STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295079	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Health and Rehabilitation	201 Koontz Lane Carson City, NV 89701

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident was treated with respect and dignity when staff members discussed another resident's preferences while performing a resident's wound care for 1 of 26 sampled residents (Resident #2). This deficient practice had the potential to result in a resident experiencing feelings of diminished self-worth due to staff members engaging in a conversation about another resident, which excluded Resident #2, while providing wound care to the resident.Findings include:Resident #2Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including pressure ulcer of sacral region, stage four and major depressive disorder, recurrent, unspecified.On 01/14/2026 at 1:14 PM, a surveyor observed a Registered Nurse (RN) performing a dressing change on Resident #2's pressure ulcer with the assistance of a Licensed Practical Nurse (LPN). The RN and the LPN were standing on either side of Resident #2. The RN began discussing how a type of medical equipment was beneficial for a different resident. On 01/14/2026 at 3:15 PM, the Director of Nursing (DON) and the Administrator verbalized staff should not have been speaking over the resident about a different resident. The DON verbalized the staff discussing a situation with a different resident while providing treatment for Resident #2 would not be dignified treatment of the resident. The facility policy titled Notice of Resident Rights Under Federal Law, updated 11/2016, documented the resident had the right to be treated with respect and dignity.

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and document review, the facility failed to ensure a resident was free from misappropriation of personal property when the volume of liquid Morphine Sulfate remaining in a medication bottle did not match the facility's narcotic count in a narcotic logbook for 1 of 5 unsampled residents' records reviewed for compliance with medication storage and administration (Resident #24). This deficient practice had the potential to result in the resident not having an adequate amount of Morphine available to treat the resident's pain.Findings include:Resident #24Resident #24 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Alzheimer's disease with late onset and low back pain, unspecified.A Physician's Order dated 03/01/2025, documented Morphine Sulfate oral solution 100 milligrams (mg)/ 5 milliliters (ml), give 0.25 ml by mouth every four hours as needed for pain or shortness of breath.On 01/15/2026 at 10:17 AM, during an inspection of the station 1C medication storage cart, a Licensed Practical Nurse (LPN) verbalized all controlled substances were counted at change of shift. Two nurses counted the total number of cards/bottles in the cart as well as the total number of tablets or amount of liquid medication remaining and verified the counts matched the narcotic logbook. If a discrepancy was identified, the nurse was to notify the Director of Nursing (DON) immediately.A bottle of liquid Morphine Sulfate with 24 ml of medication remaining in the bottle was found in the medication storage cart. The label on the bottle documented it belonged to Resident #24. A narcotic count sheet in the facility's narcotic logbook documented the bottle had 24.75 ml of Morphine Sulfate remaining.The LPN confirmed the amount of medication in the bottle was less than the quantity remaining listed on the narcotic count sheet and confirmed the LPN had completed a count of all controlled substances on the cart at the beginning of the LPN's shift.On 01/15/2026 at 10:36 AM, the DON reviewed the narcotic count sheet and confirmed the count sheet documented Resident #24's bottle of Morphine Sulfate should have had 24.75 ml remaining inside. The DON placed the bottle of Morphine Sulfate on top of the medication cart and confirmed the amount remaining in the bottle was 24 ml. The DON verbalized the DON would begin investigating the discrepancy.On 01/15/2026 at approximately 11:45 AM, the DON explained the DON had reviewed Resident #24's record and found one dose of Morphine Sulfate administered in March 2025 was not documented on the narcotic count sheet. The DON confirmed the undocumented dose accounted 0.25 ml of medication and denied the DON could find any documentation to account for the additional 0.5 ml of missing Morphine Sulfate.The DON confirmed the facility's process for narcotic inventory included documenting each administered dose on the narcotic count sheet including the amount remaining in the bottle/card and two nurses were to count the number of total cards/bottles in the cart as well as the amount of tablets/liquid remaining and ensure the counts matched. Both nurses were to sign the logbook after completing the counts and confirming there were no discrepancies. The facility did not have a formal process for oversight and frequency of auditing narcotic inventory practices amongst staff.On 01/15/2026 at 12:20 PM, the Administrator verbalized the discrepancy in Resident #24's Morphine Sulfate was being investigated for misappropriation of resident property and possible neglect.On 01/15/2026 at 1:03 PM, the Administrator verbalized when there was suspicion or an allegation of misappropriation of resident property the facility's process included implementing an immediate action to keep the resident safe, submitting an initial report to the State Agency and reporting to law enforcement if necessary. If the alleged perpetrator was a staff member, the facility would suspend the employee immediately and the Administrator would proceed with an investigation.The Administrator verbalized after interviewing the LPN, it was determined the LPN did not use correct technique when completing the counts of controlled substances in the medication cart the morning of 01/15/2026. The LPN denied the LPN placed the bottle of Morphine Sulfate on a flat surface prior to determining the volume inside. The Administrator verbalized a competency checklist used for training (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of nursing staff included use of the facility's narcotic logbook, however; the facility did not have training or documentation of staff's competency specific to measurement of liquid medications. The Administrator explained the narcotic logbook was recently added to the competency checklist and the Administrator was not sure if the facility had documentation of the logbook being included in the LPN's training as the LPN was hired prior to the change made to the list.The facility did not have a policy related to tracking of narcotics. The facility policy titled Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation, updated 03/2025, documented misappropriation of resident property was the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of resident's belongings or money without the resident's consent. Examples of misappropriation of resident property and exploitation which must be reported included missing prescription medications or diversion of a resident's medications, including but not limited to, controlled substances for staff use or personal gain.Cross Reference tag F607

