STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325066	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bloomfield Nursing and Rehabilitation Center	803 Hacienda Lane Bloomfield, NM 87413

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's right to retain his personal property for 1 (R #16) of 1 (R #16) resident reviewed when: Facility staff removed containers, a backpack, a small box, and other reuseable bags filled with resident's items from his room. The facility did not give R #16 consistent access to his personal belongings stored in a conference room. If staff do not respect a resident's right to personal property, then the resident may become angry, frustrated, and feel disrespected. The findings are: A. Record review of R #16's face sheet revealed he was re-admitted to the facility on [DATE] with the following diagnoses: Epilepsy (a seizure disorder),Traumatic brain injury (TBI; injury to the brain caused by an outside force, usually a violent blow to the head),Intellectual disabilities (lifelong condition characterized by significant limitations in intellectual functioning and adaptive behavior, affecting everyday skills and learning),Alcoholic cirrhosis of the liver (alcohol-associated liver disease causes toxic fat to build up in your liver, which leads to inflammation and scarring). B. Record review of R #16's quarterly Minimum Data Set (MDS is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) dated 10/20/25 revealed R #16 had a Brief Interview for Mental Status (BIMS checks the resident cognitive impairment and whether further intervention is required for dementia diagnosis) of a 15 (0-7 severely impaired cognition, 8-12 moderately impaired, 13 -15 intact cognition) indicating R #16 was cognitively intact.?? C. Record review of R #16's care plan dated 10/20/25 indicated R #16 had a tendency to collect and store things in his room including but not limited to perishable items, cleaning supplies, facility linens, silverware, toilet paper, towels, and wash rags. Interventions included the following: Educate R #16 and his family for safety reasons, there are certain things that are not allowed to be kept at the bedside.Educate staff about R #16's tendency to keep and collect things and this should be reported to the nurse or nurse management if there is a safety concern.Educate R #16's family that all cleaning is done by our housekeeping department and if R #16 needs something cleaned, he can speak to any staff member, and we can get it done. R #16 does not need to have his own cleaning supplies. D. Record review of R #16's nursing progress note dated 12/19/25 revealed, R #16 had been hoarding his belongings, and they have just begun to pile up. R #16 was told he was not allowed to have all his things packed under his bed. R #16 became upset and agitated. R #16 was required to sign a behavioral agreement as there had been other unknown issues that had been happening. E. Record review of R #16's behavioral agreement dated and signed on 12/19/25 indicated the following:? Behavior expectations: 1. Uncooperative with care. 2. Inappropriately touching staff. 3. Hoarding.? R #16 will receive verbal warning and documentation of incident will be recorded that any further escalation of the?behavior observed or reported can and will result in further?consequences including up to potential discharge from the facility.Police may be contacted to intervene in the?situation.Referrals/transfers to other facilities (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(emergency room in-patient behavioral?health) may be deemed appropriate for the safety of the resident?and others.Discharge from the facility may be deemed appropriate and?30-day discharge notice may be issued. F. Record review of R #16's electronic health record (EHR) did not reveal orders for monitoring the behaviors noted in the behavioral agreement. G. On 01/06/26 at 8:30 am, during an interview with R #16, he stated the Administrator (ADM) came and took a lot of his stuff out of his room on 12/19/25. R #16 stated water bottles, shampoo bottles, soaps, snacks, pens, and other items were removed from his room. R #16 stated he had two containers with items in them behind his bed and those were taken from him, and they took some bags and other items. He stated the ADM told him he had too much stuff and moved his things into the conference room across the hall. R #16 stated he wanted his things and his snacks back, but he was told by the ADM that the containers he had were a fire hazard. R #16 stated he felt like he was being singled out and picked on, and he did not understand why. H. On 01/06/26 at 10:27 am, an observation was made of R #16's belongings stored in the conference room. There were two black containers exactly as described by R #16 with his backpack, a small box, and some bags sitting on top of the containers. Inside of the containers were snacks, pistachios, boxes of cookies, several 2-liter bottles of various drinks, colored pens, anime (Japanese art form) drawing book, a comic, and