STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295073	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Springs Healthcare and Rehab	8501 Del Webb Blvd Las Vegas, NV 89134

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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on interview and document review, the facility failed to ensure annual dementia training was provided to 3 of 11 employees reviewed (Employee 1, 2 and 13). The deficient practice placed residents with dementia at risk for receiving inappropriate care. Findings include:The Facility Assessment, dated 02/2026, documented training for care management for persons with dementia would occur upon hire and annually.On 03/13/2026 at 7:50 AM, the Director of Staff Development (DSD) explained annual trainings were scheduled and tracked to ensure completion.On 03/13/2026 at 7:57 AM, personnel records revealed Employee 1, 2, and 13 had not completed annual dementia training.Employee 1 was hired on 08/17/2021 as the Administrator. The Administrator completed dementia training on 01/27/2025.Employee 2 was hired on 09/14/2001 as the Director of Nursing (DON). The DON completed dementia training on 01/27/2025.Employee 13 was hired on 10/30/2019 as the Infection Preventionist (IP). The IP completed dementia training on 01/09/2025.On 03/13/2026 at 8:12 AM, the DSD confirmed Employees 1,2, and 13 had not completed the annual dementia training. The DSD explained the training was expected to be completed annually and staff needed to be aware of the need to complete required training.On 03/13/2026 at 11:30 AM, the Administrator explained the expectation was for dementia training to be completed timely and completed annually. The facility policy titled Dementia Training, revised 03/2026, documented all facility employees must complete at least three hours of continuing education in dementia care annually.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to develop and implement a comprehensive care plan for the use of an electronic communication device (a camera) for audio and video recording for 1 of 40 sampled residents (Resident 7). The deficient practice placed residents, staff, and visitors at risk for violations of privacy, dignity, and confidentiality.Findings include:Resident 7 (R7) was admitted [DATE], readmitted [DATE], with diagnosis including acute respiratory failure with hypoxia, other symptoms and signs involving cognitive functions following cerebral infarction, and chronic pain syndrome.On 03/10/2026 in the morning, R7 was observed lying in bed with eyes open, with their body in a contorted position. A camera was installed on the wall opposite R7's bed, positioned above eye level. A posted sign indicated an electronic communication device was in use and may record audio and or video at all times. A roommate was present in R7's room. On 03/11/2026 at 1:43 PM, the Director of Nursing, DON explained R7's family was involved in R7's care and requested a camera be installed in R7's room. The DON confirmed a camera was present in R7's room and was actively recording audio and video. The DON stated R7's family continuously monitored the audio and video from the camera.An Interdisciplinary Care Plan Conference dated 09/30/2024, documented a care conference was held regarding the installation of a monitoring device in the shared resident room in accordance with the law.A Care Plan dated 02/10/2026 lacked documented evidence a care plan was developed for the use of the camera. On 03/11/2026 at 3:30 PM, the Director of Nursing (DON), confirmed R7's care plan lacked documented evidence a care plan had been developed for the use of the camera.A facility policy titled Care Plans, Comprehensive Person-Centered Revised December 2016 documented the Interdisciplinary Team, in conjunction with the resident and the family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.Resident 7 (R7)R7 was admitted [DATE], readmitted [DATE], with diagnosis including acute respiratory failure with hypoxia, other symptoms and signs involving cognitive functions following cerebral infarction, and chronic pain syndrome.On 03/10/2026 in the morning, R7 was observed lying in bed with eyes open, with the body in a contorted position. A [NAME] was observed installed on the wall opposite the R7's bed, positioned above eye level. A posted sign indicated an electronic communication device was in use in the room and may record audio and or video at all times. A roommate was present in R7's room. 03/11/2026 at 1:43 PM, the Director of Nursing, DON explained R7's family was involved in R7's care and requested a [NAME] be installed in R7's room. The DON confirmed a [NAME] was present in R7's room and was actively recording audio and video. The DON stated R7's family continuously monitored the audio and video from the [NAME]. An Interdisciplinary Care Plan Conference dated 09/30/2024, documented a care conference was held regarding the installation of a monitoring device in the shared resident room in accordance with the law. A Care Plan dated 02/10/2026 lacked documented evidence a care plan was developed for the use of the electronic communication device ([NAME]). On 03/11/2026 at 3:30 PM, the Director of Nursing (DON), confirmed R7's care plan lacked documented evidence a care plan had been developed for the use of the electronic communication device ([NAME]). The DON acknowledged a care plan should have been developed for the [NAME] to ensure staff awareness of recording, including the development of goals and interventions, such