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and document review, the facility failed to ensure the facility's policies related to misappropriation of resident property, abuse, and neglect were implemented timely for an allegation of misappropriation of resident property and neglect. This deficient practice resulted in delayed removal of an alleged perpetrator from resident care and access to residents' medications, placing all residents at risk for misappropriation of property and neglect.Findings include:Resident #24Resident #24 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Alzheimer's disease with late onset and low back pain, unspecified.A Physician's Order dated 03/01/2025, documented Morphine Sulfate oral solution 100 milligrams (mg)/ 5 milliliters (ml), give 0.25 ml by mouth every four hours as needed for pain or shortness of breath.On 01/15/2026 at 10:17 AM, during an inspection of the station 1C medication storage cart, a Licensed Practical Nurse (LPN) verbalized all controlled substances were counted at change of shift. Two nurses counted the total number of cards/bottles in the cart as well as the total number of tablets or amount of liquid medication remaining and verified the counts matched the narcotic logbook. If a discrepancy was identified, the nurse was to notify the Director of Nursing (DON) immediately.A bottle of liquid Morphine Sulfate with 24 ml of medication remaining in the bottle was found in the medication storage cart. The label on the bottle documented it belonged to Resident #24. A narcotic count sheet in the facility's narcotic logbook documented the bottle had 24.75 ml of Morphine Sulfate remaining. The LPN confirmed the amount of medication in the bottle was less than the quantity remaining listed on the narcotic count sheet.On 01/15/2026 at 10:36 AM, the DON reviewed the narcotic count sheet and confirmed the count sheet documented Resident #24 should have had 24.75 ml of Morphine Sulfate remaining in the bottle. The DON placed the bottle of Morphine Sulfate on top of the medication cart and confirmed the amount remaining in the bottle was 24 ml. The DON verbalized the DON would begin investigating the discrepancy.On 01/15/2026 at approximately 11:45 AM, the DON explained the DON had reviewed Resident #24's record and found one dose of Morphine Sulfate administered in March 2025 was not documented on the narcotic count sheet. The DON confirmed the undocumented dose accounted 0.25 ml of medication and denied the DON could find any documentation accounting for the additional 0.5 ml of missing Morphine Sulfate.The DON confirmed the facility's process for narcotic inventory included documenting each administered dose on the narcotic count sheet including the amount remaining in the bottle/card and two nurses were to count the number of total cards/bottles in the cart as well as the amount of tablets/liquid remaining and ensure the counts matched. Both nurses were to sign the logbook after completing the counts and confirming there were no discrepancies.On 01/15/2026 at 11:59 AM, the LPN remained on the unit and continued to have possession of the keys to the medication storage cart, including a key to the drawer containing controlled substances.On 01/15/2026 at 12:20 PM, the Administrator verbalized the discrepancy in Resident #24's Morphine Sulfate was being investigated for misappropriation of resident property and possible neglect. The Administrator explained the facility's corporate leadership had instructed the Administrator to suspend the LPN, however; the Administrator hadn't gotten to the suspension yet.On 01/15/2026 at 12:39 PM, the LPN remained working on the unit.On 01/15/2026 at 1:03 PM, the Administrator verbalized when there was suspicion or an allegation of misappropriation of resident property the facility's process included implementing an immediate action to keep the resident safe, submitting an initial report to the State Agency and reporting to law enforcement if necessary. If the alleged perpetrator was a staff member, the facility would suspend the employee immediately and the Administrator would proceed with an investigation.The Administrator verbalized the Administrator was notified of the discrepancy in Resident #24's Morphine Sulfate just before 11:00 AM, approximately 20 minutes after the discrepancy was confirmed by the DON. The LPN was currently completing a count of the controlled substances on the medication cart with another nurse, (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the LPN was being suspended. The Administrator confirmed the LPN was not suspended and removed from resident care areas immediately following the identification of the discrepancy and the DON's inability to account for the discrepancy.The facility policy titled Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation, updated 03/2025, documented misappropriation of resident property was the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of resident's belongings or money without the resident's consent.The facility policy titled Abuse Investigation, updated 10/2022, documented the facility would conduct a thorough investigation of potential, suspected, and/or allegations of abuse, neglect, and exploitation of residents and misappropriation of resident property. The facility would protect the alleged victim during and after the course of the investigation, refer to Abuse Protection policy.The facility policy titled Abuse Protection, updated 10/2022, documented the facility would protect residents from physical and psychosocial harm during and after an investigation. The facility would respond immediately to suspicion and/or allegations of abuse, neglect, and misappropriation of resident property in order to protect the alleged victim and integrity of the investigation. The facility would suspend and/or remove the alleged perpetrator from resident care areas immediately. Cross reference tag F602

