STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. Building B. Wing	09/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blumenthal Health and Rehabilitation Center	3724 Wireless Drive Greensboro, NC 27455

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and staff, resident, and Physician Assistant interviews, the facility failed to assess a resident for the ability to self-administer medications for 1 of 1 resident reviewed for self-administering medications (Resident #82).The findings included:Resident #82 was admitted on [DATE] with diagnoses that included progressive supranuclear ophthalmalgia (a disease that makes a person unable to move their eyes at will in all directions, especially looking upward), type II diabetes, and cognitive communication deficit.Resident #82 had an active physician's order for Refresh Tears Solution; instill 1 drop in both eyes every 1 hour as needed for dry eye, ordered 5/29/25, and Systane Solution 0.4-0.3%; instill 1 drop in both eyes three times a day for eye lubricant, ordered 6/9/25.Resident #82's significant change Minimum Data Set (MDS) assessment dated [DATE] assessed him to be cognitively intact with supervision or touching assistance with personal hygiene. A review of Resident #82's care plan dated 5/25/25 did not include a plan for self-administration of medication. The review of Resident #82's medical record did not reveal an assessment for self-administration of medication. During an observation of Resident #82's room and interview on 9/8/25 at 11:37 AM, a partially used bottle of Systane eye drops as well as an unopened bottle of Refresh eye drops were found on the resident's nightstand. The resident stated he had been administering his own eye drops every 3 hours whenever he needed them. Resident #82 said the nurses were aware he was giving his own eye drops as needed.A subsequent observation on 9/9/25 at 2:00 PM revealed a partially used bottle of Systane eye drops, a partially used bottle of Refresh eye drops, and an unopened bottle of Refresh eye drops continued to remain on Resident #82's nightstand.On 9/9/25 at 2:08 PM Nurse #1 was interviewed and stated she was aware Resident #82 had eye drops at the bedside because the resident's spouse kept bringing bottles of eye drops to the facility for his use. Nurse #1 stated she had told the spouse the facility was able to supply the resident's eye drops, but she did not instruct the spouse not to bring them in. Nurse #1 indicated she was not aware if the resident had an order to self-administer medications, and she had not reported the eye drops being left at the bedside to management because she was not aware they needed to be reported. Unit Manager #2 was interviewed on 9/9/25 at 2:14 PM who stated residents were not supposed to have medications kept at their bedside. She indicated Resident #82 had not been assessed for self-administration of medications, and the nurses should have kept all medications, including eye drops, locked in the medication cart.On 9/10/25 at 12:19 PM the Director of Nursing (DON) was interviewed who stated eye drops were not supposed to be left on the resident's nightstand unless the resident had a care plan to self-administer. He verified Resident #82 did not have an order to self-administer medications.The Physician's Assistant (PA) was interviewed on 9/11/25 at 12:50 PM who stated he had not written an order for Resident #82 to self-administer his medications or have eye drops at the bedside. The PA stated due to the resident's multiple diagnoses, he was not sure if the resident knew how to administer eye drops correctly.

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) form 10555 prior to discharge from Medicare Part A skilled services for 2 of 3 residents reviewed for beneficiary protection notification review (Resident #28 and Resident #83).The findings included:1. Resident #28 was admitted to the facility and to Medicare Part A skilled services on 5/22/25.Resident #28's Medicare Part A skilled services ended on 7/2/25. She remained in the facility.Record review revealed there was no documentation Resident #28, or her Responsible Party (RP) were issued a SNF-ABN. During a phone interview with the previous facility Social Worker on 9/11/25 at 12:56 PM she stated it was her job to issue the SNF-ABN. She stated when a resident's Medicare Part A skilled services were about to end, she provided the SNF-ABN to either the resident if they were their own Responsible Party or to the family if they were still going to remain in the facility. The Social Worker did not provide a reason as to why the SNF-ABN for Resident #28 was overlooked.An interview was conducted with the Administrator on 9/12/25 at 10:35 AM who indicated it was the Social Worker's responsibility to issue all SNF-ABN's if the resident remained in the facility after the Medicare Part A skilled services ended and that Resident #28 should have received the SNF-ABN as required by Federal guidelines. 