was 106.2 degrees F and tasted cool; -The mechanical soft ground smothered chicken with gravy was 113.9 degrees F and tasted cool; -The garlic green beans were 116.8 degrees F and tasted cool; -The stuffing was 109.8 degrees F and tasted cool. 3. Review of the facility's diet spreadsheet menu for the dinner meal served on 12/8/25 (Day 9 of menu cycle) showed the following: -Staff were to serve cheesy potato soup, egg salad cold plate, and cucumber and tomato salad to residents on a regular diet; -Staff were to serve cheesy potato soup, egg salad cold plate (no lettuce), and chopped chilled steamed vegetables to residents on a mechanical soft diet. Observation in the kitchen on 12/8/25 at 4:41 P.M., showed [NAME] Y placed food items into the steam table. He/She put a pan of egg salad sandwiches into a steam table compartment that contained ice water. He/She placed a second pan of egg salad sandwiches on the upper shelf of the steam table (not on ice). Observation on 12/8/25 from 4:51 P.M. to 5:43 P.M., in the kitchen at the steam table, showed the following: -Dietary Aide X served regular and mechanical soft diet food items (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	onto residents' plates on trays, added a plate cover to each plate, and placed the trays of food items into insulated tray carts to go to the 100, 200, 300, 800, and 900 hall dining areas; -He/She ran out of egg salad sandwiches in the steam table. He/She put the pan of egg salad sandwiches from the upper shelf onto the steam table in the compartment with ice water. Observation on 12/8/25 at 5:44 P.M., in the kitchen at the steam table, showed [NAME] Y plated a test tray with regular and mechanical soft food items and placed the test tray on the cart staff took to the 900 hall dining room. Observation on 12/8/25 from 5:49 P.M. to 6:11 P.M., in the 900 hall dining room, showed CNA EE served trays off the meal tray cart (that arrived from the kitchen) to residents with regular and mechanical soft diets. Observation on 12/8/25 at 6:12 P.M., of the temperature of the food items on the test tray taken with a calibrated probe-style thermometer, after the last resident was served, showed the following: -The cheesy potato soup was 103.6 degrees F and tasted cool; -The egg salad sandwich was 68.2 degrees F and tasted lukewarm; -The peas and lima beans were 84.7 degrees F and tasted lukewarm; -The cucumber and tomato salad was 81.1 degrees F and tasted lukewarm. 4. During an interview on 12/9/25 at 3:07 P.M., [NAME] DD said hot food should be served to residents above 135 degrees F and cold food should be served below 40 degrees F. Staff should place ice in the steam table compartment where cold food items were held. During an interview on 12/9/25 at 3:30 P.M., the Dietary Manager said she expected hot foods to be served to residents at a temperature of at least 140 degrees F and cold foods at less than 40 degrees F. #2631124#2646556#2658069

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure staff served food items according to the menu for three residents (Residents #36, #127, and #135), in a review of 47 sampled residents, and for one additional resident (Resident #125), who had physician's orders for a mechanical soft diet. The facility census was 172. 1. Review of Resident #36's physician order sheet (POS) for December 2025, showed the resident had an order for a regular diet with mechanical soft texture (original order dated 11/20/25). Review of the facility's resident Diet Orders listing, printed 12/7/25, showed the resident had an order for a regular diet, mechanical soft texture. Review of the facility's diet spreadsheet menu for the breakfast meal served on 12/8/25 (Day 9 of menu cycle) showed residents on a mechanical soft diet were to receive ground sausage patty with gravy.Observation on 12/8/25 at 8:19 A.M., showed staff served the resident a sausage patty that was cut into bite-size pieces. (Staff did not serve the resident ground sausage patty with gravy as directed on the spreadsheet menu). Review of the facility's diet spreadsheet menu for the lunch meal served on 12/8/25 (Day 9 of menu cycle) showed residents on a mechanical soft diet were to receive ground smothered chicken with gravy. Observation on 12/8/25 from 12:22 P.M. to 12:46 P.M., in the kitchen at the steam table, showed the resident's meal ticket showed he/she was to receive a regular texture diet. Dietary Aide X prepared the resident's meal tray and placed a regular piece of smothered chicken (not ground chicken with gravy) onto the resident's plate. Observation on 12/8/25 at 12:49 P.M., in the 900 hall dining room, showed the following:-Certified Nurse Aide (CNA) EE served trays off the meal tray cart (that arrived from the kitchen) to residents; -The resident received a regular texture meal with smothered chicken (not ground chicken);-The resident had difficulty cutting the chicken with his/her fork;-CNA EE attempted to cut up the resident's chicken with a fork but had difficulty cutting the chicken. During an interview on 12/8/25 at 1:04 P.M., CNA EE said Resident #36 used to be on a mechanical soft texture diet because he/she had difficulty chewing food, but he/she was back on a regular texture diet. Observation on 12/8/25 at 1:13 P.M., of food items on the test tray obtained after all residents were served in the 900 hall dining room, showed the smothered chicken was dry. It was very difficult to cut with a fork, was tough in texture, and was difficult to chew. Review of the facility's diet spreadsheet menu for the breakfast meal served on 12/9/25 (Day 10 of menu cycle) showed the following: -Residents on a mechanical soft diet were to receive ground sausage patty with gravy;-Residents on a regular diet were to receive bacon. During an interview on 12/9/25 at 8:30 A.M., CNA G said the resident was served bacon at breakfast instead of the mechanical soft diet choice. During an interview on 12/9/25 at 8:34 A.M., the resident said he/she was served bacon (not ground sausage) at breakfast and did not eat it because he/she could not chew it. During an interview on 12/11/25 at 12:20 P.M., the resident said his/her bottom dentures did not fit, so he/she only