STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285293	A. Building B. Wing	04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Country Estates-Cottages	6082 Grand Lodge Avenue Papillion, NE 68133

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure a baseline care plan was completed in 48 hours after Resident 59 was admitted to the facility. The resident was 1 of 12 residents surveyed. The facility had a census of 47. Findings are: A record review of the residents' electronic health record revealed Resident 59 was admitted to the facility on [DATE] with unspecified encephalopathy (a general term for any brain dysfunction, characterized by an altered mental state). The resident also had the following diagnoses: paroxysmal atrial fibrillation, (an irregular rapid heartbeat), presence of automatic (implantable) cardiac defibrillator (a device that applies an electric charge to the heart to restore a normal heartbeat), essential (primary) hypertension (chronic heart disease that causes abnormally high blood pressure for unknown reasons, personal history of transient ischemic attack (Brief blockage of blood to the brain), and cerebral infarction without residual deficits (stroke with damage), hemiplegia and hemiparesis (partial paralysis) following cerebral infarction affecting right dominant side, dysphagia (difficulty swallowing), difficulty in walking. Resident is a full code and requires the assistance of 1 person to walk with a walker. A record review of a care plan dated 4/1/25 revealed it contained 2 care areas, Risk for falls and Risk of Impaired Nutritional Status. The care plan did not contain elements a through g of the facility's Baseline Care Plan Policy. A record review of the facilities Baseline Care Plan Policy dated 1/1/2023 revealed the following: A baseline plan of care should be developed for each patient within twenty-four (24) hours of admission. The care plan should include the interventions needed to provide person centered care. Policy and Compliance Guidelines: 1.The baseline care plan should be initiated by an interdisciplinary team member and must be developed with 24 hours of admission and should include: a. The patients' initial goals for care (Transition goals) (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Immediate ADL needs (transfers, weight bearing status, assist needed etc) c. Initial orders including medications and treatments (may include reference to medication and treatment record) d. Dietary orders e. Therapy plan of care (may include reference to therapy plan of care) f. Social services to include discharge planning and needs. g. PASRR recommendations, if applicable. An interview on 4/8/2025 at 3:03PM with Regional Consultant [NAME] confirmed a baseline care plan for the resident was not developed within 24 hours of admission. The resident was admitted on [DATE].

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. B Record review of a practitioners order dated 3/22/2025 revealed the following information -Nebulizer tubing set up: Change Duoneb tubing, mask and aersol chamber weekly. Ensure the date and initials are on the new tubing and mask with the change being scheduled overnights on Saturdays. A record review of a practitioners order dated 3/22/25 revealed the following: -C-PAP (a continuous positive airway pressure device that is a common treatment for obstructive sleep apnea). Staff were to set the CPAP in the morning and to store CPAP Mask when not in use in clean dry area. Staff may use respiratory set up bag when not in use. .An observation on 4/7/25 at 2:51 PM revealed Residents 58's nebulizer (a small electric powered device that converts liquid medication into an inhalable mist) mask was sitting on top of their side table without a bag in place. The nebulizer tubing was not dated. Residents CPAP mask was hanging from the residents' bedside lamp. An observation on 4/8/25 at 11:45 AM revealed Residents 58's CPAP mask was hanging from the bedside table and the nebulizer mask was resting on the nebulizer machine. The nebulizer tubing was not dated. An observation on 4/14/2025 at 7:23 AM revealed Residents 58's CPAP mask was hanging on the bedside lamp. An observation on 4/14/2025 at 7:23 AM revealed Residents 58's nebulizer mask was resting on the bedside table and the nebulizer tubing was undated. An interview on 4/8/25 at 11:55 AM with Registered Nurse (RN) H confirmed the CPAP mask was hanging from the lamp and it should not have been. RN-H further confirmed the nebulizer tubing was not dated and it should have been dated. An interview on 4/14/2025 at 7:23 AM with RN-I confirmed the nebulizer tubing was undated. RN-I confirmed the nebulizer mask was resting on the bedside table and the CPAP mask was hanging from the bedside lamp. RN-I confirmed the nebulizer tubing should have been dated and the CPAP mask should have been in a bag. Licensure Reference Number 175 NAC 12-006.09 & 12-006.09(H)(iii) Based on record review and interview the facility failed to monitor for neurological changes after a head injury and failed to evaluate and monitor changes in skin integrity for 1 (Resident 47) of 1 residents sampled and failed to follow