several socks wrapped up with a decorative ribbon. Most of his items were in the two containers. The conference room door was locked and could only be unlocked by facility staff. R #16 did not have access to his items in the conference room. ? I. On 01/08/26 at 8:35 am, during an interview with Certified Nursing Assistant (CNA) #8, she stated R #16 can at times be a little stubborn and he keeps to himself a lot. She stated R #16 likes to keep everything, even if the item is past the expiration date.J. On 01/08/26 at 3:01 pm, during an interview with the stand in Administrator, he stated R #16's behavioral contract (for hoarding items in his room), should not be in place. He stated, assisting R #16 with maintaining his items should be addressed if he is having issues, and putting R #16 on a behavioral contract for hoarding is not an appropriate reason for a behavioral contract. His understanding of the behavioral agreement was to address R #16 taking items from the facility, not hoarding items. K. On 01/08/26 at 12:50 pm, during an interview with Social Services Director (SSD), she stated R #16 is in constant need of his room being decluttered because R #16 had items on top of his wardrobe and under his bed. She stated he can be very combative and resistant. The SSD stated when they ask him to go through his things he becomes very upset, so she and the Administrator went through R #16's belongings while R #16 was present in the room. L. On 01/15/25 at 11:28 am during an interview with the ADM, she stated the items were removed from R #16 because they were all behind the headboard in his room and taking up too much space. He had two totes, a duffle bag, shopping bags and a brown box. She stated she implemented the behavior agreement so R #16 would cooperate with them around all of the items in his room. The ADM confirmed R #16 should have access to his belongings that are stored in the conference room whenever he wanted, but that was not happening.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review and interview, the facility failed to ensure the resident's current advance directive (a document which provides an individual's wishes for emergency and lifesaving care) was available in the resident's Electronic Health Record (EHR) and/or available in physical form for the facility staff for 1 (R #43) of 1 (R #43) resident reviewed for advance directives. This deficient practice is likely to cause confusion and delay potentially lifesaving procedures. The findings are: A. Record review of R #43's face sheet revealed an admission date of 10/14/25 with the following diagnosis: Huntington's disease (is a fatal neurodegenerative disease that is usually inherited). B. Record review of R #43's Electronic Health Record (EHR) revealed there was no advanced directive, medical orders for scope of treatment (MOST is a form outlining patients' wishes for medical interventions and end-of-life care when individuals have a serious or life-threatening illness) completed or available for R #43. C. On 01/07/26 at 1:16 pm, during an interview with the Director of Nursing (DON), she stated she looked for R #43's advanced directive, but she could not find it. The DON confirmed R #43 did not have an advanced directive/MOST form readily available and should have.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to notify the physician and obtain appropriate medical orders for 1 (R #25) of 1 (R #25) residents reviewed who experienced a significant change in condition, requiring oxygen (O2) therapy. If the facility fails to notify the physician and obtain a medical order when a resident experiences a significant change in condition, it may result in delayed or inadequate treatment. The findings are: A. Record review of R #25's face sheet revealed R #25 was admitted into the facility on [DATE] with the following diagnoses: Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors, difficulty with walking, movement and coordination),Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),Epilepsy (a seizure disorder). B. On 01/05/26 at 9:35 a.m., during an observation of R #25, the resident sat in his wheelchair in his room with a portable oxygen concentrator (medical device that provides continuous O2) delivering oxygen at 2 liters per minute via nasal cannula (a small, flexible tube that delivers oxygen to the nose through soft prongs). C. Record review of R #25's oxygen levels dated 01/05/26 at 4:58 pm, revealed R #25's oxygen level was at 98 percent on O2. D. On 01/06/26 at 1:26 p.m., during an observation of R #25, he was observed lying in bed asleep with a nasal cannula in place and connected to an oxygen concentrator delivering oxygen at 2 liters per minute. E. On 01/07/26 at 3:00 p.m., during an observation of R #25, he was observed lying in bed asleep with a nasal cannula in place and connected to an oxygen concentrator delivering oxygen at 2 liters per minute. F. Record review of R #25's physician orders dated 01/07/26, revealed there was no order present for O2 use. G. On 01/07/26 at 3:05 