STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325069	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Albuquerque Heights Healthcare and Rehabilitation	103 Hospital Loop NE Albuquerque, NM 87109

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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 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** 52440 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 #61) of 1 (R #61) resident reviewed for MDS assessments. This deficient practice could result in failure to provide adequate care and treatment of the resident's needs. The findings are: Cognition A. Record review of R #61's face sheet revealed an admitted [DATE] and included the following diagnoses: - Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement.) - Other symptoms and signs involving cognitive function and awareness. This is not an all inclusive list. B. Record review of R #61's MDS, dated [DATE], revealed the following: - Brief Interview for Mental Status (BIMS; screening for cognitive impairment) was not completed due to resident was rarely or never understood. - Cognitive skills for daily decision making: Severely impaired decision making. - Evidence of an acute change in mental status from resident's baseline: No. - Hearing, speech, and vision: Usually understands and usually understood. C. Record review of R #61's MDS, dated [DATE], revealed the following: - BIMS was not completed due to resident was rarely or never understood. (continued on next page)

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Cognitive skills for daily decision making: Moderately impaired, decisions poor, cues/supervision required. - Evidence of an acute change in mental status from resident's baseline: No. - Hearing, speech, and vision: Rarely/never understands and rarely/never understood. D. Record review of R #61's MDS, dated [DATE], revealed the following: - BIMS score of 2, moderately impaired. - Cognitive skills for daily decision making: Staff did not complete. - Evidence of an acute change in mental status from resident's baseline: No. - Hearing, speech, and vision: Understands and understood. E. Record review of R #61's progress note, dated 01/31/25, and completed by the Physician Assistant, revealed the resident was unable to give any meaningful history or to answer appropriate questions during visit. General: Alert and awake. Oriented to self (knows who they are.) F. On 04/15/25 at 3:15 pm, during an interview, the MDS Coordinator stated R #61's MDS was coded incorrectly for making self-understood and understanding others. Behaviors G. Record review of R #61's annual MDS, dated [DATE], revealed the resident did not exhibit behaviors. H. Record Review R #61's Progress Notes revealed the following: -Dated 03/16/25, R #61 yelled and screamed at others. -Dated 03/19/25, R #61 yelled, cursed, and screamed. -Dated 04/02/25, R #61 yelled, cursed, and disrupted others. -Dated 04/03/25, R # 61 yelled and cursed. -Dated 04/03/25, R # 61 yelled and cursed. -Dated 04/03/25, R #61 yelled repetitively and cursed. -Dated 04/04/25, R #61 yelled loudly and said she wanted to go to bed. -Dated 04/08/25, R #61 yelled, cursed, and screamed. -Dated 04/08/25, R #61 yelled, cursed, and screamed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dated 04/08/25, R #61 yelled, cursed, and screamed. I. On 04/14/25 at 1:48 pm, during an interview with the Dementia Program Director, she stated R #61 had behaviors weekly. J. On 04/15/25 at 3:15 pm, during an interview with the MDS Coordinator, she stated R #61's MDS was coded incorrectly for behavioral symptoms. The MDS Coordinator stated R #61's MDS should indicate R #61 had behaviors. MDS Coordinator stated the resident's progress notes showed staff recorded R #61's behavior almost every other day. The MDS Coordinator stated she screened resident MDS's for accuracy. MDS Coordinator stated R #61's MDS appeared to contradict the information in the resident's record. MDS Coordinator stated the staff who completed the information in the MDS should follow-up on discrepancies for a more accurate representation of the resident. The MDS Coordinator reviewed R #61's record and stated she saw discrepancies.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 35632 Based on observation, interview, and record review, the facility failed to provide a light meal or a snack for 1 (R #177) of 1 (R #177) before the resident left the facility to go to dialysis (a medical treatment which filters waste and excess fluid from the blood.) This deficient practice could potentially cause prolonged recovery time for the resident after dialysis. The findings are: A. Record review of the facility's Dialysis Policy, last revised on 08/07/23, revealed nutritional/fluid management included the provision of meals before, during, and after hemodialysis (dialysis) and monitoring intake and output measurements as ordered. B. Record review of R #177's face sheet revealed the resident was admitted to the facility 03/19/25, with the following diagnoses: - Non-st elevation (NSTEMI) myocardial infarction (a heart attack that happens when a part of the heart is not getting enough oxygen), - Congestive heart failure (the heart cannot supply enough blood to meet