wore his/her top dentures. He/She preferred to eat soft foods. Review of the diet spreadsheet for residents for lunch meal served on 12/11/25, showed residents on a mechanical soft diet were to receive ground chicken alfredo over chopped fettuccini. Observation on 12/11/25 at 12:38 P.M., showed the following:-The resident sat at the lunch table. The resident wore top dentures only; -The resident's meal card was dated 11/7/25, and showed the resident was on a regular diet with regular texture. Card had not been updated to the most current order;-Staff served the resident chicken alfredo over fettuccini. The chicken was in chunks and was not ground, and the fettuccini was not chopped.During interviews on 12/11/25 at 12:55 P.M., 1:15 P.M. and 2:30 P.M., the Dietary Manager said the following:-The Assistant Dietary Manager printed the meal cards daily;-The resident was on a mechanical soft diet;-The resident's meal card for 12/11/25 said the resident was on a regular diet and mechanical soft texture; -The meal card on the resident's tray at lunch was an old card, dated 11/7/25, that showed the resident was on a regular diet and regular texture;-He/She was not sure who placed the old meal card on the resident's tray;-Dietary staff were to use the printed (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meal card dated for that day. During an interview on 12/9/25 at 3:07 P.M., [NAME] DD said the following:-Staff should check each resident's meal ticket to ensure they serve the correct food items to residents;-Dietary staff printed residents' meal tickets weekly and then photocopied the tickets as needed throughout the week unless there were changes. Each meal (breakfast, lunch, and dinner) had a different meal ticket for each resident;-If there were changes to a resident's diet order, nursing staff updated the electronic system and notified dietary staff of the changes. During an interview on 12/9/25 at 3:30 P.M., the Assistant Dietary Manager said she printed meal tickets weekly and if there were any changes, such as were discussed during the daily nursing meeting, the tickets were updated and reprinted. It was possible that staff were using outdated versions of the residents' meal tickets if they hadn't discarded the previous meal tickets. 2. Review of the facility's resident Diet Orders listing, printed 12/7/25, showed Residents #125 and #127 had orders for regular diets with mechanical soft texture. Review of the facility's diet spreadsheet menu, for the dinner meal served on 12/8/25 (Day 9 of menu cycle), showed the following: -Residents on a regular diet were to receive cucumber and tomato salad; -Residents on a mechanical soft diet were to receive chopped chilled steamed vegetables. During an interview on 12/8/25 at 4:41 P.M., [NAME] Y said staff were to serve mixed peas and lima beans to residents on a mechanical soft diet for the 12/8/25 dinner meal service. Observation on 12/8/25 from 4:51 P.M. to 5:43 P.M., in the kitchen at the steam table, showed the following:-Dietary Aide X served food items onto residents' plates on trays and placed the trays into insulated carts to go to the 100, 200, 300, 800, and 900 hall dining areas;-Mixed peas and lima beans were on the steam table to serve to residents with a mechanical soft texture diet;-Cucumber and tomato salad were on the steam table to serve to residents with a regular texture diet;-The meal tickets for Resident #125 and #127 showed they were to receive a mechanical soft texture diet;-Dietary Aide X served cucumber and tomato salad onto Resident #125's and #127's plates. During an interview on 12/8/25 at 4:50 P.M., Dietary Aide X said he/she was new to the dietary department and was still getting used to serving different food items at each meal to residents based on their diet orders. Observation on 12/8/25 at 5:49 P.M., in the 900 hall dining room, showed the following:-CNA EE served trays off the meal tray cart (that arrived from the kitchen) to residents; -Residents #125 and #127 received cucumber and tomato salad. Observation on 12/8/25 at 1:13 P.M., of food items on the test tray served in the 900 hall dining room, showed the cucumber pieces in the cucumber and tomato salad were approximately 1.5 inches in size, were crunchy, and were very firm. 3. Review of Resident #135's Care Plan, revised 11/24/23, showed the following:-The resident was on a regular diet with mechanical soft texture and thin liquid;-Modify diet as appropriate according to resident's food tolerances and preferences. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/24/25, showed the resident had moderate cognitive impairment. Review of the resident's Physician's Orders, dated December 2025, showed an order for regular diet mechanical soft texture. No bread. Review of the facility's resident Diet Type Report, printed 12/7/25, showed the resident had an order for a regular diet, mechanical soft texture. No bread. During interviews on 12/7/25 at 4:37 P.M. and 12/9/25 at 7:59 P.M., the resident said the following:-He/She has had his/her esophagus (muscular tube connecting the throat to the stomach, acting as the food pipe that transports chewed food and liquids downward using rhythmic muscle contractions called peristalsis) dilated (medical procedure that stretches or widens a narrowed section of the esophagus to make it easier to swallow food and liquids) multiple times because he/she had swallowing problems;-He/She was supposed to get ground meat and no white bread;-He/She had to be able to mash his/her foods because he/she had no teeth;-White bread balled up in his/her throat and choked him/her;-On 12/6/25, staff served him/her a sandwich on white bread;-He/She sent the sandwich back, and staff served him/her two whole fried chicken breasts;-He/She choked on the first bite of chicken;-On 12/8/25, staff served him/her cheesy soup and a sandwich on white bread;-He/She can't eat white bread because it gets stuck in his/her throat. During an interview on 12/7/25 at 4:38 P.M., the Dietary Manager said staff (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should have served the resident the appropriate diet texture and no bread. 4. During an interview on 12/12/25 at 3:39 P.M., the Corporate Registered Nurse/Interim Director of Nursing (DON) said the following:-She expected dietary staff to follow current diet orders and serve the residents their ordered diet;-She expected dietary staff to use current meal cards that were printed for that day. During an interview on 12/18/25 at 2:25 P.M., the Registered Dietitian said the following:-She expected staff to follow physician orders;-She expected the residents' meal tickets to match the residents' current diet orders. During an interview on 12/12/25 at 3:48 P.M., the Administrator said he expected staff to follow the residents' diet orders. #2631124