as the need for signage to be posted.A facility policy titled Care Plans, Comprehensive Person-Centered Revised December 2016 documented the Interdisciplinary Team, in conjunction with the resident and the family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to revise the comprehensive care plan when modifications were made to a resident's nephrostomy tube for 1 of 40 sampled residents (Resident 29) and when a resident returned from the hospital under hospice care with a change in code status for 1 of 40 sampled residents (Resident 227). The deficient practice had the potential to negatively impact on the quality of care the residents received.Findings include: Resident 29 (R29) was admitted on [DATE] and readmitted on [DATE], with diagnoses including hydronephrosis with renal and ureteral calculus obstruction, encounter to nephrostomy and other artificial openings of urinary tract.A care plan initiated 02/15/2025, revealed R29 was admitted with bilateral nephrostomy tubes with a goal of having no signs and symptoms of infection by checking tubing for kinks, monitoring and recording output, monitoring discomfort and notifying physician if no urine output.A hospital Discharge summary dated [DATE], revealed R29 was admitted with bilateral nephrostomy tubes and the left nephrostomy tube was exchanged with a stent by interventional radiology. R29 to return to skilled nursing facility with a right-sided nephrostomy tube. The medical record lacked documented evidence R29's care plan was updated to reflect removal of left nephrostomy tube.On 03/11/2026 at 2:52 PM, the Unit Manager indicated R29's care plan for nephrostomy was not updated when R29 returned with only one nephrostomy tube. The Unit Manager indicated this would have been a good time to review R29's care plan to identify and include interventions which were lacking such as cleansing site with normal saline and changing dressing every one to three days per facility policy.Resident 227 (R227) was admitted on [DATE] and readmitted on [DATE], with diagnoses including malignant neoplasm of the bronchus or lung. A physician's order for life-sustaining treatment (POLST) dated 12/19/2025, revealed R227 did not have decisional capacity and a family member elected full code or attempt resuscitation in the event of cardiopulmonary arrest.A History and Physical dated 01/01/2026, revealed R227 returned to the facility on [DATE] following hospitalization for acute chronic hypoxic respiratory failure. The physician previously discussed hospice which the resident and family declined. After being medically stabilized at the hospital, R227 returned to the skilled nursing facility under hospice care.A hospice do not resuscitate (DNR) election form dated 12/29/2025, revealed R227's family member agreed to allow natural death do not perform medical procedure to try to restart heart.The medical record lacked documented evidence R227's comprehensive care plan was updated to reflect R227's hospice status and R227's change in code status.On 03/13/2026 at 11:06 AM, the Director of Nursing (DON) confirmed R227's comprehensive care plan was not updated to reflect changes in the resident's condition specifically code status from full code to DNR and hospice election while at hospital. The facility's Comprehensive Person-Centered Care Plan policy revised December 2016 revealed assessments of residents were ongoing and care plans were revised as information regarding the residents and the residents' condition changed.Complaint 272374

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure documentation of care pertaining to a nephrostomy catheter site, suprapubic catheter site and Foley catheter site were factual and aligned with actual care provided for 1 of 40 sampled residents (Resident 29). The deficient practice placed residents at risk for receiving substandard quality of care.Findings include:Resident 29 (R29) was admitted on [DATE] and readmitted on [DATE], with diagnoses including hydronephrosis with renal and ureteral calculus obstruction, encounter to nephrostomy catheter and other artificial openings of urinary tract.On 03/11/2026 at 9:40 AM, a licensed practical nurse (LPN) lifted R29's gown which revealed R29 had a suprapubic catheter (a thin, indwelling tube inserted through the lower abdomen into the bladder to drain urine) on left lower quadrant of the abdomen. The LPN used fingers to open abdominal fold and described the insertion site as not clean, had white build up, and no dressing. R29 was asked when the last time a staff member cleaned the catheter site. R29 responded, Never. No one comes to clean it!On 03/11/2026 at 9:43 AM, a certified nursing assistant (CNA) pulled R29's gown from behind which revealed a right-sided nephrostomy site covered in dressing dated 03/03. The CNA and LPN described the dressing as appearing old, coming loose having a brown stain at the center which maybe blood or Betadine. R29 was asked the last time staff provided care to the nephrostomy. R29 responded, no one comes. The LPN attempted to remove the dressing to assess the site, but it was stuck to the site and difficult to remove. The LPN indicated needing to get supplies to change the dressing.A physician order dated 02/10/2026, documented to cleanse suprapubic catheter with soap and water every shift.A physician order dated 02/10/2026, documented to cleanse nephrostomy tube catheter site with soap and water every shift.A physician order dated 02/10/2026, documented to cleanse Foley catheter site with soap and water every shift.The