2. Resident #83 was admitted to the facility and to Medicare Part A skilled services on 6/6/25.Resident #83's Medicare Part A skilled services ended on 7/2/25. He remained in the facility.Record review revealed there was no documentation Resident #83, or his Responsible Party were issued a SNF-ABN. During a phone interview with the previous facility Social Worker on 9/11/25 at 12:56 PM she stated it was her job to issue the SNF-ABN. She stated when a resident's Medicare Part A skilled services were about to end, she provided the SNF-ABN to either the resident if they were their own Responsible Party or to the family if they were still going to remain in the facility. The Social Worker did not provide a reason as to why the SNF-ABN for Resident #83 was overlooked.An interview was conducted with the Administrator on 9/12/25 at 10:35 AM who indicated it was the Social Worker's responsibility to issue all SNF-ABN's if the resident remained in the facility after the Medicare Part A skilled services ended and that Resident #83 should have received the SNF-ABN as required by Federal guidelines.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on record review, and resident representative and staff interviews, the facility failed to maintain documentation of resolved grievances for 2 of 3 residents (Resident #121 and Resident #170) and evidence of the results of all grievances for 6 of 11 months reviewed (February 2025 to July 2025). Findings included: Review of the facility policy last reviewed on 3/8/24 titled Grievance Policy read in part: The facility must ensure that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent finding or conclusions regarding the resident's concerns, a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken by the facility, and the date the written decision was issued.Review of the current facility grievance log for November 2024 through present showed there were no grievances logged between 2/1/25 through 7/31/25.During a phone interview with the previous Social Worker (SW) on 9/11/25 at 12:56 PM who stated her last date of work at the facility was 8/15/25. The SW reported that she was taking paper grievances until the facility began using a new computer system sometime during the Spring of 2025. The SW stated she would pass out the grievances to the different department heads as needed if she couldn't resolve the issue on her own and then kept a copy of all of the grievances in her office in a binder. The SW she did not know who was in charge of the grievances after the computer program was initiated and stated she only handled the paper ones that were given directly to her by residents and/or family members. The SW added she thought it was each department head's responsibility to follow-up on their specific grievances.The facility did not have a staff member in the role of Social Worker during the survey.During an interview on 9/9/25 at 1:11 PM with Resident #121's Responsible Party (RP), she stated she was very concerned about the length of time it took for staff to provide incontinent care for Resident #121 who was not cognitively intact. Resident #121's RP reported she did notify the facility Social Worker of her concerns regarding incontinent care on 7/12/25 after a Medicaid representative advised her to file a grievance with the facility. Resident #121's RP reported the facility never responded to her or resolved her concerns with a written response.During an interview on 9/10/25 at 4:25 PM with Resident #170's Responsible Part (RP), she stated she filed a paper grievance with an unnamed nurse aide on 7/31/25 regarding a delay with incontinent care on behalf of Resident #170 who was not cognitively intact. Resident #170's RP reported she did not receive any communication from the facility regarding the issue. During an interview with Administrator #1, the current administrator, on 9/11/25 at 2:20 PM she stated the grievances from February 2025 through July 2025 were not available and could not be reviewed because she did not have the grievances as the facility had been unable to locate the grievances in the Social Worker office. The Administrator stated any paper grievances she had received from residents or resident family members were handed off to the Social Worker who would enter them into the computer system. The Administrator stated she had been made aware the previous facility Social Worker had not been maintaining any paper grievances for several months during an internal mock survey by the company last month. The Administrator reported she was currently handling grievances since 8/1/25 until they can hire a new Social Worker. The Administrator presented a draft plan of correction to show they were working on a plan to correct that issue. The draft plan of the plan of the correction was found to be incomplete due to a lack of information regarding who was going to be responsible for grievances in the future and there was no information as to how grievances would be monitored to ensure compliance.