the body's needs), - Ischemic cardiomyopathy (a type of heart failure caused by low blood flow to the heart muscle), - Type II diabetes (means that your body does not use insulin properly), - End stage renal disease (kidneys reach advanced state of loss of function), - Dependence on renal dialysis (a blood purifying treatment given when kidney function is not optimum.) C. On 04/07/25 at 9:36 am, during an interview with R #177, she stated she lived at the facility for awhile, and staff have not offered her anything to eat before dialysis. She stated she usually had to wait to eat until she came back sometime after lunch. She stated her lunch tray was always on her table when she came back from dialysis, and she ate that when she returned. D. On 04/07/25 at 9:45 am, during an interview with Certified Nursing Assistant (CNA) #8, she stated that she did not offer R #177 snacks or lunch, because R #177 left for dialysis right after breakfast. CNA #8 stated the resident would not need a snack or lunch. E. On 04/09/25 at 9:48 am, during an observation, staff propelled R #177 in her wheelchair to the transport van for dialysis. The resident did not have a snack or lunch with her. F. On 04/09/25 at 9:50 am, during an interview with R #177, she stated staff did not offer her a snack or a lunch before she left for dialysis. G. On 04/11/25 at 11:07 am, during an interview with CNA #9 she stated she did not offer a snack to the residents going to dialysis. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. On 04/11/25 at 11:09 am, during an interview with Nurse #10, she stated all staff were responsible to make sure dialysis residents received a snack or lunch before the resident left for dialysis. She stated if there was not something already prepared in the refrigerator for the dialysis residents, then someone should go down to the kitchen to get something. I. On 04/11/25 at 11:17 am, during an interview with the Dietary Manager (DM), he stated they had a list of residents who went to dialysis, and they made them sack lunches or snacks. He stated it depended on what time the resident went to dialysis whether they received breakfast and were back by lunch, or they left later in the morning and they needed a sack lunch. He stated they had five or six residents who were on dialysis. J. On 04/11/25 at 1:29 pm, during an interview with the Director of Nursing (DON), she stated it was expected for staff to offer all dialysis residents a snack or a lunch depending on their dialysis times. The DON stated she was unaware staff did not offer snacks or lunch to residents going to dialysis.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40671 Based on record review and interview, the facility failed to provide activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) assistance for baths and showers for 2 (R #6 and #38) of 2 (R #6 and #38) residents sampled for ADLs when staff failed to: 1) Change R #6's soiled brief prior to assisting him to bed. 2) Clean and change R #38's ileostomy (a surgically made opening that connects your small intestine to your abdominal wall) bag. These deficient practices could likely result in residents being at a higher risk for infection and to feel unimportant, embarrassed and undignified. The findings are: R#6 A. Record review of R #6's face sheet, dated 07/23/24, revealed an initial admitted [DATE]. B. Record review of R #6's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 03/22/25, indicated R #6 required substantial staff assistance for toileting hygiene. C. Record review of R #6's care plan, dated 04/01/25, revealed the following: - Focus: R #6 required assistance from staff for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to limited mobility and weakness. - Goal: Resident's ADL care needs will be anticipated and met throughout the next review period. D. On 04/08/25 at 12:10 pm during an observation, R #6 appeared unclean and disheveled (untidy and disordered.) He lay in bed dressed in a hospital gown, his hair was greasy, and his beard had food crumbs throughout it. E. On 04/08/25 at 12:12 pm during an interview, R #6 stated he frequently went to bed with dirty brief. He stated he was not sure how often he went to bed with a dirty brief, but it happened a lot. R #38 F. Record review of R #38's face sheet, dated 01/22/25, revealed an initial admitted [DATE] with a diagnosis of colostomy (a surgically made opening that connects your small intestine to your abdominal wall.) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. Record review of R #38's MDS, dated [DATE], indicated R #38 required partial staff assistance for toileting hygiene or management of an ostomy (allows bodily waste to pass through an opening on the abdomen into a bag), to include wiping the opening. H. Record review of R #38's care plan, dated 04/01/25, revealed the following: - Focus: R #38 required assistance from staff for ADL care. - Goal: Resident's ADL care needs will be anticipated and met throughout the next review period. I. On 04/08/25 at 12:23 pm during an observation, R #38 was dressed in a soiled hospital gown with feces on it, and his ileostomy bag leaked at the base (where it connected at the abdomen). He stated his gown was soiled since last night. He stated staff come in to his room, tell him they will be right back to change him, and never return. R #38 stated his colostomy bag leaked at the base, and it took a long time for staff to answer the call light. He stated he waited to be changed since early in the morning. J. On 04/08/25 at 12:42 pm during an interview, an Anonymous Certified Nursing Aide (ACNA) stated often there were not enough Certified Nursing Aides (CNAs) working, and it sometimes took a while to get to residents who needed hygiene care. ACNA stated R #6 and R #38 required assistance with personal hygiene.