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, interview and record review, the facility failed to provide nourishing snacks when substantial meals were scheduled 14 hours apart. Multiple residents during the group interview said snacks were not specifically offered and were not substantial. One resident (Resident #167), in a review of 47 sampled residents, and three additional residents (Resident #83, #39 and #95) said snacks were not offered on a routine basis at the facility. The census was 172. Review of the undated facility policy, Snacks, showed the following:-Policy: Daily snacks are provided in accordance with the prescribed diet and in accordance with state law. Individual and/or bulk snacks are available at the nurses' station for consumption by residents whose diet orders are not restrictive;-Procedure: At least one serving or a minimum of two of the following four food components is offered for the bedtime snack:-Fruit and/or vegetable or full-strength fruit or vegetable juice;-Whole grain or enriched cereals or breads;-Milk or other dairy products;-Meat, fish, poultry, cheese, eggs;-Combo meat sandwiches. 1. During the resident council meeting on 12/09/25 at 9:59 A.M., residents said the following:-Resident #83 said bedtime snacks were no longer passed;-Resident #39 said snacks only come at supper time and were not passed individually, you must go up and ask for them;-Resident #95 said staff just open the snack room door at night and do not monitor it to make sure that everyone gets a snack; some residents take too many and then the snacks are all gone and not everyone gets one;-Resident #167 said the diabetics never get a diabetic snack or anything with protein;-Multiple residents said the snacks that were provided only included chips, snack cakes, cookies or crackers and never any sandwiches, fruits or drinks. 2. Observation on 12/09/25 at 7:35 P.M., showed the locked nourishment kitchen on the 100/200 hall to have individually packaged potato chips available for snacks. Snacks were kept in the nourishment kitchen and not passed individually. No drinks, sandwiches or other food was observed in the nourishment kitchen refrigerator. Observation on 12/09/25 at 8:04 P.M., showed the locked nourishment kitchen on 300 hall had about half a box of individually packaged cheese puffs and about three-fourths a box of individually packaged Chex mix available for snacks. Residents were asking for snacks, and staff gave snacks out as residents asked for them. Staff did not pass snacks to everyone on the unit. No drinks, sandwiches or other food was observed in the nourishment kitchen refrigerator. 3. During an interview on 12/09/25 at 8:23 P.M., Nursing Assistant (NA) Q said snacks were delivered to the floor with the supper cart. Snacks included chips, sometimes fudge round cakes, sometimes bananas and occasionally sandwiches. Sandwiches were not brought very often, and it would be nice for the residents to have a sandwich if they wanted one. Staff did not pass the snacks; they were just available in the nourishment kitchen and staff had to get them for residents when they asked for them because the nourishment kitchen was locked. During an interview on 12/09/25, at 8:33 P.M., NA E said the only snacks delivered to the 300 hall included chips, crackers and sometimes snack cakes. No drinks or sandwiches were ever brought to the hall. During an interview on 12/12/25, at 4:08 P.M., the dietary manager said bedtime snacks were sent to the floor every night with the supper cart. During an interview on 12/12/25, at 3:39 P.M., Director of Nursing (DON) #2 said she would expect a bedtime snack to be passed by staff to all the residents. The bedtime snack should be of substantial nutritive value and variety. During an interview on 12/18/25 at 2:25 P.M. the Registered Dietitian said the following:-Bedtime snacks should be a substantial snack containing a protein, carbohydrate, and fat;-Examples of substantial bedtime snacks would be milk, a sandwich or fruit;-She would expect staff to offer a bedtime snack to all residents every evening. #2646556

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to implement effective pest control measures to eliminate mice from areas throughout the facility, including resident rooms, the facility's dry food storage room, and nourishment kitchens. The facility census was 172. Review of the facility policy, Pest Control Program Policy, revised 05/14/24, showed the following:-It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents;-Effective pest control program is defined as measures to eradicate and contain common household pests (e.g., bed bugs, lice, roaches, ants, mosquitoes, flies, mice and rats). 