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interview and document review, the facility failed to ensure the accuracy of a Minimum Data Set 3.0 (MDS) assessment for 1 of 26 sampled residents (Resident #74). This deficient practice had the potential to deprive the resident of a person-centered care plan and the associated interventions relative to their current health management needs.Findings include: Resident #74 Resident #74 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of dysphagia following cerebral infarction, conversion disorder with seizures or convulsions, and epilepsy, unspecified. Resident #74's weight measurements dated 01/13/2025 documented 107.0 pounds, 02/17/2025, 102.0 pounds, and 03/17/2025, 99.0 pounds. A physician progress note dated 02/02/2025, documented dysphagia following cerebral infarction, abnormal weight loss, started on Mirtazapine 7.5 milligrams (mg) at bedtime, weekly weights, monitor oral intake, registered dietitian to follow up. A Clinically Unavoidable Review and Acknowledgment for Weight Loss, signed by the provider on 03/11/2025, documented the resident's weight loss was unavoidable related to neurological disease. A physician progress note dated 03/24/2025, documented abnormal weight loss, eight-pound weight loss from January to March 2025, continue mirtazapine, followed by nutritionist. Resident #74's annual MDS assessment dated [DATE], section K0300, Weight Loss: Loss of 5 percent or more in the last month or loss of 10 percent or more in last 6 months, documented, yes, the resident was on a prescribed weight-loss regimen. On 01/15/2026 at 1:40 PM, the Director of Nursing confirmed Resident #74 had a diagnosis of dysphagia following cerebral infarction and had not been on a prescribed weight loss program. On 01/15/2026 at 1:51 PM, the MDS Licensed Practical Nurse (MDS-LPN), confirmed the coding for Resident #74's annual assessment dated [DATE], section K0300, documented the resident as having been on a prescribed weight loss program. The MDS-LPN verbalized having been unable to locate any documentation the resident had been on a prescribed weight loss program. The MDS-LPN confirmed the MDS had been coded incorrectly, and the facility followed the Resident Assessment Instrument (RAI) Manual. On 01/15/2026 at 3:14 PM, the Staff Development LPN verbalized the facility did not have a policy on MDS completion and followed the RAI manual. On 01/15/2026 at 3:23 PM, the Regional MDS Coordinator Registered Nurse verbalized having expected nurses to have reviewed and verified an MDS section for accuracy prior to signing. The Long-Term Care Facility, Resident Assessment Instrument (RAI) 3.0, User's Manual, Version 1.20.1, dated October 1, 2025, Chapter 1.3, Completion of the RAI, documented the RAI process required assessments to accurately reflect the resident's status.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to ensure 1) a comprehensive care plan was developed related to a COVID-19 infection for 1 of 26 sampled residents (Resident #108), and 2) a resident's care plan for the care of the resident's pressure ulcer was implemented for 1 of 26 sampled residents (Resident #2). These deficient practices had the potential to result in staff being unaware of resident needs and resident needs going unmet and to result in a resident not receiving the care necessary to prevent the worsening of a chronic wound. Findings include:Resident #108 Resident #108 was admitted to the facility on [DATE], and readmitted on [DATE], with a primary diagnosis of acute systolic heart failure. A physician's order, dated 01/11/2026, documented Droplet Precautions were necessary when a patient was infected with a pathogen such as influenza, pertussis, mumps, and respiratory illnesses such as those caused by coronavirus infections every shift for COVID positive for 10 days. An acute care progress note, dated 01/12/2026, documented Resident #108 tested positive for rapid antigen coronavirus on 01/11/2026. Resident #108's clinical record lacked a care plan related to a COVID-19 infection or use of Droplet Precautions. On 01/12/2026 at 9:18 AM, a sign was posted on the upper right-hand side of room [ROOM NUMBER]'s doorway. The sign documented Special Droplet/Contact Precautions. Everyone must clean their hands when entering and leaving the room, wear a face mask, wear eye protection, and wear gown and glove at the door. A Personal Protective Equipment (PPE) organizer hung on the door facing outward toward the hallway. The placard on the wall outside the room indicated the room belonged to Resident #108. On 01/14/2026 at 12:55 PM, a Licensed Practical Nurse (LPN) verbalized Droplet Precautions were used for residents with a confirmed COVID-19 infection. Staff were to don an N95 respirator, a gown, and gloves prior to entering the resident's room and doff the PPE upon exiting. The LPN verbalized Droplet Precautions were used to prevent the spread of viruses and keep a virus contained. Resident #108 tested positive for COVID-19 and was on Droplet Precautions. On 01/15/2026 at 1:27 PM, the Director of Nursing (DON) verbalized care plans guided resident care in all areas. Care plans were to be reviewed and updated continuously by facility management and nursing staff. New interventions should immediately be documented on the resident's care plan. The DON would expect to see a care plan related to COVID-19 if the resident or the resident's roommate was exposed to COVID-19. The DON explained two residents on the 200's unit of the facility tested positive for COVID-19, including Resident #108. The DON verbalized Resident #108 should have had a care plan related to the COVID-19 infection and the use of Droplet Precautions but did not. The facility policy titled, Nursing Personnel Education and Training, dated 11/2016, documented in the absence of company policy or procedure the facility utilized the [NAME] manual as a supplemental resource. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross Reference with Tag F880. Resident #2 Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including pressure ulcer of sacral region, stage four and major depressive disorder, recurrent, unspecified On 01/12/2026 at 10:41 AM, the resident verbalized the resident had a wound. A Skin Evaluation, dated 01/09/2026, documented the resident had a stage IV pressure ulcer on the resident's coccyx. The wound measurements were 0.9 centimeters (cm) in length, 0.7 cm in width, and had a depth of 0.5 cm. A Physician's Order and the Treatment Administration Record (TAR) for Resident #2 documented the following: Cleanse coccyx pressure ulcer with wound cleanser, pat dry. Skin prep to peri-wound. Place iodoform packing strip into wound bed until lightly packed. Cover with dry dressing. Every other day shift. The start date for the order was 11/29/2025. The January 2026 TAR documented the wound care should have been completed on Monday 01/12/2026. The wound care was not documented as completed on 01/12/2026. A care plan, revised on 12/02/2025, documented the resident had a chronic stage IV coccyx wound and was at risk for further skin breakdown and impairment. Treatment would be completed as ordered. On 01/14/2026 at 11:50 AM, the Resident Care Manager (RCM) verbalized the resident's pressure ulcer dressing should have been changed on Monday, but the resident's record indicated the dressing had not been changed as ordered on Monday. On 01/14/2026 at 3:14 PM, the DON verbalized wound care would be documented on the Treatment Administration Record and confirmed the wound care ordered to be completed for Resident #2's pressure ulcer on 01/12/2026, was not documented anywhere in the resident's clinical record. The facility's Standard of Practice titled Lippincott Nursing Procedures, Ninth Edition, copyright 2023, documented the nursing care plan would serve as a database for conferring with the practitioner, other members of the health care team, and documenting resident care. Documentation of the resident's progress (or lack of it) was required by regulatory agencies monitoring health care quality. Cross reference with tag F686

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident was provided pressure ulcer care as ordered by the resident's provider for 1 of 26 sampled residents (Resident #2). This deficient practice had the potential to result in a resident's pressure ulcer worsening or developing an avoidable infection.Findings include:Resident #2Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including pressure ulcer of sacral region, stage four and major depressive disorder, recurrent, unspecified.On 01/12/2026 at 10:41 AM, the resident verbalized the resident had a wound.A Skin Evaluation, dated 01/09/2026, documented the resident had a stage IV pressure ulcer on the resident's coccyx. The wound measurements were 0.9 centimeters (cm) in length, 0.7 cm in width, and had a depth of 0.5 cm.A Physician's Order and the Treatment Administration Record (TAR) for Resident #2 documented the following:Cleanse coccyx pressure ulcer with wound cleanser, pat dry. Skin prep to peri-wound. Place iodoform packing strip into wound bed until lightly packed. Cover with dry dressing. Every other day shift. The start date for the order was 11/29/2025.The January 2026 TAR documented the wound care should have been completed on Monday 01/12/2026. The wound care was not documented as completed on 01/12/2026.A care plan, revised on 12/02/2025, documented the resident had a chronic stage IV coccyx wound and was at risk for further skin breakdown and impairment. Treatment would be completed as ordered.On 01/14/2026 at 11:50 AM, the Resident Care Manager (RCM) verbalized the resident's pressure ulcer dressing should have been changed on Monday, but the resident's record indicated the dressing had not been changed as ordered on Monday.On 01/14/2026 at 3:14 PM, the Director of Nursing (DON) verbalized wound care would be documented on the Treatment Administration Record and confirmed the wound care ordered to be completed for Resident #2's pressure ulcer on 01/12/2026, was not documented anywhere in the resident's clinical record.The facility policy titled Skin Integrity, updated 07/2025, documented a resident with a pressure ulcer would be provided care to treat, heal, and prevent, if possible, further development of pressure ulcers.Cross reference with tag F656

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, interview and document review, the facility failed to ensure staff provided adequate supervision for 1 of 26 sampled residents (Resident #87) when staff failed to verify all residents were present after discovering an open window on a secured memory care unit. This deficient practice resulted in delayed identification of a resident elopement and delayed implementation of the facility's elopement response procedures, with the potential to result in psychosocial and physical harm to the resident including injury or death.Findings include:Resident #87Resident #87 was admitted to the facility on [DATE], with diagnoses including paranoid schizophrenia and unspecified psychosis not due to a substance or known physiological condition.An initial Facility Reported Incident (FRI) dated 12/03/2025, documented Resident #87 eloped from the facility.Elopement Risk Evaluations completed on 03/27/2025, 06/26/2025, 09/25/2025, and 10/03/2025 documented Resident #87 was an elopement risk due to the resident's diagnosis of schizophrenia and wandering behaviors. Resident #87's Care Plan documented behavior monitoring. Target behaviors included exit seeking/pushing on exit doors. Interventions included ensuring the resident's safety on a secured unit. A Nursing Progress Note dated 12/03/2025, documented Resident #87 eloped from the facility. An investigation was initiated, a search of the surrounding area began, the sheriff's department was notified, and the resident was located by facility staff. Upon return to the facility, the resident was assessed by two nurses with no injuries noted.On 01/12/2026 at 10:32 AM, Resident #87 was pacing in the hallway of the 300 unit, one of the facility's secured memory care units. The resident was alert, muttering to self and was not able to engage in logical conversation.On 01/14/2026 at 12:06 PM, a Licensed Practical Nurse (LPN) verbalized the LPN was working the morning Resident #87 eloped from the facility