medication administration record (MAR) for March 2026, revealed staff signed off on cleansing R29's nephrostomy site, suprapubic catheter site and Foley catheter site with soap and water every shift. On 03/11/2026 at 10:00 AM, the LPN reviewed R29's MAR for March 2026 and confirmed the LPN had signed off on cleansing tasks for R29's nephrostomy, suprapubic and Foley catheter site with soap and water every shift without performing the tasks on 03/03/2026, 03/04/2026, 03/05/2026, 03/10/2026 and 03/11/2026. The LPN indicated not being aware of dressing change protocols for suprapubic catheters and nephrostomy tubes. The LPN confirmed R29 did not have a Foley catheter.On 03/11/2026 at 10:11 AM, the CNA steadily assigned to R29 indicated not being responsible for cleansing of R29's nephrostomy and suprapubic catheter insertion site because it was the duty of the nurse since it was the expectation the nurses would assess the site during the task.On 03/11/2026 at 10:29 AM, the Unit Manager indicated it appeared the MAR was signed off mechanically since R29 did not have a Foley catheter and the LPN had already admitted signing off on cleansing tasks for R29's nephrostomy and suprapubic catheter site without performing the care.On 03/11/2026 at 1:25 PM, the Director of Nursing (DON) indicated nephrostomy site care should be done daily. The DON indicated when a resident was admitted with a nephrostomy the admitting nurse must enter care orders to include cleansing of the site and dressing change to reflect time of last care.On 03/11/2026 at 1:27 PM, the DON indicated suprapubic catheter site should be assessed and cleaned with soap and water daily. The DON indicated nurses should not have been signing for cleansing tasks which were confirmed to have not been performed as this was a disservice to the residents who were placed at a higher risk for recurrent UTI.On 03/11/2026 at 1:29 PM, the DON indicated nurses who signed off on Foley care were not paying attention and this reflected mechanical documentation since R29 did not even have a Foley catheter.The facility's Documentation Standards of Nursing Practice (undated), documented Center for Medicare and Medicaid Services (CMS) standards and guidelines for MAR charting stated documentation must be accurate, truthful, comprehensive, timely and aligned with actual care provided. Accuracy of documentation ensured safe patient outcomes.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure physician orders coincided with the documented treatment preferences as indicated on the Physician Order for Life Sustaining Treatment (POLST) form for 1 of 40 sampled residents, (Resident 32). The deficient practice had the potential for residents to receive medical interventions inconsistent with expressed wishes regarding life sustaining treatment. Findings include: Resident 32 (R32) was admitted on [DATE] with diagnoses including unspecified dementia with psychotic disturbance, Alzheimer's disease, and chronic kidney disease. A physician order dated 03/27/2025 documented Do Not Resuscitate (DNR). The POLST dated 09/07/2025 documented R32 was a Full Code, resident lacks decisional capacity. The POLST was signed by the physician and R32's family member. On 03/11/2026 at 10:50 AM, a Unit Manager explained the process for obtaining a resident code status was to explain Full Code versus DNR if resident was alert, if the resident was not alert the staff contacted the resident's representative. Once code status was verified a physician order would be entered and the POLST form filled out for the physician to sign. During an event requiring life sustaining treatment staff would obtain the POLST to confirm the resident's code status.The Unit Manager reviewed R32's POLST and physician orders and confirmed documented treatment preferences did not match. The Unit Manager explained the POLST and Physician orders needed to match. The Unit Manger was unable to determine R32's correct code status based on the conflicting orders. On 03/12/2026 at 9:35 AM, the Director of Social Services (SSD) explained the role of the social services for verifying advance directives and code status was to discuss with resident, responsible party, or Power of Attorney (POA) every three months regarding resident life sustaining treatment wish to ensure if any changes needed to be made. The SSD explained R32's family was responsible for making decisions. The SSD was unaware of any changes made to R32's code status. The SSD reviewed R32's medical record and confirmed no documented evidence of any conversation with family regarding code status since admission on [DATE]. On 03/12/2026 at 10:53 AM, the Director or Nursing (DON) explained the POLST was part of the admission packet and completed upon admission and a physician's order was to correspond with the POLST.