p.m., during an interview with Licensed Practical Nurse (LPN) #1, he stated R #25 was very weak and had a diagnosis of Parkinson's disease. LPN #1 stated oxygen therapy was initiated on Monday (01/05/26) after staff noted R #25 was desaturating (decrease in oxygen saturation levels), with readings observed in the low 80 percent range (normal O2 saturation levels are 95 to 100 percent). LPN #1 stated R #25 appeared increasingly weak at the time oxygen was initiated. LPN #1 stated he provided O2 to R #25, but he did not observe a physician's order authorizing oxygen use. LPN #1 further stated staff were not consistently documenting R #25's O2 use, O2 saturation levels, or episodes of desaturation. LPN #1 confirmed he was unable to identify documentation reflecting ongoing monitoring, physician notification, or clinical follow-up related to the R #25's O2 needs. H. On 01/07/26 at 3:23 p.m., during an interview with the Assistant Director of Nursing (ADON), she stated she was not aware R #25 had been receiving O2 prior to 01/07/26. The ADON stated she was informed approximately 10 minutes earlier by LPN #1 that R #25 was receiving O2 therapy. The ADON confirmed she should have been made aware when O2 was initiated for R #25, as changes in respiratory status and the initiation of O2 therapy require nursing leadership oversight, physician notification, and appropriate documentation. The ADON was unable to identify documentation reflecting physician notification, a physician's order, or supervisory review related to the resident's O2 use prior to 01/07/26.I. On 01/07/26 at 3:36 p.m., during an interview with the Director of Nursing (DON), she stated the physician, or medical director, should have been notified on the first day O2 was initiated for R #25, but that did not happen. J. On 01/13/26 at 1:00 p.m., during an interview with the Medical Director (MD), he stated there should have been a standing order for O2 use (a pre-authorized physician order permitting nursing staff to initiate oxygen therapy when clinically indicated based on established parameters) for R #25, but there was not. The MD stated it was his expectation to be notified of any decrease in a resident's O2 saturation levels. The MD confirmed he would expect to (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be notified so that O2 therapy could be authorized and administered in response to the resident's change in condition, but he was not notified for R #25's required O2 use.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS; a federally mandated comprehensive assessment?of a resident's?functional, medical, psychosocial and cognitive assessment completed by facility staff) was accurate for 1 (R #66) of 1 (R #66) resident reviewed for MDS accuracy. This deficient practice could result in failure to provide adequate care and treatment of the?resident's needs. The findings are: A. Record review of R # 66's Face Sheet revealed an admission date of 05/18/23 with the following diagnoses:? Expressive language disorder?(a condition where a person?has trouble using words and sentences to communicate),Sensorineural hearing loss, bilateral?(hearing loss in both ears?caused by?damage to the inner ear (cochlea) or auditory nerve, leading to?reduced ability to hear and understand sounds,?especially speech),Dysphagia?(difficulty or discomfort in swallowing, as a symptom of disease),Other drug induced secondary Parkinsonism (movement disorder caused by certain medications, resulting?in?symptoms similar to Parkinson's disease?(tremor, rigidity, slow movements),Cognitive communication deficit?(a?communication disorder caused by impairments in cognitive processes). B. Record of R #66's Physicians Orders, dated 01/07/26 revealed a referral for speech therapy evaluation and treatment as recommended non-verbal, communication board. ?C. Record review of R #66's Psychiatric Notes, dated 05/08/25, revealed the following:? Resident?uses paper and pencil to answer questions on notebook,Due to resident being non-verbal in today's assessment, this note is completed per chart review and staff support. D. Record review of R #66's Care Plan, dated 05/16/25 revealed the following:?Potential for impaired communication r/t (related to) impaired hearing,Resident will express needs through non-verbal communication as needed daily,Resident will use alternative methods of communication such as writing as needed daily,Speak facing the resident,Ensure availability and functioning of adaptive equipment,Resident is at risk or is experiencing adjustment issues related to communication challenges.E. Record review of R #66's Progress Notes, dated 05/18/25, revealed the following: Resident is primarily non-verbal communication board, pen and paper,?Resident has the following needs for special adaptive equipment to participate in desired engagement opportunities,?Communication board written instructions/gestures for hearing lost.No cognitive limitations.? F. Record review of R #66's Psychiatric Notes, dated 10/23/25, revealed Due to resident being non-verbal