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and interviews with staff, family, Nurse Practitioner, Medical Director, and responsible party (RP), the facility failed to protect the residents' right to be from resident- to- resident sexual abuse when a cognitively intact male resident (Resident #5) touched a female resident's (Resident #160's) breasts without her consent and made sexually explicit statements to her that included talking about the size of his penis. In addition, Resident #178 who was a moderately impaired male resident touched a female (Resident #163) between her legs near her vaginal area without her consent. This was for 2 of 4 residents reviewed for resident-to-resident abuse (Resident #160 and Resident #163). The findings included: Resident #160 was admitted to the facility on [DATE]. with diagnoses that included depression and anxiety. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #160's cognition was intact, she had no behaviors and was independent with using her wheelchair. Resident #160's care plan dated 8/4/2025 indicated the resident had problem areas that included the risk for complications related to cognitive impairment secondary to memory impairment; and the resident had signs and symptoms of depression and was at risk for adverse reactions. Resident #160 had no care plan related to behaviors. Resident #5 was admitted to the facility on [DATE] with diagnoses that included stroke, hemiplegia (paralysis or complete loss of movement on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction affecting right dominant side, and depression. Resident #5's care plan dated 6/25/25 indicated the resident had a problem area that included the resident having behaviors. The care plan provided no specifics as to the type of behaviors the resident had. The interventions included to administer medication as ordered, assign staff members that were familiar or preferred by the resident when possible, and referral to psychiatric services as needed. A quarterly MDS assessment dated [DATE] indicated that Resident #5's cognition was intact, he had no behaviors and was independent with using his wheelchair. An initial report dated 8/18/25 at 3:36 PM completed by the Administrator indicated there was an allegation of resident-to-resident sexual abuse between Resident #160 and Resident #5 on 8/17/25. The initial report recorded the facility became aware of the incident on 8/18/25 at 3:00PM. Details of the allegation stated that Resident #5 sexually assaulted Resident #160. Resident #160 stated that Resident #5 brushed her breast area and was asking her if she wanted to have sex and was talking to her about his privates. Resident #160 stated this happened while she was outside in the courtyard on Sunday (8/17/25) morning. Resident #160 stated that Resident #5 approached her in his electric wheelchair. Resident #5 was put on 1 on 1 supervision until an assessment could be completed by the physician. The facility notified the local law enforcement of the allegation on 8/18/25 at 3:00 PM. Written statements completed by the Administrator dated 8/18/25 indicated the following: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident #160 was upset when she shared the allegations with the Administrator. Resident #160 reported to Nurse Practitioner (NP) #2 that she was having difficulty sleeping due to the trauma but also reported that she had been having trouble sleeping since her admission to the facility. - Resident #5 stated that he and Resident #160 were very close friends and Resident #160 had enjoyed time with him and his family during their visits. Resident #5 stated that he and Resident #160 talked in the courtyard and on 8/17/25 Resident #160 asked him for cigarettes and Resident #5 refused to share. Resident #5 stated that she was upset but they continued to talk. Resident #5 stated that he told Resident #160 a story about an ex-girlfriend and private times that they shared together. The Administrator asked Resident #5 if he thought it was appropriate to discuss sex or private parts when talking with females and Resident #5 stated “we are just friends, but I guess not.” Resident #5 stated that he didn't mean anything by what he was talking about and that he thought they were just friends. Resident #5 stated that he probably touched Resident #160's arm and maybe around the area of her breasts. Resident #5 stated that it was nothing. The police report dated 8/18/25 at 2:59 PM indicated the following: Resident #160 reported that Resident #5 sexually assaulted her. She indicated that she arrived at the rehabilitation center 4 months prior and met Resident #5. Resident #160 