physician's orders for 1 (Resident 58) of 9 residents sampled. The facility census was 47. The findings are: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A.Record review of Resident 47's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 04-30-2024 revealed the facility staff assessed the following about the resident: - short and long term memory problems - moderately impaired decision making skills -required moderate assistance with eating and hygiene. -required maximum assistance with toileting, dressing, bathing, bed mobility and transfers. -was taking an anticoagulant medication (a medication that prevents blood to clot). Record review of Resident 47's Progress Note dated 05-28-2024 revealed a skin evaluation was conducted and the staff identified a large bruise on forehead. Record review of Resident 47's Progress Notes dated between 05-28-2024 and 06-03-2024 revealed no communication with Resident 47's practitioner or responsible party. Record review of the facility investigation for Resident 47's bruise revealed measurements of the bruise were not obtained until 06-04-2024 and etiology was not investigated until 06-10-2024. An interview with Clinical Care Coordinator (CCC) F on 04-14-2025 at 8:39 AM confirmed the absence of measurements and neurological checks and confirmed the bruise should have been measured, an incident report should have been completed and due to having a new bruise to the head, neurological checks should have been initiated. Record review of the facility policy dated 01-01-2023 titled Hillcrest Country Estates Skin Integrity and Wound Assessment, Treatment and Documentation policy revealed: -all team members are responsible for preventing, caring for and providing treatment for any patient with altered skin integrity. -altered skin integrity can include bruises, abrasions, skin tears, contusions, lacerations, surgical incisions, and deep tissue injuries. -a full body skin assessment should be conducted by a licensed nurse upon admission and then weekly and as needed. -when a skin integrity concern is identified during a weekly skin evaluation the nurse will communicate the assessment of the wound upon identification and as needed for a treatment plan. -assessment of the skin integrity concern includes determining the etiology of the concern, measurements, presence of pain, the appearance of the concern and the surrounding area. Record review of the facility policy dated 11-20-2017 titled Hillcrest Country Estates Neuro Checks revealed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-a Neuro Check is a simple and standardized assessment to detect changes in level of consciousness. These may be performed on an individual with a post-fall head injury, traumatic brain injury, new stroke or any individual with a neurological event or diagnosis. -Neuro checks will be completed on the individual with a known or suspected head injury, unwitnessed fall or diagnosis warranting neuro checks.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Licensure Reference Number 175 NAC 12-006.12(A)(vi) Based on interviews and record reviews; the facility failed to ensure pharmacy recommendations were completed for 3 (Residents 5, 8, and 9) of 5 sampled residents. The facility staff identified a census of 47. The findings are: Record review of a facility policy entitled Medication Regimen Review Policy updated 02/03/2025 revealed: -A medication regimen review will be completed for each resident by a licensed pharmacist in order to identify irregularities and to identify clinically significant risks and/or actual or potential adverse consequences which may result from or be associated with medications. The documented medication regimen review completed by the pharmacist will be provided to the primary care provider and Director of Nursing (DON). -Recommendations by the consultant pharmacist per the medication regimen review, will be provided for review to the primary care provider and Director of Nursing/designee prior to the next review. -Recommendations will be carried out by a licensed nurse prior to the next review. A. Record review of Resident 5's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) identified an admission date of 12/28/2022. The Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) was not completed as the resident was rarely or never understood. The MDS further identified that the resident received antipsychotic, antianxiety, and antidepressant medications and the resident exhibited wandering. Record review of Resident 5's admission Record revealed the resident had diagnoses of Anxiety, Mild Dementia with Mood Disturbance, and Depression. Record review of pharmacy notes entered by the licensed pharmacist into Resident 5's electronic medical record from April 2024 through March 2025 revealed the following: -09/30/2024 due for duration reassessment on PRN (as needed) Lorazepam (an antianxiety medication). -10/31/2024, 11/29/24, and 12/30/24 re-issue PRN Lorazepam request. Further review of Resident 5's electronic medical record revealed there were no indications the facility staff followed up with the recommendation from the Pharmacist with the request dates of 9/30/2024,10/31/2024,11/29/2024 and 12/30/2024. An interview on 04/10/25 at 7:41 AM with the Director of Nursing (DON) revealed the expectation for completing pharmacy recommendations is within one week of receipt. The DON confirmed that pharmacy recommendations had not been completed for Resident 5 and should have been. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Record review of Resident 8's MDS identified an admission date of 01/17/2024 and a BIMS score of 9/15. According to the MDS Manual, a BIMS score of 9 indicated that the resident had moderate cognitive impairment. The MDS revealed the resident did not exhibit behaviors and was receiving antidepressant, diuretic, opioid, and hypoglycemic medications. Record review of Resident 8's admission Record identified diagnoses of type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD, pulmonary disease that is characterized by chronic typically irreversible airway obstruction resulting in a slowed rate of exhalation), Osteoarthritis, Depressive episodes, and Hypertension. Record review of pharmacy notes entered by the licensed pharmacist into Resident 8's electronic medical record from April 2024 through March 2025 revealed the following which showed the pharmacy recommendations had not been followed up on: -04/30/2024 Re-issue GDR -05/30/2024 Re-issue GDR on Escitalopram (an anti-depressant medication) -06/30/2024 Re-issue GDR -07/28/2024 Follow-up with GDR. -08/29/2024 Re-issue GDR on Escitalopram. -09/30/2024 Re-issue GDR on Escitalopram. -10/31/2024 Re-issue GDR on Escitalopram. -11/29/2024 Re-issue GDR evaluation. -12/30/2024 F/U with GDR recommendation. Record review of Pharmacist's Recommendation to Provider dated 02/05/2025 revealed a GDR recommendation on the resident's Escitalopram that was addressed by the primary care provider, nine months after the recommendation was first issued. An interview on 04/09/2025 at 2:39 PM with the DON confirmed there were no additional pharmacy recommendation records for Resident 8 for review. An interview on 04/10/25 at 7:41 AM with the DON revealed the expectation for completing pharmacy recommendations is within one week of receipt. The DON confirmed that pharmacy recommendations had not been completed for Resident 8 and should have been. C. Record review of Resident 9's admission Record identified the facility admitted the resident on 01/29/2023 and identified diagnoses of dementia without behavioral disturbance, chronic kidney disease, depression, and hypertension. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 9's MDS identified that the BIMS score was not completed as the resident was rarely or never understood. The MDS further identified the resident displayed no behavioral symptoms and revealed the resident was receiving antipsychotic and antidepressant medications. Record review of pharmacy notes entered by the licensed pharmacist into Resident 9's electronic medical record from April 2024 through March 2025 revealed the following which showed the pharmacy recommendations had not been followed up on: -12/30/2024 GDR evaluation for quetiapine/Mirtazapine. -01/30/2025 Re-issue GDR on psych medications. No new recommendations. -02/26/2025 Re-issue GDR on psych medications. Record review of Pharmacist's Recommendation to Prescriber dated 02/26/2025 revealed GDR recommendations for Mirtazapine and quetiapine were addressed on 03/01/2025, three months after the recommendation was first issued. An interview on 04/09/2025 at 2:39 PM with the DON confirmed there were no additional pharmacy recommendation records for Resident 9 for review. An interview on 04/10/25 at 7:41 AM with the DON revealed the expectation for completing pharmacy recommendations is within one week of receipt. The DON confirmed that pharmacy recommendations had not been completed for Resident 9 and should have been.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. Based on interviews and record reviews, the facility failed to identify specific behavioral symptoms for the continued use of antidepressant medications for 2 (Residents 5 and 9) of 5 sampled residents. The facility staff identified a census of 47. The findings are: Record review of a facility policy entitled Psychotropic Medication Policy dated 01/01/2023 revealed: -Patients are not prescribed psychotropic medications unless they are necessary to treat a specific condition, as diagnosed and documented in the medical record, and the medication is beneficial to the patient, as evidenced by monitoring and documentation of the patient's response to the medication(s). -The indications for initiating, withdrawing or withholding medication(s), as well as the use of nonpharmacological approaches, shall be determined by the provider along with the interdisciplinary team. -The patient response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the patient's medical record. A. Record review of Resident 5's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) identified an admission date of 12/28/2022. The Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) was not completed as the resident was rarely or never understood. The MDS further identified that the