in today's assessment, this note is completed per chart review and staff support.G. Record review of R #66' Speech Therapy evaluation, dated 11/14/25, revealed the following:? Evaluation of speech with evaluation of language and comprehension and expression,Resident is nonverbal,Hearing details- None (uses notepad to communicate),Resident reports not knowing all the words but communicates through a notebook,Speech clarity (the degree to which spoken words are produced clearly and can be easily understood by a listener) no speech,Auditory Comprehension-Not indicated (profound hearing loss),Ability to hear: highly impaired (absence of useful hearing), Due to the documented physical impairments, without skilled therapeutic interventions, the resident is at risk for anxiety, general health, decreased leisure participation and social isolation. H. Record review of R #66's Psychiatric Notes, dated 11/20/25, revealed the following:?Resident?uses paper and pencil to answer questions on notebook,Due to resident being non-verbal in today's assessment, this note is completed per chart review and staff support. I. Record review of R #66's MDS assessments revealed the following: Quarterly MDS Section B (Hearing, Speech, Vision), dated 12/18/24, was coded as having adequate hearing and clear speech.Quarterly MDS Section B (Hearing, Speech, Vision), dated 03/18/25, was coded as having adequate hearing and clear speech,Annual MDS Section B (Hearing, Speech, Vision), dated 08/13/25, was coded as having adequate hearing and clear speech,Quarterly MDS Section B (Hearing, Speech, Vision), dated 08/13/25, was coded as having (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	adequate hearing and clear speech,Quarterly MDS Section B (Hearing, Speech, Vision), dated 11/11/25, was coded as having adequate hearing and clear speech.J. On 01/06/26, at 11:06 AM, during an interview with R #66, the resident was nonverbal and used his notebook to communicate.?K. On 01/07/26, at 3:19 PM, during an interview with the Activities Director (AD), she stated R #66 used a whiteboard or his notebook as his source of communication.?? L. On 01/07/2026, at 3:21 PM, during an interview with Certified Nurse Aide (CNA) #1, she stated R #66 is nonverbal and?writes his questions on a piece of paper. CNA #1 stated since the admission of the resident, she had never heard him speak. ? M. On 01/07/26, at 3:26 PM, during an interview with Registered Nurse (RN) #1, she stated R #66 is nonverbal and communicates with a notebook. She stated the resident also has hearing loss.? N. On 01/07/26, at 3:27 PM, during an interview with CNA #2, she stated R #66 doesn't speak and uses his notebook to communicate.? She stated the resident has difficulty hearing. O. On 01/07/26, at 3:36 PM, during an interview with Certified Medication Assistant (CMA) #1, she stated R #66 doesn't speak and uses his notebook to communicate. She stated the resident also has a hearing impairment.?P. On 01/08/26, at 10:20 AM, during an interview with the Activities Director (AD), she stated R #66 has been nonverbal since he admitted in 2023.? Q. On 01/08/26, at 10:21 AM, during an interview with the MDS Coordinator (MDSC), she stated she was responsible for the completion of R #66's MDS assessments. She stated R #66's MDS dated [DATE], 05/16/25, 08/13/25, and 11/11/25 Section B (Hearing, Speech, Vision), were coded correctly, reflecting the resident had adequate hearing and speech. The MDSC confirmed R #66's MDS Section B should have been accurate, but it was not. R. On 01/08/2026, at 1:38 PM, during an interview with the Director of Rehab (DOR), she stated R #66 is nonverbal and uses a communication board to communicate.?? S. On 01/08/2026, at 1:44 PM during an interview with the Social Services Director (SSD), she stated R #66 is nonverbal and uses a pen and notebook to answer questions and communicate.??

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to create a Baseline Care Plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) within 48 hours of admission for 1 (R #25) of 1 (R #25) resident reviewed for Baseline Care Plans. This deficient practice could likely result in the residents' preferences and care needs not being met. The findings are: A. Record review of R #25's face sheet revealed R #25 was admitted into the facility on [DATE] with a diagnosis of: Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors, difficulty with walking, movement and coordination),Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),Epilepsy (a seizure disorder).B. Record review of R #25's care plan revealed the facility did not develop or implement a baseline care plan within 48 hours of admission as required. R #25's care plan initiation dates reflected 12/22/2025. C. On 01/14/26 at 2:00 p.m., during an interview with the Director of Nursing (DON), she stated nursing staff are responsible for initiating the baseline care plan and stated her expectation was that R #25's baseline care plan would be completed within 48 hours of admission, and it was not.