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure admission care orders which were transcribed into the medical record for a resident's nephrostomy tube, suprapubic catheter and Foley catheter were accurate, complete and were in accordance with facility policy and documented care for the resident's nephrostomy tube and suprapubic catheter aligned with actual care provided for 1 of 40 sampled residents (Resident 29). The deficient practice placed the resident at risk for recurrent urinary tract infection (UTI).Findings include: Resident 29 (R29) was admitted on [DATE] and readmitted on [DATE], with diagnoses including hydronephrosis with renal and ureteral calculus obstruction, encounter to nephrostomy catheter and other artificial openings of urinary tract.On 03/11/2026 at 9:35 AM, R29 laid alert in specialty bed and permitted a surveyor to be present for site assessment of their suprapubic catheter and nephrostomy tube. The Licensed Practical Nurse (LPN) assigned to R29 stood on left side of the bed while a certified nursing assistant (CNA) stood on right side of the bed. On 03/11/2026 at 9:40 AM, the LPN liftedR29's gown which revealed R29 did not have a Foley catheter but rather a suprapubic catheter (a thin, indwelling tube inserted through the lower abdomen into the bladder to drain urine) on left lower quadrant of the abdomen. The LPN used fingers to open abdominal fold and described the insertion site as not clean, had white build up, and no dressing. R29 was asked when a staff member cleaned the catheter site, R29 responded, Never. No one comes to clean it The LPN described the urine which was draining into the bag to be yellow with sediments.On 03/11/2026 at 9:43 AM, the CNA pulled R29's gown from behind which revealed a right-sided nephrostomy site covered in dressing dated 03/03. The CNA and LPN described the dressing as appearing old, coming loose having a brown stain at the center which could either be old blood or Betadine. R29 was asked the last time staff provided care to the nephrostomy. R29 responded, no one comes. The LPN attempted to remove the dressing to assess the site, but it was stuck to the site and difficult to remove. The LPN indicated needing to get supplies to change the dressing. The CNA indicated not being assigned to R29 and could not speak to care of the resident's suprapubic catheter and nephrostomy.The admission minimum data set (MDS) dated [DATE], documented R29 was admitted with an indwelling catheter (including suprapubic catheter and nephrostomy tube) and active diagnoses including renal insufficiency, obstructive uropathy and urinary tract infection (UTI) in the last 30 days.A physician order dated 02/10/2026, documented to cleanse suprapubic catheter with soap and water every shift.A physician order dated 02/10/2026, documented to cleanse nephrostomy tube catheter site with soap and water every shift.A physician order dated 02/10/2026, documented to cleanse Foley catheter site with soap and water every shift. The medical record lacked documented evidence orders for dressing change were entered or carried out for R29's nephrostomy tube and suprapubic catheter.The medication administration record (MAR) for March 2026, revealed staff signed off on cleansing of R29's nephrostomy site, suprapubic catheter site and non-existent Foley catheter site with soap and water every shift. On 03/11/2026 at 10:00 AM, the LPN reviewed R29's MAR for March 2026 and confirmed the LPN had signed off on cleansing tasks for R29's nephrostomy and suprapubic catheter site with soap and water every shift without performing the tasks on 03/03/2026, 03/04/2026, 03/05/2026, 03/10/2026 and 03/11/2026. The LPN indicated not being aware of dressing change protocols for suprapubic catheters and nephrostomy tubes. The LPN acknowledged signing off for Foley catheter site care when R29 did not have a Foley catheter. On 03/11/2026 at 10:11 AM, the CNA steadily assigned to R29 indicated not being responsible for cleansing of R29's nephrostomy and suprapubic catheter insertion site because it was the duty of the nurse since it was the expectation the nurses assess the site during the task.On 03/11/2026 at 10:29 AM, the Unit Manager reviewed R29's medical record and confirmed orders for dressing changes for R29's nephrostomy and suprapubic catheter (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sites were not entered and were required to reflect time of last care. The Unit Manager indicated it appeared the MAR was signed off mechanically since R29 did not have a Foley catheter and the LPN had already admitted signing off cleansing tasks for R29's nephrostomy and suprapubic catheter site.On 03/11/2026 at 1:25 PM, the Director of Nursing (DON) indicated nephrostomy site care should be done daily. The DON indicated when a resident was admitted with a nephrostomy the admitting nurse must enter care orders to include cleansing of the site and dressing change to reflect time of last care. On 03/11/2026 at 1:27 PM, the DON indicated suprapubic catheter site should be assessed and cleaned with soap and water daily. The DON indicated nurses should not have been signing for cleansing tasks which was confirmed to have not been performed as this was a disservice to the resident who was placed at a higher risk for recurrent UTI.On 03/11/2026 at 1:29 PM, the DON indicated nurses who were signing off on Foley care reflected mechanical documentation since R29 did not even have a Foley catheter.The facility's Care of Nephrostomy Tube policy revised October 2010 documented the purpose of the policy was to provide guidelines for care of percutaneous nephrostomy tube. Verifying a physician's order was in place for the procedure. Review the resident's care plan to assess any special needs for the resident. Change dressing every one to three days, observe for skin breakdown, infection or drainage. Place sterile drain dressings and secure with adhesive tape. Document date and time procedure was performed, resident response, any assessment data, to report abnormal findings.The facility's Use of Indwelling Catheter policy revised September 2010 revealed routine meatal (the urethral opening or surrounding area of an indwelling catheter) care was performed with soap and water on a daily basis and as needed.