1. During an interview on 12/07/25 at 11:50 A.M., Resident #118 said the following:-Mice were bad at the facility. A few days ago, a mouse ran out from under his/her bed and ran into the bathroom; -Maintenance staff did not check the mouse traps or rebait them. During an interview on 12/7/25 at 11:54 A.M., Resident #42 said the following:-He/She found a mouse in his/her bed;-He/She had four mice in his/her room;-There was a hole in the wall behind the air conditioner, and the mice were in the hole;-There was a bait box in his/her room, but there wasn't any bait in the box;-Staff were aware there were mice on the unit where he/she lived. During an interview on 12/07/25 at 12:59 P.M., Resident #160 said there was a mouse that lived in his/her air conditioner, and it ran across his/her foot. During an interview on 12/07/25 at 1:09 P.M., Resident #33 said there were mice in his/her room. The mice live behind the air conditioner unit. During an interview on 12/07/25 at 3:02 P.M., Resident #51 said the mice were bad in the facility. He/She could hear the mice running in the ceiling and walls at night, and he/she saw them recently in his/her room. Maintenance staff were to check the black bait boxes, but they never checked them. During an interview on 12/07/25 at 3:15 P.M., Resident #127 said the following:-He/She saw a mouse yesterday across from the 100/200 hall nursing station; -He/She recently found mouse droppings in his/her bed;-He/She heard mice in his/her closet. During an interview on 12/07/25 at 4:38 P.M., Resident #120 said he/she saw mice run in and out of his/her room. During an interview on 12/08/25 at 12:48 P.M., Resident #149 said the following:-He/She saw quite a few mice;-The mice climbed under his/her bed and had climbed in bed with him/her;-There was a bait box in his/her room, but staff didn't put bait in the box. During an interview on 12/09/25 at 8:35 A.M., Resident #177 said the following:-When he/she woke up this morning, he/she saw a mouse run across the floor in his/her room;-He/She saw mice all the time; -Staff were aware there are mice on the unit. During an interview 12/09/25 at 9:39 A.M., Resident #20 said the following:-There were mice on Homestead (the hall where he/she lived);-He/She saw a mouse in the shower room. 2. Observation and interview on 12/8/25 at 8:22 A.M. in occupied resident room, 705, showed mouse droppings/feces on the top surface of the resident's dresser. A bait station was located under the resident's vanity/sink. The resident who resided in the room said there was a mouse in the room. He/She saw the mouse twice a day, and it had been there for four weeks. The mouse got on his/her pillow in his/her bed. Observation and interview on 12/8/25 at 10:59 A.M. in occupied resident room, 500, showed a hole in the wall near the floor next to the heating/ventilation unit. The resident who resided in the room said there was a hole in the wall where the mice go. There were six mice in his/her room. He/She didn't want mice in his/her room. Observation on 12/8/25 at 3:17 P.M. in occupied resident room, 105, showed there was no rodent bait station in the room. The resident asked maintenance staff for a bait station box and said he/she had mice in his/her room. Observation and interview on 12/8/25 at 4:45 P.M. in occupied resident room, 815, showed shredded tan shavings in the corner of the room. During interview, the resident who resided in the room said a mouse lived in his/her bed, underneath the mattress, and had been there for one to two months. Observation showed the resident flipped over the mattress to show a hole in the bottom of the mattress. During interview, the resident said he/she saw a mouse run out from under the bed and into the adjoining bathroom. The other resident who resided in the room said he/she got shavings from his/her family snake cage to repel the mice, because the (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shavings would smell like snakes and the mice would be afraid. Observation on 12/9/25 at 9:36 A.M., in the dry storage room located near the kitchen, showed a dead mouse and mouse droppings under the dry food storage shelves. Observation on12/09/25 at 8:43 A.M. and 7:35 P.M. of the locked 200 hall nourishment kitchen, where staff stored resident supplies showed the following: -A moderate amount of mouse droppings throughout the empty cabinet below the microwave; -A moderate amount of mouse droppings in a drawer to the right of the microwave. The drawer also had three empty plastic containers that appeared to have been gnawed on and a small amount mouse droppings around the empty containers. Observation of the 200-hall nourishment kitchen on 12/09/25 at 7:35 P.M., showed the following: -One shelf along the wall had approximately 30 snack size bags of plain potato chips for resident evening snacks;-A few mouse droppings were on the shelf around the bags of potato chips. Observation on 12/09/25 at 8:50 P.M., showed a mouse ran across the 400 hallway from occupied resident room, 408, to occupied resident room, 409. 3. During an interview on 12/8/25 at 5:31 P.M., Certified Medication Technician (CMT) II said the following:-There were mice on the Homestead unit (400 and 500 halls);-He/She saw a mouse in the medication room. The mouse fell into the sharps container, and he/she disposed of the sharps container. During interview on 12/8/25 at 8:22 A.M. and 10:50 A.M., the Maintenance Director said maintenance staff checked the mouse traps and bait stations weekly or when staff had time. Staff rebaited the bait stations with peanut butter. The pest control vendor did not do anything with mice inside the building. The cold weather had mice trying to get inside the building. The facility had mice because the residents had open food out everywhere and all over the floors. During an interview on 12/18/25 at 10:44 A.M., the pest control vendor service technician said he/she went to the facility weekly to treat for roaches. He/She walked around the exterior of the building to check rodent bait stations twice monthly. He/She did not perform any rodent services inside the building, except for one bait station inside the maintenance department. He/She was aware there were reports of rodents in the building as residents would sometime make comments to him/her as he/she sprayed for roaches inside of the building. The facility had never reported mice inside the building to the pest control company nor had the facility asked the company to treat for mice inside the building. He/She did not enter any residents' rooms at the facility unless he/she was informed of specific areas needing attention. The pest control company would consider five mice in the building to be an infestation, but one mouse was a problem. The facility told residents to clean up food on the floors etc. The company he worked for had been doing pest control for the facility since September 2025. #2652363#2655329