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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 record review, observations, and interviews, the facility failed to ensure nursing services were provided in accordance with professional standards of practice for 1 (R #25) of 1 (R #25) resident reviewed, when: The facility nursing staff administered oxygen (O2) without physician orders. The facility nursing staff did not document R #25's O2 use.The facility did not notify the physician when R #25 experienced O2 desaturation (a drop in a person's oxygen level in the blood below normal, meaning the body is not getting enough oxygen). If nursing staff initiate and continue O2 therapy for a resident without a physician order, fail to document oxygen use, and do not notify the physician when a resident experiences O2 desaturation, then residents are at risk for receiving unauthorized treatment without appropriate medical oversight. These deficient practices are likely to lead to delayed or inappropriate medical intervention, and potential adverse outcomes related to untreated or improperly managed medical conditions. The findings are: ?A. Record review of R #25's face sheet revealed R #25 was admitted into the facility on [DATE] with the following diagnoses: Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors, difficulty with walking, movement and coordination),Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),Epilepsy (a seizure disorder). B. On 01/05/26 at 9:35 a.m., during an observation of R #25, the resident sat in his wheelchair in his room with a portable oxygen concentrator (medical device that provides continuous O2) delivering oxygen at 2 liters per minute via nasal cannula (a small, flexible tube that delivers oxygen to the nose through soft prongs). ?C. On 01/06/26 at 11:34 a.m., during an observation of R #25, he was observed seated in his wheelchair and being escorted to the dining area while receiving oxygen via nasal cannula. D. On 01/06/26 at 1:26 p.m., during an observation of R #25, he was observed lying in bed asleep with a nasal cannula in place and connected to an oxygen concentrator delivering oxygen at 2 liters per minute.E. On 01/07/26 at 3:00 p.m., during an observation of R #25, he was observed lying in bed asleep with a nasal cannula in place and connected to an oxygen concentrator delivering oxygen at 2 liters per minute.F. Record review of R #25's physician orders dated 01/07/26, revealed there was no order present for O2 use. G. On 01/07/26 at 3:05 p.m., during an interview with Licensed Practical Nurse (LPN) #1, he stated R #25 was very weak and had a diagnosis of Parkinson's disease. LPN #1 stated oxygen therapy was initiated on Monday (01/05/26) after staff noted R #25 was desaturating (decrease in oxygen saturation levels), with readings observed in the low 80 percent range (normal O2 saturation levels are 95 to 100 percent). LPN #1 stated R #25 appeared increasingly weak at the time oxygen was initiated. LPN #1 stated he provided O2 to R #25, but he did not observe a physician's order authorizing oxygen use. LPN #1 further stated staff were not consistently documenting R #25's O2 use, O2 saturation levels, or episodes of desaturation. LPN #1 confirmed he was unable to identify documentation reflecting ongoing monitoring, physician notification, or clinical follow-up related to the R #25's O2 needs. H. On 01/07/26 at 3:23 p.m., during an interview with the Assistant Director of Nursing (ADON), she stated she was not aware R #25 had been receiving O2 prior to 01/07/26. The ADON stated she was informed approximately 10 minutes earlier by LPN #1 that R #25 was receiving O2 therapy. The ADON confirmed she should have been made aware when O2 was initiated for R #25, as changes in respiratory status and the initiation of O2 therapy require nursing leadership oversight, physician notification, and appropriate documentation. The ADON was unable to identify documentation reflecting physician notification, a physician's order, or supervisory review related to the resident's O2 use prior to 01/07/26.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations and interviews, the facility failed to ensure the environment was free of accident hazards when a portable electric space heater was plugged in and operating in a common hallway accessible to residents.This deficient practice is likely to affect all residents that walk by the front entrance of the facility and could place residents at risk for burn injuries, particularly residents with impaired cognition or limited safety awareness (inability to recognize or avoid the hazard). The findings are: A. On 01/05/26 at 12:27pm, during an observation of the front entrance hallway, a portable electric space heater was positioned directly on the hallway floor next to the vending machine. The heater was plugged in and operating with a digital display reading 72 degrees Fahrenheit (F). The heater was placed against the wall and immediately next to the vending machine. The space heater was located in a common hallway area accessible to residents. B. On 01/08/26 at 2:30 pm, during an interview with substitute Administrator, he stated the space heater should not be plugged in and left in the hallway unattended. He stated the residents could burn themselves on the heater.? C. On 01/13/26 at 11:28 am, during an interview with Maintenance Director, he stated the space heater should not be plugged in as a resident with dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment) could get burned on the heater.??

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure the Director of Nursing (DON) was not working the floor as a charge nurse when the facility census was over 60 residents. This deficient practice is likely to affect all 72 residents who reside in the facility (facility census provided by the Director of Nursing on 01/05/26). If the DON is working as a charge nurse, they may be unable to complete their DON responsibilities, indicating low staffing levels and impacting all residents. The findings are: A. Record review of the facility's census for 11/07/25 through 01/06/26 revealed the following: 11/07/25 the facility census was 78, 11/17/25 the facility census was 82, 11/28/25 the facility census was 78,12/13/25 the facility census was 81,12/26/25 the facility census was 72,12/27/25 the facility census was 74,12/30/25 the facility census was 72,01/03/26 the facility census was 72,01/06/26 the facility census was 72. B. Record review of the facility's staffing logs for 11/07/25 through 01/06/26 revealed the following: On 11/07/25 the DON worked the floor as a nurse/charge nurse. On 11/17/25 the DON worked the floor from 5:00 pm to 2:30 am as a nurse/charge nurse. On 11/28/25 the DON worked the floor as a nurse/charge nurse. On 12/13/25 the DON worked the floor as a nurse/charge nurse. On 12/26/25 the DON worked the floor as a nurse/charge nurse. On 12/27/25 the DON worked the floor as a nurse/charge nurse from 9:00 am to 5:00 pm. On 12/30/25 the DON worked the floor as a nurse/charge nurse. On 01/03/25 the DON worked the floor as a nurse/charge nurse from 12:00 pm to 3:45 pm. ? On 01/06/25 the DON worked the floor as a nurse/charge nurse. C. On 01/07/26 at 11:47 am, during an interview with the Director of Nursing (DON), she stated she worked the floor last night (01/06/25) for six hours because there was not enough nurse coverage. The DON stated when she works the floor as a nurse/charge nurse, it is hard for her to get her other tasks completed. She stated she lost three agency nurses in the last couple of weeks, and they are trying to get new contracts for the agency nurses. ?The DON confirmed she worked the floor as a nurse/charge nurse for the dates listed on the staffing log (finding B).