stated that the two were friendly and would interact when she went outside to smoke. Resident #160 stated that her relationship with Resident #5 was never romantic and that they only interacted in common areas. She stated that “about a week and a half ago his behaviors changed. ” Resident #160 reported that Resident #5 began making sexual comments and following her around the facility. She indicated that Resident #5's comments consisted of referring to his penis as “Robo” and discussing “Robo” with her. Resident #160 reported that Resident #5 grabbed her right breast on two different occasions. She stated that one time it happened in the courtyard and another time near one of the nurse's stations. Resident #160 stated that both times she pushed his hand away and firmly stated “no.” On 9/11/25 at 8:05 AM call was placed to the local police department, message was left for the investigating officer, but no return call was received. The facility's investigation report dated 8/22/25 completed by the Administrator indicated the following: The resident-to-resident abuse was not a willful intent to inflict harm. Both Resident #160 and Resident #5 were instructed not to visit each other and Resident #5 continued to have 1 on 1 staff supervision until he was cleared through the behavioral health provider's visit scheduled for 8/25/25. The facility unsubstantiated the allegation of abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/09/2025 at 8:45 AM an interview occurred with Resident #160. Resident #160 stated that an incident had occurred between she and Resident #5 two to three weeks ago. Resident #160 was unable to give an exact date. Resident #160 stated that she spent a lot of time outside in the smoking area daily. Resident #160 stated that sometimes Resident #5 came to her in the smoking area and said inappropriate things to her when no one else was around. Resident #160 revealed a video from her phone of Resident #5 on 8/15/25 at 5:00pm. In the video, Resident #5 was sitting in his wheelchair and only parts of his legs and feet could be seen. Resident #5 was heard saying I have a big dick, and the girls call it Robo like a big ship. ” Resident #160 was not heard in the video responding but she stated that she told Resident #5 that she did not want to hear those types of things about him. Resident #160 reported that she told Resident #5 that she just wanted him to leave her alone. Resident #160 stated that she did not report this initial occurrence because she figured that Resident #5 would just leave her alone after she told him to. She indicated that at no time had she ever expressed any interest in Resident #5 speaking to her this way. Resident #160 reported that this occurrence was a different occurrence from the one that she reported to the Administrator on 8/18/25. She explained that the incident she reported to the Administrator occurred on the morning of 8/17/25 in the courtyard when Resident #5 grabbed her breasts inappropriately. Resident #160 reported that it occurred quickly, and it happened over top of her t-shirt that she was wearing. Resident #160 reported that she did not consent to this sexual act. Resident #160 reported that she told Resident #5 to leave her alone and he did. Resident #160 reported that she did not report the incident on that day but did report it the following afternoon because her friend encouraged her to do so. Resident #160 reported that her friend assisted her in pressing charges against Resident #5 through the police department. Resident #160 reported that at no time had she ever expressed any interest in Resident #5 inappropriately touching her. Resident #160 reported that there were other residents outside during the time of the incidents, but she was unable to recall who they were. Resident #160 reported that no one else saw what happened. Resident #160 reported that Resident #5 would not come around her if others were around her already. Resident #160 did not report that this incident was preventing her from doing anything in her normal daily routine. She indicated that she had continued to go outside and smoke whenever she wanted. She stated that she had seen Resident #5 since the incident but only from a distance. Resident #160 reported that initially staff were supervising Resident #5 when he was outside smoking but that had stopped. On 9/10/25 at 11:20 AM an interview occurred with Resident #5. Resident #5 revealed that the incident between him and Resident #160 did occur on 8/17/25 where he touched her breasts and said sexual things to her in the smoking courtyard area. Resident #5 reported that he touched Resident #160's arm and maybe around her breasts. Resident #5 reported that it all happened in seconds, and Resident #160 was wearing a t-shirt that she wears a lot. Resident #5 reported that he was telling Resident #160 a story about his ex-girlfriend and