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50752 Based on record review and interview, the facility failed to provide mental health services for 1 (R #57) of 1 (R #57) resident after the resident witnessed his roommate unconscious and unresponsive as staff performed life saving procedures on the roommate. If residents are not provided with mental health services, then residents are likely to experience a decline in their psychosocial well-being. The findings are: A. Record review of R #33's face sheet revealed R #33 was admitted on [DATE] with a diagnosis of major depressive disorder. B. Record review of R #33's progress notes, dated [DATE], revealed R #33 was found unconscious in the bathroom of a suspected overdose of street drugs. R #33's son and R #57 (roommate) were in the room. Registered Nurse (RN) #1 and Physician Assistant (PA) performed cardiopulmonary resuscitation (CPR; full code, an emergency procedure that combines chest compression with artificial ventilation) on R #33. C. Record review of R #57's face sheet revealed R #57 was admitted on [DATE] with the following diagnoses: -Heart failure, -Unspecified hearing loss, bilateral (both ears.) D. Record review of R #57's progress notes, dated [DATE] through [DATE], revealed the record did not contain documentation a medical professional saw R #57 on the day of the incident, [DATE], or afterwards. Further review revealed staff did not document any information in R #57's record regarding the incident on [DATE]. E. On [DATE] at 10:00 AM during an interview, R #57 had difficulty hearing and did not respond. F. On [DATE] at 3:00 PM, during an interview with RN #1, she stated she received a call to assist in R #57's and R #33's room. She stated she found R #33 unconscious and unresponsive in the bathroom due to a suspected opioid overdose. She stated she and the PA entered the room and started CPR on R #33 RN #1 stated she saw R #57 sitting on his bed near the bathroom and watching the situation unfold. She stated staff escorted R #57 out of the room while RN #1, the PA, and Emergency Medical Services (EMS) conducted life-saving measures on R #33. RN #1 stated a nurse (unidentified) assessed R #57 and said he was fine. RN #1 stated she was unsure if a therapist saw R #57 after the incident. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	G. On [DATE] at 1:58 PM during an interview with the PA, she stated R #57 sat on the edge of his bed near the bathroom while she performed CPR on R #33, and R #57 was crying and scared. The PA stated a staff (unidentified) came and took R #57 out of the room. She stated she did not write a order for R #57 to see a psychiatric provider, but she should have written one. She stated R #57 was traumatized by what he saw, and a psychiatric provider should have evaluated him. H. On [DATE] at 2:15 PM during an interview with Social Services, he stated he was aware of the incident on [DATE] in R #57's room, but he failed to go and talk with R #57. He stated it was expected for a psychiatric professional to see R #57, because the experience was likely a traumatic experience for R #57. He stated it was probably necessary for R #57 to see someone to talk about what happened. He stated he did not do a referral for talk therapy for R #57. I. On [DATE] at 2:30 PM during an interview with the Administrator, she stated she was aware of the incident in R #33's and R #57's room on [DATE]. She stated R #57 could have benefited from support after the incident. She stated supportive services were provided to R #57. The Administrator stated Social Services should have seen R #57. She stated she also expected the resident to be seen by a psychiatric professional. The Administrator reviewed R #57's medical records for the month of February and stated she did not find any record of psychiatric services ordered for the resident.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52440 Based on record review and interview, the facility failed to discontinue a duplicate order of carvedilol (a blood pressure medication used to prevent high blood pressure and strokes in persons with heart disease or hypertension) for 1 (R #61) of 1 (R #61) resident reviewed for unnecessary medications. This deficient practice is likely to result in a resident failing to obtain maximum wellness or suffering prolonged illness. The findings are: A. Record review of R #61's face sheet, undated, revealed an initial admitted [DATE] and included the following diagnoses: - Cerebral infarction (stroke) due to embolism (obstruction in a blood vessel) of bilateral (both sides) middle cerebral (relating to the brain) arteries. - Paroxysmal (sudden occurrence or