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure head of bed (HOB) was elevated during tube feeding infusion in accordance with the facility policy for 2 of 40 sampled residents (Resident 53 and 176). The deficient practice placed residents receiving tube feeding at risk for aspiration.Findings include:Resident 53 (R53) was admitted [DATE], with diagnoses including nontraumatic intracranial hemorrhage and gastrostomy status. The quarterly minimum data set (MDS) dated [DATE], revealed R53 had moderately impaired cognition and was receiving nutritional by enteral means. On 03/10/2026 at 9:39 AM, R53 laid awake in low bed with Jevity 1.2 infusing by tube feeding pump at 80 milliliters per hour (ml/per). R53's HOB appeared flat to approximately 10 degrees. On 03/10/2026 at 9:47 AM, a charge nurse entered R53's room and confirmed tube feeding was running and would be turned off at 10:00 AM. The charge nurse confirmed R53's HOB was flat up to approximately 10 degrees. On 03/11/2026 at 9:22 AM, R53 laid in bed awake while tube feeding was infusing at 80 cc/hr. R53's HOB was elevated approximately 15 to 20 degrees. On 03/11/2026 at 9:24 AM, a Licensed Practical Nurse assigned to R53 confirmed R53's HOB was less than 30 degrees. On 03/13/2026 at 9:25 AM, a Certified Nursing Assistant (CNA) assigned to R53 entered the room with this surveyor. R53's tube feeding was infusing at 80 ml/hr; the CNA described R53's HOB as flat. On 03/13/2026 at 9:38 AM, the Unit Manager indicated the facility protocol was to keep HOB between 30 to 45 degrees during tube feeding infusion and up to one hour after to prevent aspiration. Resident 176 (R176) was admitted [DATE], readmitted [DATE], with diagnosis including cerebral palsy, dependence on respirator (ventilator status), and dysphagia oropharyngeal phase. On 03/10/2026 at 8:30 AM, R176 was lying in bed with eyes closed, with the torso and face turned toward the right in a contorted position. R176's head of the bed (HOB) was observed in a flat position (not elevated), while the enteral feeding pump was running with Jevity 1.2 (a feeding formula) at a rate of 65 milliliters per hour. A Care Plan dated 01/29/2026, documented R176 required tube feeding related to dysphagia. Goals included R176 would remain free of aspiration, side effects, and complications related to tube feeding. Interventions included maintaining the head of the bed elevated at 30 to 45 degrees during enteral feeding and for 30 minutes after feeding. A physician order dated 04/18/2025, documented to elevate HOB 30 to 45 degrees during and one hour after feeding. On 03/10/2026 at 8:37 AM, a Registered Nurse (RN), confirmed R176's HOB was flat while the enteral (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	feeding pump was running. The RN reported the HOB was lowered to help R176 sleep. The RN explained the HOB should not have been flat during enteral feeding and should have been maintained at 45 degrees. The RN acknowledged R176 should not have been left in a flat position at any time during feeding to prevent aspiration and vomiting. On 03/11/2026 at 1:43 PM, the Director of Nursing (DON), confirmed the HOB should have been maintained elevated at a minimum of 30 degrees during enteral feeding and for 1 hour after feeding to prevent aspiration. The DON explained if a resident had been identified to benefit from a lower degree of HOB elevation, a new physician order and corresponding care plan update would have been required. A facility policy titled Enteral Feedings-Safety Precautions, revised November 2018, documented to elevate the HOB at least 30 degrees during tube feeding and at least one hour after feeding. If elevating the HOB was medically contraindicated, use the reverse Trendelenburg position.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure psychotropic medication and opioid side effects were monitored for 2 of 40 sampled residents (Residents 7 and 64). The deficient practice had the potential to place residents at risk for experiencing adverse effects of medications. Findings include: Resident 64 (R64) was admitted on [DATE] with diagnoses including cerebral infarction, atherosclerotic heart disease of native coronary artery, and chronic obstructive pulmonary disease. On 03/10/2026 at 10:10 AM, R64 was lying supine in bed, eyes fluttering when spoken to, unable to stay awake and head dropping to the left side. On 03/10/2026 at 11:51 AM, a Certified Nurse Assistant (CNA) attempted to wake R64 and verbally encouraged R64 to wake up for food consumption. R64 was lying in bed with eyes closed, not eating. R64 responded to name being spoken by opening eyes and closed eyes again. A care plan dated 02/21/2026 documented R64 had insomnia related to altered sleep pattern as evidenced by need for sleep aid Trazodone. Interventions included to monitor side effects such as daytime drowsiness, dizziness, and orthostatic hypotension. A physician order dated 11/22/2025 documented Trazodone Hydrochloride Tablet 50 MG, give one tablet by mouth at bedtime for insomnia. R64's medical record lacked the monitoring of side effects and hours of sleep for Trazadone. On 03/11/2026 at 10:15 AM, R64 was lying in bed with eyes closed, not responding to knock on the door or call of name. On 03/11/2026 at 10:30 AM, a CNA explained R64 liked to sleep most of the day. On 03/11/2026 at 10:36 AM, a Registered Nurse (RN) explained R64 was sometimes confused with day and night when awakened to take morning medications. The RN explained with medications administered