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on record review and interviews, the facility failed to complete an annual performance review of Certified Nursing Assistants (CNAs) for 3 (CNAs #6, #7, and #8) of 5 (#6, #7, #8, #9, and #10) CNAs randomly reviewed. If the facility is not completing a performance review of every CNA at least once every 12 months, then residents are likely to not receive the appropriate care and services, and the CNAs may not meet the needs of all residents. The findings are: A. Record review of the facility's training transcripts for CNA's #6, #7, and #8 revealed the following hire dates.?? CNA #6 was hired on 10/01/18, and an annual performance review was not present. CNA #7 was hired on 10/01/18, and an annual performance review was not present. CNA #8 was hired on 09/15/22, and an annual performance review was not present. B. On 01/09/26 at 11:24 am during an interview with the Director of Nursing (DON), she stated she only had the training logs for the staff requested but CNAs #6, #7, and #8 did not have annual performance reviews completed. C. On 01/14/26 at 2:30 pm, during an interview with the DON, she stated she does not have performance reviews available for CNAs #6, #7, and #8. The DON confirmed CNA annual performance reviews should be completed as required, but that did not happen.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation and interview the facility failed to:? Lock a medication cart (a movable piece of equipment used in healthcare facilities to store, transport, and dispense medications) while staff were away from the cart.Ensure all medications were not expired in the medication storage room. These deficient practices are likely to result in resident injury, through dosing with medications that have been improperly stored, having access to medications not prescribed for them, and possible overdose. The findings are: Medication Carts: A. On 01/06/26 at 8:55 AM, during an observation of the 100 Hall, the medication cart was found unlocked and unattended.? B. On 01/06/26 at 8:57 AM, during an interview with Licensed Practical Nurse (LPN) #1, he stated he stepped away for a moment and left the medication cart unlocked. He stated it was his expectation to lock the medication cart when it was unattended and not in use. LPN #1 stated if a resident ingests a medication not prescribed to them, the resident could have had an adverse drug interaction, resulting in the resident becoming ill. C.?On 01/08/26 at 2:17 PM, during an interview with the Director of Nursing (DON), she stated staff should never leave a medication cart open and unattended. The DON stated it is her expectation all medication carts are locked when not in use and unattended. She stated if a medication cart was unlocked, residents could ingest a medication and have an adverse reaction, causing the residents to become ill. D. On 01/08/26 at 2:25 PM, during an interview with the Administrator (AD), he stated it was his expectation that all medication carts be locked when not in use. The AD stated if a resident were to have access to an unlocked medication cart, the resident could take a medication not prescribed to them, which could result in illness. Expired Medications: E. On 01/06/26 at 11:11 am, during a medication storage room observation, one sealed bottle of Aspirin 325 milligrams (mg) had an expiration date of 06/25. F. On 01/06/26 at 11:22 am, during an interview with LPN #3, she confirmed the Aspirin had expired and should have been removed.? G. On 01/06/26 at 11:33 am, during an interview with the DON, she stated finding expired medications in the medications room does not meet her expectations and the medication should have been disposed of properly and immediately.