private times that they shared together. Resident #5 reported that he did this because he thought they had a relationship going. Resident #5 reported that in the past (unable to provide a date) he and Resident #160 had even talked about getting an apartment together once they got out of the facility. Resident #5 stated that when he grabbed Resident #160's breasts she did get upset with him, told him to stop, and reported him the next day for doing it. Resident #5 stated that the Administrator had him come into her office the same day that Resident #160 reported him. Resident #5 stated that since that happened, he had been maintaining his distance from Resident #160 and has not touched anyone else. Resident #5 stated that generally he is a follow the rules kind of guy. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/10/25 at 11:30 AM an interview with Nurse Practitioner (NP) #1 revealed that he had been working with both Resident #5 and Resident #160 on addressing the concerns from the reported allegations. NP #1 stated that he had been given the impression through conversations by both residents that they had been in a long-standing relationship up until recently. NP #1 stated that the allegations of sexual misconduct including touching and inappropriate comments were reported to him and both parties did agree that it happened but with different versions of the incident. NP #1 stated he asked Resident #5 if he touched Resident #160 and he stated that he probably touched her arm and maybe her breasts. NP #1 stated that Resident #160 reported that Resident #5 grabbed her breast area and was talking to her about his private parts. NP #1 indicated that after the incident was reported he referred both residents to be evaluated by psychiatry. A psychiatry progress note was completed on 8/19/25 by NP #2 (Psychiatric Nurse Practitioner) for Resident #160. Resident #160 was seen on this date per request due to allegations of sexual misconduct. Resident #160 reported that another resident had sexually assaulted her a few days prior. Resident #160 reported to NP #2, I'm okay, I already told that other guy what happened, Resident #5 grabbed my breast yesterday, I've told him several times to leave me alone and he will not. He talks dirty and says sexual things to me constantly and I try to ignore him but then he keeps telling me how big his dxxx is, I don't care anything about his dxxx and I want him to leave me alone. They moved me to another hallway, and he still comes to hunt for me. Yesterday when he grabbed my boob, I called the police and reported him. Resident #160 reported to NP #2 that her appetite was good and she was sleeping good. Resident #160 denied any suicidal thoughts or depressive symptoms reporting to NP #2 I just want him to leave me alone. Staff reported no new behavioral issues to NP #2. NP #2 referred Resident #160 to psychotherapy for follow up as she did not want any medication changes. Plan was to continue with Effexor and Remeron for her mood. Staff were to continue supportive care as needed. Staff were to continue to encourage self-care and socialization. Resident #160 was encouraged to notify staff if Resident #5 made any contact with her. A psychiatry progress note was completed on 8/25/25 by NP #2 for Resident #160. Resident #160 was seen on this date to follow up regarding depression and anxiety. Resident #160 reported to NP #2, I'm doing fine, just wish everyone would stop bothering me, I'm not even thinking about Resident #5, so everyone just needs to hush about the situation. Resident #160 reported that Resident #5 had not bothered her since her last visit with NP #2. Resident #160 reported to NP #2 that her appetite was good, and she was sleeping well. Resident #160 denied any suicidal thoughts or depressive symptoms during this visit. Staff reported no new behavioral issues to NP#2. Plan was to continue with Effexor and Remeron for her mood. Staff were to continue supportive care as needed. Staff were to continue to encourage self-care and socialization. Resident #160 was encouraged to notify staff if Resident #5 made any contact with her. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A psychiatry initial consult was completed on 8/26/25 by NP #2 for Resident #5. Resident #5 was seen on this date for initial psychiatric evaluation and to establish care under psychiatry services. NP #2 also seeing Resident #5 regarding recent allegations made by another resident that he grabbed her breast. Resident #5 reported that he had been eating and sleeping just fine. Resident #5 stated to NP #2 he thought she was there because of Resident #160. Resident #5 indicated he thought we were friends, and they had been talking to each other for a long time. Resident #5 stated, I did grab her boob a while ago. The resident told NP #2 he would not bother Resident #160 again because she's not going to