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their policy to ensure staff completed weight monitoring, notifications with weight loss, provision of ordered supplements and reevaluation of the care plan for two residents with weight loss (Resident #45 and #103) in a review of 47 sampled residents. The facility census was 172. Review of the facility policy, Weight Monitoring Policy, revised 05/07/24, showed the following: -Purpose: Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;-Monitoring weight: weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem;- The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes: - Identifying and assessing each resident's nutritional status and risk factors; -Evaluating/analyzing the assessment information; -Developing and consistently implementing pertinent approaches; -Monitoring the effectiveness of interventions and revising them as necessary;-Information gathered from the nutritional assessment and current dietary standards of practice are used to develop an individualized care plan to address the resident's specific nutritional concerns and preferences. The care plan should address the following, to the extent possible:-a. Identified causes of impaired nutritional status;-b. Reflect the resident's personal goals and preferences;-c. Identify resident-specific interventions;-d. Time frame and parameters for monitoring;-e. Updated as needed, such as when the resident's condition changes, goals are met. interventions are determined to be ineffective or new causes of nutrition-related problems are identified;-f. If nutritional goals are not achieved, care planned interventions will be reevaluated for effectiveness and modified as appropriate;-g. The resident and/or resident representative will be involved in the development of the care plan to ensure it is individualized and meets personal goals and preferences;- Interventions will be identified, implemented, monitored and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status;-A weight monitoring schedule will be developed upon admission for all residents. Residents with with weight loss will be monitored weekly-Weight Analysis: The newly recorded resident weight should be compared to the previous recorded weight. A significant change in weight is defined as:-a. 5 percent (%) change in weight in 1 month (30 days);-b. 7.5% change in weight in 3 months (90 days);-c. 10% change in weight in 6 months (180 days);.-The physician should be informed of a significant change in weight and may order nutritional interventions;-The Registered Dietitian or Dietary Manager should be consulted to assist with interventions;-Actions are recorded in the nutrition progress notes. 1. Review of Resident #103's face sheet showed diagnoses included chronic obstructive pulmonary disease/COPD (a progressive lung disease that makes breathing difficult), unspecified vitamin deficiency, gastroesophageal reflux disease/GERD without esophagitis (a chronic condition where stomach acid frequently flows back into the esophagus, causing irritation, heartburn, and vomiting), hyperlipidemia (elevated fats in blood) and schizophrenia (a mental health disorder that disrupts how a person thinks, feels, and behaves). Review of the resident's care plan, revised on 07/08/24, showed the following: -He/She was on a regular diet with regular liquids and does have a diagnosis of GERD and vitamin deficiency, initiated on 06/25/24 and revised on 07/08/24;-He/She will have no negative outcomes from current dietary status, initiated on 06/25/24;-Dietary department will monitor diet monthly to ensure proper dietary recommendations, initiated on 06/24/24;-Dietician will review chart quarterly to ensure regular diet is still proper diet for resident, initiated on 06/24/24. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by facility staff, dated 04/14/25, showed the following:-Weight of 187 pounds (lbs.);-No weight loss or weight gain;-No therapeutic diet or dietary interventions. Review of the resident's electronic health record, weights and vital signs summary, showed staff documented the resident's weight on 06/06/25 as 187.3 lbs. Review of the resident's electronic health record, dietician progress notes, dated 06/09/25, showed the following:-Annual assessment: The resident was at mild nutritional risk related to COPD and schizophrenia;-Weight was 187 pounds, up one pound in one month, down ten pounds in three months, down 17 pounds in six months and down 22 pounds over the past year;-Body Mass Index (BMI) equals 26.9, overweight range;-No new recommendations at this time. Review of the resident's electronic health record, weights and vital signs summary, showed staff documented the resident's weight on 07/11/25 as 190 pounds (a 2.7 lb. gain). Review of the resident's quarterly MDS, dated [DATE], showed the following:-Weight of 190 pounds;-No weight loss or weight gain;-No therapeutic diet or dietary interventions. Review of the resident's electronic health record, weights and vital signs summary, showed staff documented the resident's weight on 08/05/25 as 180 lbs. (a 10 lb. 5.3% weight loss in one month). Review of the resident's medical record showed no documentation the physician, Registered Dietitian or Dietary Manager were notified of the 5.3% weight loss in one month identified on 08/05/25 per facility policy. Review of the record showed no evidence staff monitored the resident's weight weekly per policy. Review of the electronic health record, dietary note progress notes, authored by the Registered Dietician, dated 08/13/25, showed the following: -Weight note: Resident is on a regular diet with thin liquids and Boost (a liquid nutritional supplement) three times a day;-Weight is 180 pounds, down ten pounds in one month (5.3% loss), down six pounds in three months and down 14 pounds in six months;-Current BMI is 25.8, overweight;-Continue current plan of care, monitor oral intake on current diet and weight for significant changes;-Registered dietician will follow and be available as needed. Review of the electronic health record, nutrition/dietary note, authored by the dietary manager, dated 09/18/25, showed addressing a concern from 09/01/25. Resident had concerns about weight loss and requested double portions. Dietary manager spoke with the