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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. Based on record reviews and interviews, the facility failed to ensure the accuracy and completeness of the electronic health record (EHR) for 1 (R #66) of 1 (R #66) resident reviewed for accuracy of resident information by: Inaccurately documenting R #66's communication and hearing impairments. This deficient practice is likely to create the potential for inaccurate or incomplete documentation within the electronic health record, which may negatively impact the resident's ability to receive the care and services needed. The findings are: A. Record review of R # 66's Face Sheet revealed an admission date of 05/18/23 and the following diagnoses:? Expressive language disorder?(a condition where a person?has trouble using words and sentences to communicate),Sensorineural hearing loss, bilateral?(hearing loss in both ears?caused by?damage to the inner ear (cochlea) or auditory nerve, leading to?reduced ability to hear and understand sounds,?especially speech),Dysphagia?(difficulty or discomfort in swallowing, as a symptom of disease),Other drug induced secondary Parkinsonism (movement disorder caused by certain medications, resulting?in?symptoms similar to Parkinson's disease?(tremor, rigidity, slow movements),Cognitive communication deficit?(a?communication disorder caused by impairments in cognitive processes). B. Record review of R #66's Psychiatric Notes, dated 05/08/25, revealed the following:? Resident?uses paper and pencil to answer questions on notebook,Due to resident being non-verbal in today's assessment, this note is completed per chart review and staff support.C. Record review of R #66's Care Plan, dated 05/16/25 revealed the following:? Potential for impaired communication r/t (related to) impaired hearing,Resident will express needs through non-verbal communication as needed daily,Resident will use alternative methods of communication such as writing as needed daily,Speak facing the resident,Ensure availability and functioning of adaptive equipment,Resident is at risk or is experiencing adjustment issues related to communication challenges. D. Record review of R #66's Progress Notes, dated 05/18/25, revealed the following: Resident is primarily non-verbal communication board, pen and paper,?Resident has the following needs for special adaptive equipment to participate in desired engagement opportunities-Communication board written instructions/gestures for hearing lost. No cognitive limitations.? E. Record review of R #66's Psychiatric Notes, dated 10/23/25, revealed Due to resident being non-verbal in today's assessment, this note is completed per chart review and staff support.F. Record review of R #66' Speech Therapy evaluation, dated 11/14/25, revealed the following:? Evaluation of speech with evaluation of language and comprehension and expression,Resident is nonverbal,Hearing details- None (uses notepad to communicate),Resident reports not knowing all the words but communicates through a notebook,Speech clarity: no speech,Auditory Comprehension-Not indicated (profound hearing loss),Ability to hear- highly impaired (absence of useful hearing),Due to the documented physical impairments, without skilled therapeutic interventions, the resident is at risk for anxiety, general health, decreased leisure participation and social isolation. G. Record review of R #66's Psychiatric Notes, dated 11/20/25, revealed the following:? Resident?uses paper and pencil to answer questions on notebook,Due to resident being non-verbal in today's assessment, this note is completed per chart review and staff support. H. Record of R #66's Physicians Orders, dated 01/07/26, revealed the facility is to provide a speech therapy evaluation and treatment as recommended. Resident is non-verbal (unable to speak or use words to communicate) and uses a communication board.I. Record review of R #66's Provider Documentation revealed the following:?Clear speech (intelligible?articulation and pronunciation, with appropriate?voice quality,?rhythm, and fluency, allowing speech to be easily understood by listeners)?and resident is deaf (partial or complete inability to hear sounds)?08/13/25,Speech is clear 08/19/25,Resident has clear speech 09/23/25, ??Resident has clear speech (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/01/25. ?? J. On 01/07/26 at 3:19 PM, during an interview with the Activities Director (AD), she stated R #66 used a whiteboard or his notebook as his source of communication.?? K. On 01/07/2026 at 3:21 PM, during an interview with Certified Nurse Aide (CNA) #1, she stated R #66 is nonverbal and?writes his questions on a piece of paper. CNA #1 stated since the admission of the resident, she had never heard him speak. ? L. On 01/07/26 at 3:26 PM, during an interview with Registered Nurse (RN) #1, she stated R #66 is nonverbal and communicates with a notebook. She stated the resident also has hearing loss.? M. On 01/07/26 at 3:27 PM, during an interview with CNA #2, she stated R #66 doesn't speak and uses his notebook to communicate.? She stated the resident has difficulty hearing. N. On 01/07/26 at 3:36 PM, during an interview with Certified Medication Assistant (CMA) #1, she stated R #66 doesn't speak and uses his notebook to communicate. She stated the resident also has a hearing impairment.? O. On 01/08/26 at 10:20 AM, during an interview with the Activities Director (AD), she stated R #66 has been nonverbal since he admitted in 2023.? P. On 01/08/2026 at 1:38 PM, during an interview with the Director of Rehab (DOR), she stated R #66 is nonverbal and uses a communication board to communicate.?? Q. On 01/08/2026 at 1:44 PM during an interview with the Social Services Director (SSD), she stated R #66 is nonverbal and uses a pen and notebook to answer questions and communicate.?? R. On 01/14/26, at 2:45 PM, during an interview with the Director of Nursing (DON), she stated R #66 was non-verbal and had profound hearing loss. The DON confirmed R #66's EHR should reflect R #66 being nonverbal with hearing loss, but it did not due to R #66's provider documentation indicating R #66 could speak without limitations (finding I).