for sleep, the side effects would be monitored and documented on the Medication Administration Record (MAR). The RN reviewed R64's medical record for Trazadone and confirmed R64 had no documented monitoring of side effects. On 03/11/2026 at 10:42 AM, the Unit Manager (UM) explained side effect monitoring was to occur daily and documented on the resident MAR. The UM reviewed R64's medical record and confirmed R64 lacked a physician's order for the monitoring of side effects. Staff had not documented daily monitoring of side effects was completed. On 03/12/2026 at 10:58 AM, the Director of Nursing (DON) explained the expectation for psychotropic medications was for staff to monitor side effects, record findings on MAR, and report to the physician as needed. The DON was unaware staff had not been monitoring for potential side effects of R64's Trazadone use. The DON confirmed excessive sleeping during the day would be a potential side effect of the medication that would need to be assessed. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Psychotropic Drug Treatment, revised 12/2016, documented facility staff would monitor for side effects, reduce dosage to the minimum required and, when possible, discontinue the use of such medications. Resident 7 (R7) R7 was admitted [DATE], readmitted [DATE], with diagnosis including acute respiratory failure with hypoxia, other symptoms and signs involving cognitive functions following cerebral infarction, and chronic pain syndrome. On 03/10/2026 in the morning, R7 was lying in bed with eyes open. R7 was observed restless, exhibiting uncoordinated movements of the arms, noted facial grimacing, and appeared uncomfortable. R7 did not verbally express needs but was able to respond to limited simple yes/no questions by nodding the head. A physician order dated 01/01/2026, documented tramadol HCl (hydrochloride), give 1 tablet via percutaneous endoscopic gastrostomy (PEG)-tube every 6 hours as needed for pain scale 7-10 (intensity of pain on a scale of 0-10). A Care Plan dated 02/26/2026, documented R7 was taking tramadol, an opioid medication, for pain medication therapy. Interventions included to monitor adverse reactions to analgesic therapy including altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritus, respiratory distress/decreased respirations, sedation, and urinary retention. The medical record lacked documented evidence tramadol HCl was monitored for side effects. On 03/13/2026 at 2:05 PM, the Director of Nursing (DON), confirmed R7's medical record lacked documented evidence of side effects monitoring for trazadone. The DON acknowledged trazadone use should have been monitored for side effects to ensure resident was not receiving more dedication than needed. A facility policy titled Medication Utilization and Prescribing – Clinical Protocol revised April 2018, documented the staff and physician will monitor for adverse effects of pain medications such as gastrointestinal bleeding from nonsteroidal anti-inflammatory drugs (NSAIDs), and anorexia, confusion, lethargy, and severe constipation related to opioids.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure 1) multiple medications were not crushed altogether instead of individually and 2) a medication with specific instructions to not crush was crushed and administered as such for one unsampled resident (Resident 217). The deficient practice resulted in a significant medication error and placed the resident at risk for potential adverse effects.Findings include: Resident 217 (R217) was admitted on [DATE] with diagnoses including end stage renal disease and hemiplegia and hemiparesis following cerebral infarction.1) Crushing multiple medications togetherOn 03/11/2026 at 8:20 AM, during a medication pass observation, a Licensed Practical Nurse (LPN) prepared R217's routine medications and dispensed the following into a medication cup:-one Buspirone 5 milligrams (mg) tablet-one Hydralazine 25 mg tablet-one Amlodipine besylate 10 mg tablet-one Vitamin C 500 mg tablet- one Aspirin 81 mg chewable tablet-one Vitamin D 1,000 units tablet-one Divalproex Sodium delayed release (DR) 125 mg tablet-one Colace 200 mg tablet-two Labetalol 200 mg tablets-one Multivitamins with minerals tablet-one Zinc Sulfate 220 mg capsulesOn 03/11/2026 at 8:28 AM, a LPN put one teaspoon of apple sauce inside a medication cup, proceeded to crush R217's medications together using a pill crusher and poured the crushed medications into the medication cup containing apple sauce. The LPN explained R217 did not receive tube feedings and did not have difficulty swallowing. R217 preferred to take medications crushed mixed into apple sauce because there were too many.On 03/11/2026 at 8:35 AM, R217 was eating breakfast waffles when the LPN interrupted the meal for morning medications. R217 ingested the medications without issues.On 03/11/2026 at 8:51 AM, the LPN acknowledged crushing R217's pills together was not in accordance with facility policy. The LPN explained pills were to be crushed separately using individual pouches for more accurate documentation of actual medications administered and to ensure medications which should not be crushed were not crushed.On 03/11/2026 at 9:09 AM, the Unit Manager explained the facility protocol was to crush medications individually in separate pouches so when a medication was refused it would be easy to document accurately in the medical record. According to the Unit Manager, this practice also ensured medications which were on the DO NOT CRUSH list was