Director of Nursing (DON) and physician about the resident's concerns. Review of the resident's medical record showed no documentation staff notified the resident's physician of the resident's weight loss, concerns or request for double portions. Review of the resident's care plan (last revised 7/8/24) showed no evidence of any update to the problem, goal or interventions to address weight loss. Review of the resident's September 2025 Physician Order Sheet (POS) showed the following: -Weights monthly and record with an order start date of 06/24/24;-Regular diet, regular texture, thin/regular consistency with an order start date of 09/19/24;-Boost (a dietary supplement) with meals three times a day for weight loss, with an order start date of 07/14/25. Review of the resident's electronic health record, weights and vital signs summary, showed staff documented the resident's weights as follows:-On 09/03/25, 179.9 pounds (0.1 pound loss);-On 10/09/25, 179.9 pounds (no change). Review of the resident's quarterly MDS, dated [DATE], showed the following:-Weight of 180 pounds;-No indication of weight loss or weight gain;-No therapeutic diet or dietary interventions. Review of the resident's electronic health record, weights and vital signs summary, showed staff documented the resident's weight on 11/04/25 as 170.2 pounds (a 9.8 pound - 5.4% loss in one month). Review of the resident's electronic health record, nutrition/dietary note progress notes, authored by the Registered Dietician, dated 11/10/25, showed the following: -Weight note: resident is on a regular diet with thin liquids and Boost three times a day;-Weight is 170 pounds, down ten pounds in one month and three months (5.6% weight loss) and down 16 pounds in six months;-Current BMI - 24.4 - normal;-Goal for weight to remain stable within normal BMI range;-Continue current plan of care, monitor oral intake on current diet and weight for significant changes;-Registered dietician will follow and be available as needed. Review of the resident's medical record showed no documentation staff notified the resident's physician of the resident's 10 lb. weight loss - 5.6% weight loss in one month on 11/10/25. Review showed no evidence staff monitored the resident's weight weekly. Review of the resident's care plan (last (continued on next page)

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	265330	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revised 7/8/24) showed no evidence of any update to the problem, goal or interventions to address weight loss. Review of the resident's December 2025 Physician Order Sheet (POS) showed the following:-Weights monthly and record with an order start date of 06/24/24;-Regular diet, regular texture, thin/regular consistency with an order start date of 09/19/24;-Boost (a dietary supplement) with meals three times a day for weight loss, with an order start date of 07/14/25. Review of the resident's electronic health record, weights and vital signs summary, showed staff documented the resident's weight on 12/06/25 as 170.4 pounds (a 16.9 pound - 9.0% loss in six months and 10.3% loss in five months). Review of the resident's care plan (last revised 7/8/24) showed no evidence of any update to the problem, goal or interventions to address weight loss. During an interview on 12/07/25 at 12:30 P.M., the resident said the following:-He/She had lost 30 pounds this year;-He/She felt better when his/her weight was around 200 pounds;-He/She has been trying to get double portions for about three months now and no one seemed to be able to make that happen;-He/She used to weigh 211 pounds and felt good at that weight;-He/She gets Boost three times a day, but the snacks were usually only a bag of chips. During an interview on 12/11/25 at 2:45 P.M., the Dietary Manager said she didn't remember Resident #103 asking for double portions. During an interview on 12/12/25 at 3:39 P.M., DON #2 said if a resident had a five percent weight loss in one month or a 10% weight loss in six months, or even a gradual loss, she would expect the physician and registered dietician to be notified for an assessment and orders. During an interview on 12/18/25 at 2:25 P.M. the Registered Dietitian said the following:-She reviewed the Monthly Weight Report and Weight Summary for weight loss/weight gain;-Staff should draw her attention to those residents with loss or gain;-She was aware that Resident #103 had lost weight, and she was monitoring the weight loss;-She was not aware Resident #103 had asked for double portions since September. She preferred to give food versus supplementation;-She would expect staff to implement weight loss interventions including supplements. 2. Review of Resident #45's Physician's Orders, dated 05/12/25, showed the following:-Magic Cup (frozen dessert used for adding calories and protein for those experiencing involuntary weight loss) three times a day for weight management;-Health shake (supplemental nutrition for adding dietary calories and protein) three times a day for weight management related to wandering;-Regular diet. Review of the resident's facility Weights and Vitals, dated 05/12/25, showed staff documented the resident weighed 161 pounds. Review of the Resident's Care Plan, dated 05/13/25, showed the following:-The resident was on a regular diet;-Dietary department will monitor diet monthly to ensure proper dietary recommendations;-Dietician will review chart quarterly to ensure regular diet was still the proper diet for resident;-No documentation regarding physician orders for health shakes and Magic cup. Review of the resident's admission MDS, dated [DATE], showed the following:-Short and long term memory problems;-Diagnoses of dementia and psychotic disorder;-Weight 161 pounds;-Required partial to moderate assistance for eating. Review of the resident's facility Weights and Vitals Record showed staff documented on 06/4/25 the resident weighed 153.8 pounds (a seven pound weight loss since 05/18/25). Review of the resident's medical record showed no documentation staff notified the physician or Dietary Manager of the resident's weight loss per facility policy. Review showed no record of weekly weights completed