increase of symptoms) atrial fibrillation (Afib; a type of irregular heartbeat.) - Essential (primary) hypertension (high blood pressure.) B. Record review of R #61's Medication Administration Record (MAR), dated April 2025, revealed the following: - Start date 04/04/24, End date: None. Carvedilol tablet 3.125 milligrams (mg). Give 6.25 mg by mouth two times a day. - Start date 04/11/25, End date: None. Carvedilol oral tablet 6.25 mg. Give one tablet by mouth two times a day. - On 04/11/25, staff administered one dose of carvedilol 6.25 mg in the morning and two doses of carvedilol 6.25 mg in the evening. - On 04/12/25, staff administered one dose of carvedilol 6.25 mg in the morning and two doses of carvedilol 6.25 mg in the evening. - On 04/13/25, staff administered two doses of carvedilol 6.25 mg twice daily. - On 04/14/25, staff administered two doses of carvedilol 6.25 mg in the morning. C. Record review of the manufacturer's instructions for Coreg (name brand for carvedilol), undated, revealed the following: - Dosage hypertension: Start at 6.25 mg twice daily and increase if needed for blood pressure control to 12.5 mg, then 25 mg twice daily over intervals of 1 to 2 weeks. - Possible side effects include low blood pressure, which may cause dizziness or fainting when standing, tiredness, slow heartbeat, and changes in blood sugar. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Overdosage may cause severe hypotension, bradycardia, cardiac insufficiency, cardiogenic shock, and cardiac arrest. Respiratory problems, bronchospasms, vomiting, lapses of consciousness, and generalized seizures may also occur. D. On 04/15/25 at 1:58 p.m. 04/30/25 at 1:55 p.m., during an interview, the Practitioner Assistant (PA) stated R #61 had two orders for carvedilol, but there should only be one order. The PA stated the second order should have been discontinued when the new order was added. The PA stated administering too much carvedilol could lower blood pressure. E. On 04/15/25 at 2:18 p.m., during an interview, the Director of Nursing (DON) stated staff administered two doses of carvedilol on 04/11/25, 04/12/25, 04/13/25, 04/14/25, and 04/15/25. The DON stated an alert would pop up in the resident orders to alert the staff of duplicate orders. She stated orders are reviewed in the daily clinical meeting. She stated the nurse who entered the order was responsible for the medication. The DON stated the nurse who entered the order needed to call the provider to verify if the medication orders were correct. The DON said if there was a duplicate order, then the nurse who entered it would delete it after they verified it with the provider. F. On 04/30/25 at 2:01 p.m., during an interview, RN #1 stated she was responsible for the duplicate order. RN #1 stated she was multitasking at the time and did not remember seeing the error message for the duplicate order.

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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. 50752 Based on observation and interview, the facility failed to protect a treatment cart (a movable piece of equipment used in healthcare facilities to store, transport, and dispense treatment supplies and tools) from unauthorized access when staff failed to lock the treatment carts while staff were away from the cart. This failure had the potential to affect all 48 residents on the 300 Unit, as identified by the Resident Census provided by the Administrator on 04/07/25. If staff fail to lock an unsupervised treatment cart, then residents could obtain medial equipment which could result in injury or death. The findings are: A. On 04/07/25 at 11:50 AM, during an observation of the 300 Unit, the intravenous (IV; in the vein) treatment cart was unlocked and opened. Further observations revealed the cart had sterile needles and intravenous catheters (a thin, flexible tube inserted into a vein to deliver fluids). Staff were not present in the area near the cart. B. On 04/07/25 at 11:55 AM, during an interview, Registered Nurse (RN) #1 stated the IV treatment cart was unlocked and opened. She said the treatment cart should be locked when the cart was not in use. C. On 04/15/25 at 2:15 PM, during an interview, Director of Nursing (DON) stated staff should never leave the IV treatment carts unlocked while unattended.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 35632 Based on observation and interview, the facility failed to serve a meal that had been at a palatable temperature for 1 (R #177) of 1 (R #177) resident when staff left the resident's lunch tray on the bedside table while the resident was at dialysis. This deficient practice could cause a resident to not eat her lunch and could cause weight loss. The findings are: Cross referenced to F658 A. Record review of R #177's face sheet revealed the resident was admitted to the facility 03/19/25 with the following diagnoses: - Non-st elevation (NSTEMI) myocardial infarction (a heart attack that happens when a part of the heart is not getting enough oxygen), - Congestive heart failure (the heart cannot supply enough blood to meet the body's needs), - Ischemic cardiomyopathy (a type of heart failure caused by low blood flow to the heart muscle), - Type II diabetes (means that your