through another resident's bedroom window. The LPN recalled another resident had previously broken multiple windows on the unit and the windows were secured with a piece of plywood until the windows could be repaired. On 12/03/2025 in the morning, the LPN was notified by a Restorative Nurse Aide the plywood was missing from one of the broken windows. The last time the LPN saw Resident #87 was at approximately 6:00 AM standing near the nurses' station. Later in the morning, during breakfast, staff identified Resident #87 was not present in the dining room and began searching for the resident. When staff could not locate Resident #87 on the unit, the facility's Administrator was notified, and several staff members began searching for the resident in the area surrounding the facility.The LPN explained when the LPN was notified of the missing plywood, staff did not confirm all residents were present on the unit as the LPN assumed the plywood was removed by the resident who previously broke the windows.On 01/15/2026 at 12:43 PM, the Administrator confirmed the Administrator was familiar with Resident #87 eloping from the facility in December 2025. The Administrator recalled another resident in the secured unit had broken multiple windows and was exit-seeking prior to the elopement. The broken windows were covered with plywood pending repair. On the morning of 12/03/2025, when staff noted the plywood on the window in the resident's room was missing, staff notified the Administrator of the plywood having been removed and the resident residing in the room was present on the unit. Staff did not complete a count of all residents on the unit at the time. During breakfast on 12/03/2025, staff noted Resident #87 was not present in the dining room and began searching for the resident. The Administrator explained if an open or unsecured window or door was identified in one of the facility's secured memory care units, staff were to complete a count to ensure all residents were present. The Administrator verbalized the Administrator felt staff had normalized the exit-seeking behavior of the resident who had broken the windows, resulting in staff's failure to complete a head count when the unsecured window was discovered sometime between 7:00 AM and 8:00 AM. The Administrator confirmed staff's identification of Resident #87 being missing from the unit and response to the resident's elopement (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was delayed.The facility policy titled Elopement/Wandering, updated 02/2025, defined an elopement as a resident exiting the facility without staff knowledge or the resident entering an unsafe area without staff knowledge or presence. Based on the results of an elopement/exit-seeking evaluation, care plan interventions to manage wandering and/or exit seeking behaviors were initiated.The facility document titled Keeping residents safe (0.02), Elopement risk, undated, documented all staff were to make sure all doors were locked and secured after entering/exiting the memory care unit. Residents in secured units were normally wandering/exit seeking/elopement risks and looked for any opportunity to exit the unit. If any potential risk of elopement were identified such as open doors and windows, a head count was to be completed immediately for the entire facility.FRI #2683842

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview, personnel record review, and document review, the facility failed to ensure 1 of 20 sampled employees had the specific competencies and skill sets necessary to care for residents' needs (Employee #15). This deficient practice had the potential to result in physical and psychosocial harm to the residents in the facility. Findings include:Employee #15 Employee #15 was hired by the facility as a Licensed Practical Nurse (LPN) on 12/03/2025. The daily staff schedules documented Employee #15 worked in the 100's unit on 01/10/2026 and 01/11/2026. On 01/15/2026 at 2:44 PM, Human Resources/Payroll (HR) verbalized newly hired nursing staff with prior experience completed a two-week orientation consisting of skills education relating both to on-the-floor and in office experience to ensure staff understood the processes for better continuity of care. A predetermined checklist was populated for all newly hired nurses, and the competencies were evaluated by a member of nursing management. HR explained Employee #15 had over ten years of nursing experience and the employee was hired as an as-needed nurse without full-time status. As-needed nurses did not always complete an orientation consistent with the two-week requirement, however, should still receive some on-the-floor and in-office experience alongside a completed competency checklist. HR verbalized competency checklists were required to be completed before the employee could be scheduled to work to ensure staff were competent and residents were taken care of. HR verbalized Employee #15's first independent shift took place on 01/10/2026 and HR observed Employee #15 working in the 100s unit without supervision on 01/10/2026 and 01/12/2026. Employee #15's competency checklist was not present in the employee's personnel record. HR reached out to the Staff Development LPN/Infection Preventionist (IP) and was informed the IP did not believe the IP possessed Employee #15's competency checklists. On 01/15/2026 at approximately 3:08 PM, HR provided six checklists and verbalized the checklist forms belonged to Employee #15. All checklists provided lacked a name or other identification indicating ownership of the documents and were signed by the IP at the bottom of the documents. The following were included:-Licensed Nursing (LN) Orientation Checklist with skills relating to abuse reporting, event reporting, alert charting, medication ordering, provider notification, the Health Insurance Portability and Accountability Act (HIPAA), Cubix, narcotic books, code blue policy, and tourniquet use.-LN Core Competency Checklist with skills relating to medication administration, enteral and parenteral nutrition and hydration, dialysis management, pain management, skin, ostomy and catheter care, restraints and bed rails, tracheostomy care and suctioning, fall and accident prevention, and infection control.-LN Supplemental Competency Checklist with skills relating to access implanted port cannula, dressing change, saline lock flush and removal, hypodermoclysis, intravenous (IV) tubing change and flush, tracheostomy care and tube feeding.