per facility policy. Review of the resident's facility Weights and Vitals Record showed staff documented on 07/09/25 the resident weighed 151 pounds (a 2.8 pound weight loss since the last weight on 06/04/25). Review of the resident's facility Weights and Vitals Record, dated 08/05/25, showed the resident weighed 149 pounds (a two pound weight loss since the last weight on 07/09/25). Review of the resident's medical record showed no documentation staff notified the physician of the resident's weight loss. Review showed no record of weekly weights completed per policy. Review of the resident's Quality Assurance (QA)/Weight Note, dated 08/13/25, showed the following:-Resident currently on a regular diet with thin liquids, health shake and Magic Cup three times daily;-Weight 149 pounds. This was down two pounds in one month and down 12 pounds in three months;-Continue current plan of care, monitor intake on current diet and weight for significant changes. Review of the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's Quarterly MDS, dated [DATE], showed the following:-Severely impaired cognition;-Required supervision or touch assist for eating;-Weight 149 pounds;-No weight loss. Review of the resident's facility Weights and Vitals Record, dated 09/4/25, showed the resident weighed 148 pounds. Review of the resident's Weight Note (completed by the Registered Dietitian), dated 10/13/25, showed the following:-Resident continues a regular diet with thin liquids, health shake and Magic Cup three times daily;-Orders for mirtazapine;-Weight 141 pounds on 10/8/25, this was down seven pounds in one month, down nine pounds in three months, and down 20 pounds in five months;-Continue current plan of care, monitor intake on current diet and weight for significant changes. Review of the resident's facility Weights and Vitals Record, dated 10/14/25, showed the resident weighed 140 pounds. Review of the resident's Physician Progress Note, dated 10/23/25, showed the following:-Staff report the resident needs reminders and assistance during meals;-Appetite appears fair but needs monitoring;-Ensure resident was eating adequately and receiving nutritional support. Review of the resident's facility Weights and Vitals Record, dated 11/5/25, showed the resident weighed 138 pounds, (a23 pound weight loss or 14% in six months). Review of the resident's medical record showed no evidence staff monitored weights weekly (from 10/14/25 to 11/05/25) per facility policy. Review of the resident's QA/Weight Note, dated 11/10/25, showed the following:-Resident currently on a regular diet with thin liquids, health shake and Magic Cup three times daily;-Weight 138 pounds on 11/05/25, this was down three pounds in one month, down 11 pounds in three months, and down 23 pounds in six months (14.2% loss);-Continue current plan of care encouraging intake especially of supplements. Review of the resident's Significant Change MDS, dated [DATE], showed the following:-Severely impaired cognition;-Required supervision or touch assist for eating;-Weight 149 pounds; (incorrect weight)-No weight loss (14% weight loss in six months);-Hospice care. Review of the resident's Physician's Orders, dated December 2025, showed orders for the following:-Magic Cup three times a day for weight management;-Health Shake three times a day for weight management. Review of the resident's medication administration record (MAR), dated December 2025, showed staff documented administering health shakes three times daily (7:00 A.M., 11:00 A.M. and 4:00 P.M.) 12/01/25 through 12/07/25. There was no evidence, or place for staff to document provision of the Magic Cup order on the MAR. Observation on 12/08/25 at 12:48 P.M., in the Homestead Dining Room, showed the following:-Staff served the resident chicken breast, gravy, stuffing and a vanilla/chocolate ice cream cup; -Staff did not serve a Magic Cup. The resident ate some of the chicken and stuffing and ate ice cream. Observation on 12/08/25 at 5:27 P.M., in the Homestead Dining Room, showed the following:-Staff served the resident two egg salad sandwiches, cheesy soup, tomato/cucumber salad and a glass of Kool aid; -The resident ate his/her meal independently;- Staff did not serve a Magic Cup. During an interview on 12/09/25 at 8:30 A.M., Certified Nurse Aide (CNA) WW said he/she had never seen Magic Cups served by dietary or nursing. During an interview on 12/08/25 at 5:31 P.M., Certified Medication Technician (CMT) II said the following:-The kitchen was responsible for the Magic Cups;-Nursing staff does not have access to the Magic Cups. During an interview on 12/11/25 at 12:20 P.M., CMT C said dietary gives Magic Cups as nursing does not have access to that supplement. During an interview on 12/11/25 at 12:27 P.M. and 1:06 P.M., and 12/11/25 at 12:55 P.M., the Dietary Manager said the following:-She received a list from nursing with the residents who were supposed to get a Magic Cup; -She was not aware the resident had an order for Magic Cups three times daily; the order in the computer was not categorized as dietary, so dietary was not aware of the order;-Nursing must let dietary know of new supplement orders as Magic Cups come from the kitchen and dietary staff are responsible for passing out the Magic Cups. During an interview on 12/18/25 at 2:25 P.M., the Registered Dietitian said the following:-If a resident had orders for nutritional supplements such as Magic Cups, she expected staff to give the supplements as ordered;-Supplement orders must be entered into the computer a certain way, or the order does not go to dietary and dietary would not be aware of the order. During an interview on 12/12/25 at 3:39 P.M., DON #2 said the following:-She would expect staff to provide (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supplements as ordered by the physician;-She would expect staff to notify the physician, guardian and RD if a resident has weight loss of 10% in six months, 5% in one month or a gradual, continual decline. During interview on 12/09/25 at 1:10 P.M., the residents' physician said he would expect staff to follow physician's orders. #2630303