resident received antipsychotic, antianxiety, and antidepressant medications and the resident exhibited wandering. Record review of Resident 5's admission Record revealed the resident had diagnoses which included anxiety, mild dementia with mood disturbance, and depression. Record review of Resident 5's Order Summary Report printed 04/08/2025 revealed an order for mirtazapine (antidepressant medication) tab 15 mg, give 1 tablet orally at bedtime for depression. Record review of Resident 5's electronic medical records revealed no monitoring for specific behavioral symptoms was identified for the use of antidepressant medication. An interview on 04/09/2025 at 1:47 PM with the Director of Nursing (DON) revealed the expectation was to monitor and record specific behavioral symptoms displayed by the resident which prompted the use of the antidepressant. An interview on 04/10/2025 at 7:41 AM with the DON confirmed there was no specific behavioral symptom identified or monitored to support the continued use of antidepressant medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Record review of Resident 9's admission Record identified the facility admitted the resident on 01/29/2023 and identified diagnoses of dementia without behavioral disturbance, chronic kidney disease, depression, and hypertension. Record review of Resident 9's MDS identified that the BIMS score was not completed as the resident was rarely or never understood. The MDS further identified the resident displayed no behavioral symptoms and revealed the resident was receiving antipsychotic and antidepressant medications. Record review of Resident 9's Order Summary Report printed 04/09/2025 revealed an order for mirtazapine tab 15 mg, give 1/2 tab orally at bedtime for depression. Record review of Resident 9's electronic medical records revealed no monitoring for specific behavioral symptoms was identified for the continued use of antidepressant medication. An interview on 04/09/2025 at 1:47 PM with the Director of Nursing (DON) revealed the expectation was to monitor and record specific behavioral symptoms displayed by the resident which prompted the use of the antidepressant. An interview on 04/10/2025 at 7:41 AM with the DON confirmed there was no specific behavioral symptom identified or monitored to support the continued use of antidepressant medications.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Nebraska Licensure Reference Number 175 NAC 12-006.11(A)(i) Based on observations, interviews, and record reviews; the facility failed to follow the menu to assure nutritional value of foods in 1 (Cottage 70) of 3 cottages. This had the potential to affect 13 residents receiving foods from that kitchen. The facility staff identified a census of 47. The findings are: Record review of a facility policy entitled Culinary Food Preparation Policy revised 11/20/2017 revealed: -All food items are prepared by methods that conserve nutritional value. -The recipe file index that supports the current menu is to be used during the preparation of food items. Record review of the Italian Tossed Salad recipe dated 2024 revealed ingredients included lettuce, sliced red onion, Italian dressing, and parmesan cheese. Observation on 04/09/2025 at 9:25 AM with the Culinary Director (CD) present while Cook-G prepared the Italian Tossed Salad revealed Cook-G obtained a large bowl and cutting board. Cook-G washed hands for 17 seconds and retrieved lettuce and cucumber from the refrigerator. Cook-G performed hand hygiene and donned (applied) gloves and tore the lettuce apart into bite sized pieces. Cook-G doffed (removed) gloves and washed hands for 22 seconds. Cook-G donned gloves, sliced the cucumber, and mixed the cucumber with the lettuce. Cook-G doffed gloves, washed hands, and obtained a zip lock bag, labeled and dated the bag, washed [gender] hands, donned gloves and transferred the salad into the bag. Throughout the entire preparation Cook-G did not use the recipe when preparing the Italian Tossed Salad for the residents. An interview on 04/09/2025 at 9:35 AM with Cook-G with the CD present revealed Cook-G stated [gender] hardly ever used the menus. Cook-G reported resident's don't like tomato or onion so kitchen staff only put cucumber in the salad. Cook-G confirmed that nutritional value could not be measured if the menu and recipe approved by the Registered Dietitian (RD) had not been followed. An interview on 04/09/2025 at 9:45 AM with the CD confirmed the expectation is to follow the recipes when preparing meals. An interview on 04/09/2025 at 12:13 PM with the CD confirmed proper nutrition cannot be confirmed if RD approved recipes are not utilized. An interview on 04/14/2025 at 8:43 AM with the RD confirmed that the omission of vegetables has the potential to alter the nutritional value of the dish. The RD further confirmed expectations to follow the menu. RD revealed if a majority of the resident in one cottage do not like a food item, the menu could be changed and that would be approved through the RD. The RD revealed [gender] was unaware the cook did not follow the recipes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Nebraska Licensure