-LN Competency Dressing Technique, Aseptic-LN Competency Point of Care Testing: Blood Glucose-Tube Feeding On 01/15/2026 at 3:08 PM, the IP verbalized the IP completed the competency checklists for Employee #15. The IP explained the facility required newly hired employees to write their own name, in their own handwriting, on the top of competency checklists to authenticate ownership by the employee. The IP confirmed the checklists provided lacked the name of Employee #15 and the IP was unable to verify Employee #15's competencies were evaluated. The facility policy titled, Nursing Personnel Education and Training, dated 11/2016, documented Core Competencies were completed within the first 30 days of employment. Medication administration competency was completed prior to the employee's first independent shift for licensed nursing (LN) personnel. Cross reference with Tag F842.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure 1) medications were secured in a locked medication cart and inaccessible to residents, staff and visitors when a Registered Nurse (RN) left two bottles of medication on top of a medication cart when the cart was not within sight of the RN and 2) outdated medications were removed from 1 of 4 medication carts inspected for medication storage. This deficient practice had the potential for residents, visitors, and unauthorized staff to have access to medications and outdated medications with diminished efficacy to be administered to residents.Findings include:Unsecured medicationsOn [DATE] at 8:37 AM, an RN was in the 100 hall and began preparing medications for administration to a resident. The RN placed a bottle of Sodium Bicarbonate and a bottle of Vitamin D3 on top of the medication cart.On [DATE] at 8:43 AM, the RN locked the medication cart and entered the resident's room. The medication cart was in the hallway, not within sight of the RN, and the bottles of Sodium Bicarbonate and Vitamin D3 remained on top of the cart.On [DATE] at 8:49 AM, the RN returned to the medication cart and placed the bottles in the cart. On [DATE] at 3:27 PM, the RN confirmed the bottles of Sodium Bicarbonate and Vitamin D3 were left on top of the medication cart during the morning medication administration pass, the bottles had medication remaining inside, and the medications were not within the RN's sight when the RN entered the resident's room. The RN verbalized medications were to be placed back in the cart, and the cart was to be locked when not within sight of the nurse. It was important for medications to be secured in a locked cart or medication storage room to ensure the medications weren't accidentally misplaced and other residents did not take the medications.On [DATE] at 10:55 AM, the Director of Nursing (DON) denied it would be appropriate to leave medications on top of the medication cart when the cart was not within eyesight of the nurse. The DON explained unsecured medications could be taken by other residents.The facility policy titled Medication Storage, dated 01/2025, documented medications were to be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medications were to be stored in a controlled environment including medication carts, medication rooms, medication cabinets or other suitable containers.The facility policy titled Medication Administration, General Guidelines, dated 01/2021, documented the medication cart was to be kept closed and locked when out of sight of the medication nurse. No medications were to be kept on top of the cart.Outdated medicationsOn [DATE] at 11:39 AM, during an inspection of the medication storage cart at the nurses' station on the 300 unit, a bottle of allergy relief Diphenhydramine 25 milligram (mg) tablets was found. The expiration date printed on the bottle was 12/2025. A Licensed Practical Nurse (LPN) confirmed the expiration date had passed and the medication was outdated. The LPN verbalized expired and discontinued medications were to be removed from the medication cart and placed in a cabinet designated for medication destruction in the medication storage room.On [DATE] at 10:55 AM, the DON verbalized expired and discontinued medications were to be removed from medication storage carts. It was important for staff to check expiration dates and to remove expired and discontinued medications to prevent a medication administration error.The facility policy titled Medication Storage, dated 01/2025, documented outdated, contaminated, discontinued or deteriorated medications were to be removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order existed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interview, and document review, the facility failed to complete a Treatment Administration Record (TAR) for the monitoring of side effects of an anticoagulant medication, the monitoring of a Foley catheter, and the monitoring of enhanced barrier precautions, for 1 of 26 sampled residents (Resident #14). This deficient practice had the potential to inaccurately reflect the prescribed monitoring of care and the associated interventions relative to the resident's current health management needs.Findings include: Resident #14 Resident #14 was admitted to the facility on [DATE], with diagnoses including unspecified atrial fibrillation, benign prostatic hyperplasia with lower urinary tract symptoms, and other obstructive and reflux uropathy. A physician's order dated 10/01/2025, documented Apixaban oral tablet, 5 milligrams (mg), give one tablet by mouth two times a day for atrial fibrillation. Resident #14's Medication Administration Record dated January 2025, documented Apixaban oral tablet had been administered per the physician's order. A physician's order dated 10/01/2025, documented anticoagulant medication side effects monitoring, new onset: bleeding, bruising, black tarry stools, red urine, sudden severe headache, every shift. A physician's order dated 10/03/2025, documented enhanced barrier precautions for Foley catheter, every shift. A physician's order dated 10/09/2025, documented to watch for signs of infection for Foley catheter, if catheter falls out or is clogged, if urine is leaking around the catheter, if urine becomes bloody, cloudy, or smelly, fever of 100.4 or above. Watch for redness, swelling, or drainage at the insertion site. Contact provider immediately if any of the following are observed, every shift. Resident #14's TAR dated 01/10/2026, lacked documentation the monitoring of side effects of the anticoagulant medication, the monitoring of the resident's Foley catheter, and the monitoring of enhanced barrier precautions for the Foley catheter had been completed. On 01/15/2026 at 2:22 PM, the Director of Nursing (DON) confirmed Resident #14's TAR dated 01/10/2026 had not been completed by the nurse. The DON verbalized 01/10/2026 had been Resident #14's nurse's first day working alone on the floor and expected the documentation to have been completed by the nurse on the TAR. The facility policy titled, Medication Administration, updated 06/2017, documented after treatment administrations, the nurse would sign after the treatment and double check the TAR for needed signatures or initials prior to leaving their shift. Cross Reference with Tag F726