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview and record review, the facility failed to post the results of the most recent survey and complaint investigations in a place readily accessible to all residents, family members, and legal representatives. The facility census was 172. Review of the facility policy, Resident Rights, revised 09/21/25, showed residents have the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The results must be made available by the facility in a place readily accessible to residents, must be clearly labeled, and the facility must post a notice of their availability. 1. During the resident council meeting on 12/09/25 at 9:59 A.M., 24 of 24 residents in attendance said they were not aware that they could see the results of the annual inspections/surveys or any complaint investigations. They did not know where the book with the results was kept. Observation on 12/09/25 at 2:10 P.M., showed the following:-Two white binders on a shelf inside the 100/200 hall (locked) nurses station;-No identification on the spine of the white binders;-Upon removal from the shelf, a single page in the front sleeve of the binder, that was not visible unless removed from the shelf, showed the state survey results identification;-No signage available to indicate where the latest state survey results were located. Observation on 12/09/25 at 3:00 P.M., showed no white binders with survey results on the 300 hall (nurses station/nourishment kitchen) and no signage available to indicate where the latest state survey results were located. Observation on 12/11/25 at 3:29 P.M., showed the following:-Two white binders on a shelf at the 600/700 hall (unlocked) nurses station;-No identification on the spine of the white binders;-Upon removal from the shelf, a single page in the front sleeve of the binder, that was not visible unless removed from the shelf, showed the state survey results identification;-No signage available to indicate where the latest state survey results were located. During an interview on 12/12/25 at 3:48 P.M., the administrator said the following:-The latest copy of the state survey inspection results should be clearly labeled and be posted for all residents/visitors to view in the facility;-He, the assistant administrator or medical records staff were responsible to ensure the survey results were accessible and visible for anyone to see.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to post required nurse staffing information, which included the facility name, the current date, the census, and the total actual hours worked by both licensed and unlicensed nursing staff directly responsible for resident care, per shift daily and in a location readily accessible to residents and visitors. The census was 172.Review of the facility policy, Nurse Staffing Posting Information Policy, revised 06/26/24, showed the following: -It is the policy of this facility to make nurse staffing information is readily available in a readable format to residents and visitors at any given time;-The Nurse Staffing Sheet will be posted daily and will contain the following information:- Facility name; -The current date;-Facility's current resident census;-The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift including Registered Nurses (RN), Licensed Practical Nurses/Licensed Vocational Nurses (LPN), and Certified Nurse Aides (CNA);- The facility will post the Nurse Staffing Sheet at the beginning of each shift;-The information posted will be presented in a clear and readable format and in a prominent place readily accessible to residents and visitors;-Nursing posting information will be maintained in the Human Resources Department for review for a minimum of 18 months or as required by State law, whichever is greater;-The facility will, upon oral or written request, make the nurse staffing data available to the public for review at a cost not to exceed the community standard;-The policy did not address a specific place the posted staffing should be displayed. 1. Observations on 12/07/25 at 9:05 A.M, 12/08/25 at 8:05 A.M. and 8:30 P.M., 12/09/25 at 8:05 A.M., 12/10/25 at 9:00 A.M., 12/11/25 at 8:00 A.M. and 12/12/25 at 8:00 A.M., showed no required posted staffing information at the front entrance by the front door. 2. Observations on 12/07/25 at 10:16 A.M., 12/08/25 at 9:24 A.M., 12/09/25 at 8:37 A.M., 12/10/25 at 10:50 A.M., 12/11/25 at 9:35 A.M., and 12/12/25 at 9:55 A.M., showed no required posted nurse staffing information by the Meadowbrook nurses' station for the 600 and 700 halls. 3. Observations on 12/07/25 at 4:00 P.M, 12/08/25 at 9:00 A.M., 12/09/25 at 12:18 P.M. and 12/10/25 at 9:30 A.M., showed no required posted nurse staffing information by the [NAME] nurses' station for the 100, 200, and 300 halls. 4. Observations on 12/07/25 at 4:00 P.M., 12/08/25 at 4:50 P.M., 12/09/25 at 2:40 P.M. and 12/10/25 at 12:00 P.M., showed no required posted nurse staffing information by the Parkwood nurses' station for the 800 and 900 halls. 5. Observations on 12/07/25 at 4:37 P.M., 12/08/25 at 8:11 A.M., 12/09/25 at 8:50 P.M., 12/11/25 at 12:22 P.M. and 12/12/25 at 10:38 A.M. showed no required posted nurse staffing information by the Homestead nurses' station for the 400 and 500 halls. During an interview on 12/12/25 at 4:20 P.M., the staffing coordinator said the following:-She was aware of what was supposed to be listed on the posted staffing;-Staffing was usually posted by the front door, but it was taken down so the wall could be painted and didn't get hung back up; -She was aware that it had not been posted for the duration of survey, and it should have been;-She was responsible for the daily posted staffing. During an interview on 12/12/25 at 3:39 P.M., Director of Nursing #2 said the following:-The nursing staffing coordinator was responsible for ensuring the posted staffing was completed daily; -The items on the posted staffing should include the hours for all nursing staff;-The staffing should be posted in a visible place daily. During an interview on 12/12/25 at 3:48 P.M., the administrator said the staffing coordinator and medical records were responsible for ensuring the nursing hours were posted daily in a visible place by the main office.