not crushed. The Unit Manager acknowledged the LPN did not follow facility policy when the LPN crushed twelve pills together before administering them to R217.2) Do not crush medicationA physician order dated 03/10/2025, documented to give Depakote (Divalproex Sodium) DR 125 mg, one tablet by mouth two times a day for agitation and restlessness associated with dementia. An alert drug interaction documented, pharmacologic effects of Depakote DR may be increased by Aspirin.On 03/11/2026 at 12:56 PM, the Director of Nursing (DON) indicated medications which were enteric-coated or delayed-released must not be crushed. The DON read aloud the manufacturer's guide for Divalproex sodium DR which specifically instructed the medication be swallowed whole and must not be crushed. The DON explained medications which came as delayed release were designed to follow a mechanism for timed and steady release. The DON verbalized crushing multiple medications were to be done individually in separate pouches to ensure accurate documentation of administration and/or non-administration and in addition may impact drug-to-drug interactions.The Divalproex DR manufacturer's medication guide revised December 2025, instructed to swallow the medication whole, do not crush or chew. If patient cannot swallow whole, call healthcare provider for new medication. Divalproex DR may affect the way other medicines worked, and other medicines may affect how Divalproex DR worked. Using Divalproex with other medicines can cause serious side effects. Active ingredient: Divalproex sodium as Valproic acid.On 03/12/2026 at 10:31 AM, the Consultant Pharmacist stated Divalproex DR must not be crushed because doing so affected the release mechanism of the drug and crushing the medication would deliver the full dose immediately. The Pharmacist confirmed R217 was receiving Aspirin 81 mg and Divalproex 125 mg and the alert warning meant taking the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications together would potentially increase bleeding risk and at the same time, Aspirin could also increase Valproic acid which increased the risk for seizures. The facility's Crushing medications policy revised March 2026, documented long-acting or enteric-coated dosage forms should not be crushed, an alternative should be sought.The facility's Nursing Professional Standards on Medication Administration - Do not crush medications (undated), revealed best practice included separating crushed medications to ensure accurate dosing. Proper medication preparation and handling were essential. These standards support avoiding unsafe medication alterations, including crushing medications which may alter absorption or efficacy.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 document review, the facility failed to ensure:Open juice containers stored in the nourishment room refrigerator were labeled with an open date and a resident food item stored in the nourishment was labeled with the resident's name and used by date for 3 of 3 nourishment rooms refrigerators inspected.The deficient practice had the potential to increase the risk for foodborne illness.Findings include: On 03/10/2026 at 8:01 AM, 100 Hall nourishment room contained an open one-gallon apple juice container and an opened 3-liter cranberry juice container, which had no labeling.On 03/10/2026 at 8:05 AM, 200 Hall nourishment room contained an open one-gallon apple juice container, a 3-liter cranberry juice container and a resident food item, which had no labeling.On 03/10/2026 at 8:09 AM, 300 Hall nourishment room contained an open one-gallon apple juice container and an opened 3-liter cranberry juice container, which had no labeling.On 03/10/2026 at 8:04 AM, the kitchen team leader stated kitchen staff were responsible for labeling resident beverages stored in the resident refrigerators and should have labeled both containers before placement. The kitchen team leader clarified that resident personal food items were to be labeled by the nursing staff before food items were placed in the refrigerator.On 03/10/2026 at 8:07 AM, a Unit Manager (UM), explained all resident food items were to be labeled before being placed into the resident refrigerator for proper identification.On 03/11/2026 at 2:57 PM, a Unit Manager, (UM1), clarified that nursing staff were responsible for labelling resident food items. UM1 verbalized there were labels in each nourishment room for proper labeling. On 03/11/2026 at 2:52 PM, a Certified Nursing Assistant, (CNA), expressed not knowing that there were labels for residents stored food items.03/11/2026 at 2:59 PM, a Certified Nursing Assistant, (CNA), confirmed the resident food items were not properly labeled and verbalized resident food should be labeled with the resident's name, room number, date stored with an expiration date.The facility policy titled Food Brought by Family/Visitors (undated) documented, food brought by family/visitors left with the resident to consume later will be labeled and stored in a manner clearly distinguishable from facility prepared food.The facility policy, titled Food Receiving and Storage revised October 2017 documented, beverages must be dated when opened and discarded after twenty-four (24) hours. All food items belonging to residents must be labeled with the resident's name, the item and the use by date.