get me in trouble. He also stated to NP #2, I don't want to be in trouble here in the facility, but it wasn't all me, but I will absolutely stay away from her, I would never touch anyone without their permission, never been in any kind of trouble before. Resident #5 reported to NP #2 that he did not want any medications changes regarding his depression. Plan was to continue Sertraline as ordered and refer to psychotherapy. NP #2 also discouraged Resident #5 from any type of interaction with Resident #160. On 9/11/2025 at 11:40 AM a phone interview occurred with NP #2. NP #2 reported that she had worked with both Resident #160 and Resident #5. NP #2 reported that it was hard to get much information from Resident #160 because she did not like to talk much. NP #2 reported that Resident #160 basically stated on 8/19/25 that she did not want Resident #5 touching her or saying sexual things to her. NP #2 reported that Resident #160 shared on 8/19/25 that her appetite was good and she was sleeping well and denied any suicidal thoughts or depressive symptoms. NP #2 stated that Resident #5 reported on 8/26/25 that he and Resident #160 were in an ongoing relationship and he admitted to touching Resident #160 stating, “I did grab her boob a while ago” because he felt that they were in a relationship and she would be fine with him touching her. NP #2 stated that during her visit with Resident #5 on 8/26/25 she told him moving forward that he needed to stay away from Resident #160 and he agreed to do so. NP #2 stated that after speaking with Resident #5 she felt like he understood the importance of staying away from Resident #160 and that he did not need ongoing 1 on 1 supervision. NP #2 stated that she referred both Resident #160 and Resident #5 to therapy. On 09/11/2025 at 3:53 PM an interview was conducted with Nurse Aide (NA) #7. She reported that she worked with both Resident #160 and Resident #5 and heard about the allegation related to both residents. She indicated she had no first-hand knowledge of the allegation, but she spoke about Resident #5's history. She stated that Resident #5 had no history of inappropriate sexual behaviors. On 09/11/2025 at 1:51 PM interview occurred with the Director of Nursing (DON). The DON reported that he and the Administrator met with Resident #5 on 8/18/25 about sexual abuse concerns and explained to him the importance of not going near Resident #160 and not saying anything to her. The DON stated that Resident #5 was placed on 1 on 1 supervision on 8/18/25 until he was cleared by both medical providers, Medical Director (MD) and NP #1, on 8/25/25. The DON stated that MD and NP #1 agreed with Resident #5 returning to the communal resident areas within the facility without 1 on 1 supervision. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/2025 at 2:19 PM an interview occurred with Administrator and revealed that Resident #160 and her family member came into her office the afternoon of 8/18/25 and reported that Resident #5 sexually assaulted Resident #160 on 8/17/25. The Administrator reported that Resident #160 stated that Resident #5 brushed her breast area and was talking to her about his privates. Resident #160 stated that this occurred while she was in the outside courtyard on the morning of 8/17/25. The Administrator reported that she called the local police department so that a report could be made. The Administrator reported that the police came and met with Resident #160 and her family member privately without staff present and took the report. The Administrator reported that she and the DON met with Resident #5 on 8/18/25 regarding the allegations of sexual assault. The Administrator reported that they explained to Resident #5 the importance of him not going near Resident #160 again. The Administrator reported that he (Resident #5) expressed understanding and stated that he would not go near her again. The Administrator reported that Resident #5 was placed on 1 on 1 supervision on 8/18/25 until he was cleared by medical providers, MD and NP #1. On 09/12/2025 at 8:44 AM a phone interview occurred with the Medical Director (MD). He indicated that he was not present at the facility when the initial reported incident allegations of sexual assault occurred, but NP #1 updated him regarding the allegations. The MD reported that he saw both Resident #160 and Resident #5 for follow-up later that week. The MD reported that he had no concerns regarding Resident #5 being taken off 1 on 1 supervision and returning to the communal resident areas within the facility without supervision effective 8/25/25. The MD indicated he did not feel that Resident #5 was a danger to others. The facility was unable to provide evidence of a corrective action plan regarding the facility's failure to protect a resident's right to be free from resident-to-resident abuse. 