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 4 (R #7, R #36, R #50, and R #62) of 10 (R #7, R #10, R #32, R #36, R #50, R #62, R#67, R #74, R#76,and R #77) residents reviewed for medication administration and infection prevention when: The facility stored R #7's oxygen (O2) concentrator (medical device that provides continuous O2) inappropriately on the floor. Facility nursing staff administered R #62's topical eye medication while touching the eyelid of R #62 with ungloved hands. Facility nursing staff did not sanitize their hands before and/or after medication administration for R #s 36, 50 and 62. These deficient practices are likely to place residents at risk of contracting infections, hospitalization, and death. The findings are: Respiratory Equipment: A. Record review of R #7's face sheet revealed R #7 was admitted into the facility on [DATE] with the following diagnoses: Acute and chronic respiratory failure with hypoxia (low oxygen levels), Pulmonary hypertension (high blood pressure that affects the arteries in the lungs and the right side of the heart), Chronic pulmonary embolism (blood clot that blocks blood flow to an artery in the lung), Dependence on supplemental oxygen. B. Record review of R #7's Physician Orders, dated 09/20/25, revealed the following:? BIPAP (bilevel positive airway pressure)?oxygen setting to 5 LPM (liters per minute) to keep oxygen saturations above 88% (percent), Oxygen at 2-5 LPM via nasal cannula (a small, flexible tube that delivers oxygen to the nose through soft prongs). C. Record review R #7's Care Plan, dated 10/10/25 revealed the following: Risk of respiratory complications related to history of respiratory failure with the need for oxygen, Observed for new or worsening cough, Administer oxygen as ordered/indicated. D. On 01/05/26 at 1:29 PM, during an observation of R #7's room, R #7's portable O2 concentrator was observed lying on the floor, next to the resident's dresser. E. On 01/05/26 at 2:18 PM, during observation of R #7's room, Certified Nursing Assistant (CNA) #3 removed R #7's portable O2 concentrator from the floor, to be filled in the facility's oxygen room.? F. On 01/05/26 at 2:19 PM, during an observation of R #7's room, CNA #3 placed R #7's portable O2 concentrator directly on the floor of R #7's room, uncovered.? G.?On 01/05/26 at 2:15 PM, during an interview with CNA #4, she stated portable O2 delivery equipment and O2 tubing should not be placed on the floor. She stated the proper storage is behind the resident's wheelchair or in the O2 storage room. CNA # 1 stated if the portable O2 concentrator is not stored properly, the resident could become sick. ?H. On 01/05/26 at 2:21 PM, during an interview with CNA #3, she stated she placed R #7's portable O2 concentrator on the floor because the resident does not like the portable on the back of her wheelchair when not in use. ? I. On 01/14/26 at 2:02 PM, during an interview with the Director of Nursing (DON), she stated it was her expectation for all O2 delivery devices to be stored properly and not on the floor of the resident's room. ?She stated if portable O2 concentrators and tubing are placed on the floor, it becomes a possible accident and hazard, or the resident may develop a respiratory infection. Topical Eye Medication and Hand Hygiene: Licensed Practical Nurse (LPN) #2: J. On 01/06/26 at 9:02 am, during medication administration for R #50, LPN #2 was observed leaving R #50's room without sanitizing her hands prior to giving R #50 her medications or sanitizing her hands after medication administration. K. 01/06/26 at 9:05 am, during an interview with LPN #2, she confirmed she did not sanitize her hands between residents and stated she should have. L. On 01/06/26 at 3:03 pm, during an interview with the Director of Nursing (DON), she stated her expectation is for nursing staff to sanitize or wash their hands before and after medication administration. Licensed Practical Nurse (LPN) #3: M. On 01/06/26 at 8:47 am, during (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication administration for R #36, LPN #3 was observed preparing medications without sanitizing his hands prior to giving R #36 her medications or after medication administration. N. On 01/06/26 at 9:24 am, during medication administration for R #62, LPN #3 was observed applying eyedrops to R #62's eye using his ungloved hand to hold R #62's eye open. LPN #3 did not sanitize his hands after completing R #62's medication administration. O. On 01/06/26 at 09:27 am, during an interview with LPN #3, he confirmed he should have sanitized his hands after touching each resident and administering their medications. P. On 01/06/26 at 3:03 pm, during an interview with the DON, she stated her expectation is for nursing staff to sanitize or wash their hands before and after medication administration, touching a resident, or touching environmental surfaces.