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to ensure 1) staff wore appropriate Personal Protective Equipment (PPE) when entering the rooms of 2 of 14 coronavirus (COVID-19) positive residents (Residents #108 and #58) and 2) enhanced barrier precautions (EBP) were appropriately implemented and a staff member performed hand hygiene appropriately when performing wound care for 1 of 26 sampled residents (Resident #2). The deficient practice had the potential to spread infectious illnesses to vulnerable residents in the facility and result in a resident developing an infection from a staff member's lack of hand hygiene or failure to follow appropriate EBP. Findings include:Resident #108 Resident #108 was admitted to the facility on [DATE], and readmitted on [DATE], with a primary diagnosis of acute systolic heart failure. A physician's order, dated 01/11/2026, documented Droplet Precautions were necessary when a patient infected with a pathogen such as influenza, pertussis, mumps, and respiratory illnesses such as those caused by coronavirus infections every shift for COVID positive for 10 days. An acute care progress note, dated 01/12/2026, documented Resident #108 tested positive for rapid antigen coronavirus on 01/11/2026. On 01/12/2026 at 9:18 AM, a sign was posted on the upper right-hand side of room [ROOM NUMBER]'s doorway. The sign documented Special Droplet/Contact Precautions. Everyone must clean their hands when entering and leaving the room, wear a face mask, wear eye protection, and wear gown and glove at the door. A PPE organizer hung on the door facing outward toward the hallway. The placard on the wall outside the room indicated the room belonged to Resident #108. On 01/14/2026 at 12:32 PM, a Licensed Practical Nurse (LPN) wearing an N95 respirator entered room [ROOM NUMBER] without donning eye protection, gown or gloves, and closed the resident's door. The LPN exited the room, walked to the nurse's station, touched the medication cart, returned to room [ROOM NUMBER] and looked at the signage at the doorway. The LPN changed the LPN's respirator. The LPN returned to the nurse's station, used sanitizer and wheeled the medication cart down the hallway. Resident #58 Resident #58 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of COVID-19. A physician's order, dated 01/07/2026, documented Droplet Precautions were necessary when a patient infected with a pathogen such as influenza, pertussis, mumps, and respiratory illnesses such as those caused by coronavirus infections every shift for 10 days. An acute care progress note, dated 01/08/2026, documented Resident #58 tested positive for COVID-19 on 01/07/2026. On 01/14/2026 at 12:48 PM, a Droplet/Contact Precautions sign was posted on the upper right-hand side of room [ROOM NUMBER]'s doorway. A PPE organizer hung on the door facing outward toward (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the hallway. The placard on the wall outside the room indicated the room belonged to Resident #58. On 01/14/2026 at 12:48 PM, the LPN wearing an N95 respirator entered room [ROOM NUMBER] without donning eye protection, gown or gloves. The LPN closed the door half-way, reopened the door, stood in the doorway, and grabbed a gown from the PPE organizer. The LPN did not don the gown. The LPN entered room [ROOM NUMBER] and closed the door behind the LPN. The LPN opened the door to 216 and exited the room. The LPN changed respirators. On 01/14/2026 at 12:55 PM, the LPN verbalized Droplet Precautions were used for residents with a confirmed COVID-19 infection. Staff were to don an N95 respirator, a gown, and gloves prior to entering the resident's room and doff the PPE upon exiting. The LPN verbalized Droplet Precautions were used to prevent the spread of viruses and keep a virus contained. Two residents tested positive for COVID-19 in the 200's unit including Resident #108 in room [ROOM NUMBER] and Resident #58 in room [ROOM NUMBER]. The LPN confirmed the LPN did not don PPE prior to entering either room. On 01/15/2026 at 12:14 PM, the Staff Development LPN/Infection Preventionist (IP) verbalized Droplet Precautions were a type of Transmission Based Precautions (TBP) to be implemented for a resident with a positive COVID-19 test. Droplet Precautions required staff to don a mask, gown and gloves when providing care to the resident with a COVID-19 infection. Staff were expected to don PPE prior to entering the resident's room to limit the risk of exposure and prevent a larger outbreak in the facility. The IP verbalized two residents tested positive for COVID-19 in the 200's hall, including Residents #58 and #108. The facility policy titled SARS CoV-2 (COVID-19) Skilled Nursing Facility (SNF), revised 10/2025, documented the facility followed current Center for Disease Control (CDC) guidelines to minimize exposure to the virus causing COVID-19. TBP was recommended if the resident tested positive for COVID-19. During an outbreak, healthcare personnel wore PPE in accordance with TBP for Droplet Precautions prior to entering any COVID-19 positive room. The CDC document titled Infection Control Guidance CDC SARS CoV-2, dated 06/24/2024, documented healthcare personnel who enter the room of a patient with a confirmed SARS-CoV-2 infection should adhere to standard precautions and use a particulate respirator with N95 filters or higher, gown, gloves, and eye protection. Cross Reference with Tag F656. Resident #2 Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including pressure