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to ensure physician's order for life-sustaining treatment (POLST) was made available to emergency personnel for a hospice resident and failed to maintain hospice paperwork in the facility in accordance with the facility policy and hospice agreement for 1 of 40 sampled residents (Resident 227). The deficient practice resulted in confusion among staff and emergency personnel and placed hospice residents at risk for advanced directives not being honored at end of life.Findings include: Resident 227 (R227) was admitted on [DATE] and readmitted on [DATE], with diagnoses including malignant neoplasm of the bronchus or lung. A POLST dated [DATE], revealed R227 did not have decisional capacity and a family member elected full code or attempt resuscitation in the event of cardiopulmonary arrest.A History and Physical dated [DATE], revealed R227 returned to the facility on [DATE] following hospitalization for acute chronic hypoxic respiratory failure. The physician previously discussed hospice which the resident and family declined. After being medically stabilized at the hospital, R227 returned to the skilled nursing facility under hospice care.A physician order dated [DATE], documented R227 under hospice care with primary diagnosis metastatic lung cancer. A general note dated [DATE], revealed R227 was found unresponsive by a nurse during morning rounds at approximately 6:00 AM. R227's still had vital signs, and hospice was notified of R227 being unresponsive and the facility nurse asked hospice to confirm R227's do not resuscitate (DNR) status. Hospice referred facility nurse to page three of the care plan which stated R227 was a DNR. R227's family was present and started doing compressions on R227 and called emergency services. Emergency services arrived at 10:05 AM and transported R227 to hospital at 10:20 AM.The medical record lacked documented evidence, a DNR POLST, and other hospice paperwork were maintained by the facility and made available to emergency services.On [DATE] at 12:37 AM, a certified nursing assistant (CNA) recalled being assigned to R227 as a sitter on [DATE] but the CNA was pulled away to provide another resident with a shower and could not speak to the event. Upon returning to the room, the CNA indicated R227 had already been sent to the hospital.On [DATE] at 9:03 AM, the Registered Nurse (RN) assigned to R227 on the day of the incident recounted doing morning rounds at start of shift and found R227 unresponsive. The RN indicated R227 appeared peaceful with no distress with presence of vital signs. The RN sought assistance from a Licensed Practical Nurse (LPN) to contact the hospice provider and R227's family. The RN recalled R227 did not have a DNR POLST in the hospice binder and the hospice provider was only able to provide a DNR election form which took a while to be received by the facility. The RN recounted the family had panicked over the resident's unresponsive state and began doing compressions while another family member called 911. The RN confirmed emergency personnel were requesting to see hospice documents and R227's DNR POLST but the facility was unable to provide this which led to the resident being transported to the hospital.On [DATE] at 9:21 AM, the Unit Manager indicated being off duty on [DATE] but was constantly receiving updates on R227's situation. R227 confirmed there was no DNR POLST in the hospice binder and hospice personnel faxed a DNR hospice election form which was signed by R227's family member and did not have a physician's signature. The Unit Manager indicated the facility was informed R227 expired shortly after arriving at the hospital. On [DATE] at 10:53 AM, an attempt to contact the hospice provider was unsuccessful.The hospice program policy dated revised [DATE], documented it was the responsibility of the facility to obtain and maintain the following information from hospice:- most recent care plan including advanced directives- hospice election form- physician certification of terminal illness/recertification- names and contact information of hospice personnel- instructions on how to access hospice's 24-hour on call system- hospice medications- hospice physician other ordersOn [DATE] at 10:53 AM, the Director of Nursing (DON) reviewed R227's medical record and (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated R227 was initially admitted on [DATE] as a full code and not a hospice resident. According to the DON, R227 was transferred to the hospital on [DATE] and returned to the facility on [DATE] under hospice care. The DON reviewed R227's hospice book and confirmed the following required information was missing namely, the hospice election form, physician certification for terminal illness, advanced directives to include a POLST reflecting DNR status. A hospice DNR election form dated [DATE], revealed R227's family member agreed to allow natural death do not perform medical procedure to try to restart heart.On [DATE] at 11:02 AM, the DON indicated the hospice provider who had oversight of R227 was responsible for completing a DNR POLST from R227's family member and clarified a DNR hospice election form was not an acceptable substitute in this state because the election form lacked a physician's order.The hospice agreement dated [DATE], documented when a resident admits into hospice, the hospice program, hospice and facility jointly developed and agreed on a hospice plan of care. Hospice and facility shall maintain a copy of each resident's hospice plan of care in the respective clinical records by each party. Coordinated care plans for residents receiving hospice services would include care and services to include advanced directives. Complaint 272374