body does not use insulin properly), - End stage renal disease (kidneys reach advanced state of loss of function), - Dependence on renal dialysis (a blood purifying treatment given when kidney function is not optimum.) B. On 04/07/25 at 9:36 am, during an interview with R #177, she stated her lunch tray was on her bedside table when she got back to her room after dialysis, and she ate the lunch trays when she got back. She stated she typically got back to the facility between 2:00 pm and 3:00 pm. She stated she did not ask staff to heat up her meal. R #177 stated she was hungry when she got back to the facility. She stated she asked staff to heat up her lunch meal, but they did not warm it up. C. On 04/07/25 at 12:45 pm, during an observation, staff delivered a meal tray to R #177's room and left the tray on the bedside table. Further observation revealed R #177 was at dialysis. D. On 04/07/25 at 1:14 pm, 2:18 pm, and 3:34 pm, during an observation, R #177's lunch tray sat on the bedside table. The lunch tray consisted of a tamale and black beans. E. On 04/07/25 at 3:37 pm, during an observation, R #177 ate her lunch of tamale and black beans. An unidentified Certified Nursing Assistant (CNA) took the tray away from the resident and stated the food was more than two hours old. F. On 04/11/25 at 11:09 am, during an interview with Nurse #10, she stated staff left a lunch tray for R #177 on her bedside table so she could eat it when she returned from dialysis. Nurse #10 stated R #177 liked having the tray available to eat when she returned. She stated they offered to heat it up for her. She could not say how long the meal tray sat out before R #177 ate it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325069	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Albuquerque Heights Healthcare and Rehabilitation	103 Hospital Loop NE Albuquerque, NM 87109

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	G. On 04/11/25 at 11:17 am, during an interview with the Dietary Manager (DM), he stated he would not expect staff to leave a meal tray on the resident's bedside table if the resident was at dialysis. He stated he expected staff to bring the meal tray back to the kitchen and save it for the resident. He stated staff could also have something else available for the resident to eat when they returned from dialysis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325069	A. Building B. Wing	04/15/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40671 Based on observation and interview, the facility failed to ensure residents had a safe and functional environment for resident rooms 205, 206, 207, 208, 211, and 213 when staff failed to: 1) Replace a broken plastic disposable glove holder in room [ROOM NUMBER] and 208. 2) Repair ripped flooring near a resident bed in room [ROOM NUMBER]. 3) Repair the hand rail end piece outside of room [ROOM NUMBER]. 4) Repair or replace a broken closet, a broken dresser, missing dresser drawer, broken blinds, and ripped flooring near the resident's bed in room [ROOM NUMBER]. 5) Maintain the shower in room [ROOM NUMBER] free of the storage of random items. 6) Replace broken blinds, cleaning a wall, and ensuring the room was free from a pungent (strong) urine odor in room [ROOM NUMBER]. This deficient practice could likely result in residents living in an unsafe environment, could increase their risk for injuries, and decrease their quality of life. The findings are: A. On 04/08/25 at 11:20 am, observation of resident room [ROOM NUMBER] revealed a broken glove holder on the wall, a broken thermostat, and a broken dresser drawer. B. On 04/08/25 at 11:26 am, observation of resident room [ROOM NUMBER] revealed an wardrobe with a broken door and a missing bottom drawer, broken blinds, and ripped flooring. Further observations revealed large foam pads and cushions stored in shower. C. On 04/08/25 at 11:28 am, observation of resident room [ROOM NUMBER] revealed the hand rail, directly outside the resident entry door, was missing the end piece. Further observation revealed sharp edges exposed. D. On 04/08/25 at 11:31 am, observation of resident room [ROOM NUMBER] revealed ripped flooring by bed A. E. On 04/08/25 at 11:34 am, observation of resident #213 revealed broken blinds; a green gum-like substance on the wall in several spots by bed B, and a strong urine odor. F. On 04/09/25 at 9:53 am, observation of the Memory Care Unit revealed the following: - Ceiling vents throughout entire unit were filthy dust build-up. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Light covering in the hallway by resident room [ROOM NUMBER] was broken and missing a piece of plastic. - Ceiling tiles near the nurses station had brown spots splattered on them. - A gap around the sprinkler head on the ceiling near the exit door. G. On 04/11/25 at 3:25 pm during an interview, the Maintenance Director stated it was the responsibility of the Certified Nurse Aides (CNAs) and the nurses to submit work order requests through their electronic system. He stated he was currently the only maintenance person. H. On 04/14/25 at 2:23 pm during an interview, the Director of the Memory Unit verified the environmental and safety concerns and stated these concerns should be repaired.