ulcer of sacral region, stage four and major depressive disorder, recurrent, unspecified. On 01/12/2026 at 10:41 AM, the resident verbalized the resident had a wound. A Skin Evaluation, dated 01/09/2026, documented the resident had a stage IV pressure ulcer on the resident's coccyx. The wound measurements were 0.9 centimeters (cm) in length, 0.7 cm in width, and had a depth of 0.5 cm. A Physician's Order and the Treatment Administration Record (TAR) for Resident #2 documented the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following: Cleanse coccyx pressure ulcer with wound cleanser, pat dry. Skin prep to peri-wound. Place iodoform packing strip into wound bed until lightly packed. Cover with dry dressing. Every other day shift. The start date for the order was 11/29/2025. On 01/14/2026 at 1:15 PM, a Registered Nurse (RN) and a Licensed Practical Nurse (LPN) began preparing to change the dressing to Resident #2's pressure ulcer. The RN brought a wound cart with all of the necessary wound care supplies to the hallway in front of Resident #2's door. The RN then donned gloves and then donned a gown. The RN proceeded to touch drawers of the EBP cart in the resident's room. The RN then changed gloves without performing hand hygiene before applying clean gloves. The RN then cleaned up the resident's bowel movement with disposable wipes. The RN then walked back to the table with the wound care supplies and handled the saline vials before doffing gloves and performing hand hygiene with an alcohol-based hand rub (abhr). The RN then applied clean gloves and completed the dressing change. On 01/14/2026 at 1:26 PM, the RN had doffed the gloves used during the resident's wound care but was still wearing the isolation gown. The RN then exited the resident's room to obtain additional supplies from the wound cart while wearing the isolation gown worn when providing care to Resident #2. On 01/14/2026 at 1:31 PM, the RN verbalized the RN had not donned PPE in the correct order and the RN should have donned the gown prior to donning the gloves. The RN confirmed the RN had touched the saline vials without performing hand hygiene after cleaning up the resident's bowel movement. The RN confirmed the RN had not removed the isolation gown before returning to the wound cart after completing the wound care for Resident #2. On 01/14/2026 at 3:15 PM, the Director of Nursing (DON) verbalized the correct order for donning PPE was to don a gown and then don gloves. The DON verbalized a staff member not removing a gown prior to exiting the resident room and opening the wound cart created a risk of transferring infections as the wound cart was storing wound care supplies for all residents. The Centers for Disease Control and Prevention infographic titled Sequence for Putting On PPE, accessed 01/15/2026, documented the correct sequence for putting on PPE was to put on a gown prior to donning gloves. The facility policy titled Handwashing/Hand Hygiene, updated 08/2025, documented hand hygiene was performed as soon as feasible, after hands became contaminated and frequently during the working day. Examples of situations when hand hygiene was performed, included before and after assisting a resident with personal care activities and after removing gloves. The facility policy titled Enhanced Barrier Precautions, revised 03/26/2024, documented EBP would be indicated when wound care was performed to reduce transmission of multidrug resistant organisms.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview, record review, and document review, the facility failed to ensure a staff member received screening and education on the Sars Coronavirus 2019 (COVID-19) vaccine for 1 of 1 staff sampled for COVID-19 vaccine review. This deficient practice had the potential to result in a staff member not having the opportunity to receive the vaccine or education on the risks and benefits of the vaccine.Findings include:Employee #23Employee #23 was hired as a Registered Nurse (RN) with a start date of 08/31/2023.On 01/15/2025 at 9:55 AM, the Infection Preventionist (IP) verbalized the facility did not have any documentation of education or screening provided to the RN and confirmed the RN had not been screened for eligibility to receive the COVID-19 vaccine.The IP verbalized the facility referred to the federal regulation as the facility policy for screening and educating staff on the COVID-19 vaccine.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on personnel record review, interview, and document review, the facility failed to ensure initial behavioral health care training, related to dementia, was completed timely for 2 of 20 sampled employees (Employee #9 and #10). This deficient practice had the potential to prevent residents with dementia care needs from attaining or maintaining their highest practicable physical, mental, and psychosocial well-being.Findings include:Employee #9Employee #9 was hired as a Certified Nursing Assistant (CNA) on 06/16/2025.Employee #9's personnel record documented initial behavioral health care training for dementia completed on 11/01/2025.Employee #10Employee #10 was hired as a Speech Language Pathologist on 06/27/2025.Employee #10's personnel record documented initial behavioral health care training for dementia completed on 10/30/2025.On 01/15/2026 at 9:50 AM, Human Resources/Payroll explained all employees, contracted employees, and agency staff were to complete behavioral health training related to dementia within the first 30 days of hire and annually thereafter. The Human Resources/Payroll confirmed Employee #9 and Employee #10 completed initial behavioral health training related to dementia more than 30 days after being hired. The facility policy titled Nursing Personnel Education and Training, published November 2016, documented Licensed Nurses and Certified Nursing Assistants. were required to complete dementia management training and Care of cognitively impaired, and behavioral health training, to address State requirements, Federal requirements, and identified core competencies within the first 30 days of employment.The facility policy titled Centers for Medicare and Medicaid Services (CMS) Hand-in-Hand Toolkit, updated July 2017, documented the CMS Hand-in-Hand Training for dementia was provided to center employees, contract staff, and routine volunteers would be completed during new employee orientation.