Reference Number 175 NAC 12.006.11(A)(i) Nebraska Food Code 2017 4-602.11(D)(5) Based on observations, interviews, and record reviews; the facility failed to ensure the cleanliness of a reach-in freezer in Cottage 80 and a reach-in refrigerator in the Rehab Cottage to prevent the potential for foodborne illness. This had the potential to affect 13 residents who received food in Cottage 80 and 21 residents who received food in the Rehab Cottage. The facility staff identified a census of 47. The findings are: A. Record review of a facility policy entitled Culinary Cleaning Policy revised 11/20/2017 revealed: -The equipment, surfaces and floor in the culinary department will be thoroughly cleaned and sanitized throughout the day and at closing. -Each piece of equipment will have a cleaning procedure and a weekly schedule for cleaning posted in the kitchen. -These procedures will be reviewed during new team member onboarding. -It is the responsibility of the culinary team to maintain the sanitation of all pieces of equipment and kitchen as a whole. -Cleaning checklist forms are to be signed off on by the team member which has completed the task then turned into the assistant directors. -The Culinary Directors will audit these procedures through cleaning check lists and visual inspections. Observation on 04/07/2025 from 8:16 AM to 8:24 AM during the initial walk through of Cottage 80's kitchen revealed a pool of dried red substance beneath a roll of ground beef in the freezer on the bottom shelf with no barrier beneath. Observation on 04/09/2025 at 8:20 AM with the CD revealed the dried red substance remained beneath the roll of ground beef with no barrier beneath. Interview on 04/09/2025 at 8:20 AM with the Culinary Director (CD) confirmed the presence of a dried red substance beneath the roll of ground beef. The CD revealed the facility had been without a CD for a long time prior to [gender] arrival and that the culinary department did not have cleaning schedules. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Observation on 04/07/2025 from 8:00 AM to 8:11 AM during the initial walk through of the Rehab Cottages' kitchen revealed standing water with floating food debris in a reach-in cooler on the bottom shelf. There were no food items stored on that shelf. Observation on 04/09/2025 at 9:02 AM with the CD revealed the standing water remained in the bottom of the reach-in cooler. A cardboard box containing eggs and another cardboard box containing individual cartons of juice were placed on the shelf in the standing water. Interview on 04/09/2025 at 9:02 AM with the CD confirmed the presence of standing water in the reach-in refrigerator and the boxed food items sitting in the water.

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Hillcrest Country Estates-Cottages	6082 Grand Lodge Avenue Papillion, NE 68133

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Licensure Reference Number 175 NAC 12-006.04(B)(ii)(1) Based on interview and record review the facility failed to ensure nursing assistants received annual abuse and dementia training for 5 of 5 employee files reviewed. The facility census was 47. The findings are: Record review of Nurse Tech (NT) A's employee file revealed a hire date of 04-04-2024 and the absence of annual abuse and dementia training. Record review of NT B's employee file revealed a hire date of 06-27-2022 and the absence of annual abuse and dementia training. Record review of NT C's employee file revealed a hire date of 04-10-2023 and the absence of annual abuse and dementia training. Record review of NT D's employee file revealed a hire date of 02-12-2024 and the absence of annual abuse and dementia training. Record review of NT E's employee file revealed a hire date of 06-13-2022 and the absence of annual abuse and dementia training. An interview conducted with the Regional Nurse Consultant (RNC) on 04-08-2025 at 3:25 PM confirmed NT A and NT B did not complete annual abuse training and NT A, B, C, D and E did not complete annual dementia training. Record review of the facility policy titled Hillcrest Health Services Inservice Education Policy dated 11-20-2017 revealed a policy statement of Hillcrest Country Estates will hold in services for all Team Members to attend. In-services are conducted in order to increase a Team Member's knowledge of the job-related skills as well as provide internal information regarding changes, within the organization, department or industry. Attending in-services is a Hillcrest Country Estates expectation in order to provide and ensure our guest's the highest quality of care and service. Also included in the policy under Procedures #2 revealed all team members must attend or complete on Hillcrest University the following mandatory in-services yearly: -guest rights - abuse and neglect -dementia behavior management -emergency preparedness- tornado, fire, evacuation. -safety accident prevention (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285293	A. Building B. Wing	04/14/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-infection and exposure control -annual competencies by department -safety data sheets-use of chemicals