2. Resident #178 was initially admitted to the facility on [DATE] with diagnoses that included communication deficit, adult failure to thrive and depression. The quarterly MDS assessment dated [DATE] revealed Resident #178 was moderately cognitively impaired and had no behavioral symptoms or wandering during the 7-day MDS look back period. Resident #178 was independent with dressing, transfers, and ambulation. Resident #178's revised care plan dated 2/17/25 did not have a care plan for behaviors or for inappropriate verbal statements to staff. Resident #178 was discharged on 4/17/25 and unavailable for interview. The telephone number listed in the record was no longer available. Resident #163 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, communication deficit and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #163 had unclear speech, had difficulty making herself-understood and was severely cognitively impaired. Resident #163 had no behavioral symptoms during the 7-day MDS look back period. Resident #163 required 1-person assistance from staff for activities of daily living and used a wheelchair for mobility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #163's revised care plan dated 4/1/25 included a focus area for impaired cognitive function and impaired thought process related to dementia/Alzheimer's disease. Resident #163's care plan did not identify any inappropriate behaviors. An interview was conducted on 9/9/25 at 9:30 AM with Resident #163 who was unable to be interviewed due to advanced dementia. The incident report completed by the former Director of Nursing on 3/7/25 at 1:35 PM revealed Resident #178 was found in the dining /activity room with Resident #163 with his hand located on Resident #163's genital area. Both residents were separated immediately. Skin assessments were done for both residents and there were no injuries noted. The nurse practitioner, physician, responsible parties for both residents and local law enforcement were notified of the incident. A full body assessment dated [DATE] was completed by the Director of Nursing revealed Resident #163 was assessed due to resident-to-resident sexual abuse. No injuries observed at time of incident. A full body assessment dated [DATE] was completed by the Director of Nursing revealed Resident #178 was assessed due to resident -to-resident sexual abuse. No injuries observed at time of incident. The initial allegation report dated 3/7/25 completed by the former Administrator indicated Resident #178 and Resident #163 were seated at a table in the dining room. Resident #178 was seen rubbing his hand near the vaginal area, on top of clothing of Resident #163, witnessed by Nurse Aide #13. Both residents were separated immediately, and Resident #178 was placed on 1:1 pending psych evaluation. The physician, state agency, local law enforcement and responsible person(s) for both residents were notified. No injury or harm or change of condition noted for either resident and they were each at baseline mental and physical status. Nurse Aide #13's written statement could not be located by the current Administrator. A telephone interview was conducted on 9/9/25 at 1:47 PM with the Nurse Aide #13 who stated Resident #178 and Resident #163 were in the dining room at the same table on 3/7/25 and Nurse Aide #13 recalled on 3/7/25 around 1:00 PM she walked through the dining/activity door and saw the two clothed residents sitting at the table. Resident #178 had one hand on the back of the wheelchair and one hand in between the legs of Resident #163 near the private area. Resident #163 was non-verbal and unaware of what was happening and did not have a direct reaction to what was being done to her. Resident #163 did not show any emotion or discomfort. Nurse Aide #13 stated she immediately separated the two residents and there were no visible signs that any force by Resident #178 was applied to Resident #163 private area. Nurse Aide #13 further stated she was not certain whether Resident #178 knew exactly what he was doing, and he did not express why he was doing what he was doing. Resident #178 walked back to his room, and she immediately reported the observation to Nurse #10. Resident #178 was placed on 1:1 supervision and Nurse #10 took over from that point. She indicated she documented a written statement of events and spoke with the Administrator and the police about the incident. Nurse Aide #13 did recall if Resident #178 had previous inappropriate behaviors. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview was conducted on 9/11/25 at 11:00 AM with Nurse #10 who stated on 3/7/25 Nurse Aide #13 reported to her she had observed Resident #178 inappropriately touching Resident #163 in the dining area. Nurse Aide #13 stated both residents were fully clothed, and Resident #178 had his hand on Resident #163's private area. Nurse #10 stated she could not recall if the nurse aide stated there was any force being applied by Resident #178 to Resident #163 private area. She stated the nurse aide reported she removed the two residents and the male resident returned to his room. She indicated the incident was immediately reported to the Director of Nursing and Nurse Practitioner at 1:21 PM. She indicated both residents were checked for any injuries or skin /mental changes. She further stated Resident #178 was immediately assigned a staff member and placed on 1:1 supervision on 3/7/25 until he could be seen by psychiatric services for evaluation. Resident #163 was non-verbal and unable to recall any part of the incident. Resident #163 did not show any visible distress, voice any complaints, or express discomfort. Nurse #10 stated she obtained a statement from Resident #178 who stated nothing happened and he was upset that he was accused of touching the female resident. Nurse #10 stated she spoke with Resident #163's RP and informed him that Resident #163 was inappropriately touched by a male resident. She further stated the RP was informed the investigation process included Resident #163 was assessed from head-to-toe with no visible injuries and Resident #178 placed on 1:1 supervision. Nurse #10 reported the RP for Resident #163 did not express that he was extremely upset and stated he was glad Resident #163 was safe, and the other person was removed immediately. Nurse #10 stated she also contacted Resident #178's RP and informed them of the incident and that Resident #178 would be referred to psychiatric services and placed on 1:1 pending the evaluation. The RP stated she was unaware of previous or a history of inappropriate sexual behaviors from Resident #178 and agreed with the monitoring and referral. Nurse #10 did not indicate Resident #178 had displayed any prior inappropriate physical or verbal behaviors. A psychiatric note dated 3/7/25 revealed a telehealth visit occurred for Resident #178 about an incident involving inappropriate touching of another patient at the facility. The facility requested the visit which was done by telehealth with assistance from facility staff. Resident #178 reported that he was trying to shoo a fly off another patient's leg and denied any inappropriate touching. He states, I got more sense than that. The patient was able to ambulate freely and is not in a wheelchair. He is currently on trazodone but denies any issues with sleep and is unsure why he is taking the medication. The psychiatric assessment revealed Resident #178 was not currently a danger to self/others. The incident involving Resident #178 and another patient was discussed, where he reportedly shooed a fly off the other patient's leg. There was no indication of inappropriate touching or any malicious intent. Resident #178 was alert and oriented, as evidenced by his correct identification of the date and his clear responses during the conversation. Plan: A reminder about appropriate behavior and personal boundaries will be given to Resident #178. A 1:1 supervision will be implemented for the rest of the day, followed by 30-minute checks four times, and then hourly checks until an in-person psychiatric evaluation can be conducted. This plan was designed to ensure the safety and well-being of all patients in the community. No new orders, labs, or referrals at this time. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview was conducted on 9/11/25 at 11:22 AM with the Psychiatric Nurse Practitioner who stated she received a referral from the facility for an evaluation for Resident #178 due to a report of inappropriate touching of a female resident. The Psychiatric Nurse Practitioner stated she had seen Resident #178 on 3/11/25. She reported Resident #178 had history of inappropriate verbal statements to staff and no reports against any residents. She indicated Resident #178 was assessed with a basic interview of mental status (BIMS) of 12 which indicated Resident #178 had moderate cognitive impairment. She further stated Resident #178 continued to report he did not touch the female inappropriate and was moving a fly away from the individual. She stated she did not feel the resident had any malicious intent to harm or inappropriately touch anyone. She noted there had been no evidence or report of Resident #178 inappropriately touching any other residents reported by facility staff prior to incident. She stated there were no medication adjustments recommended based on this incident, however psychotherapy was the recommended intervention of choice to work with Resident #178 on cognitive behaviors on how to handle verbal emotions, motivation interactions/therapy. She reported Resident #178 had multiple psychotherapy visits until 4/17/25. She reported based on her evaluation the therapy was effective at the time, and the resident did not present as threat to other residents. The Investigation Report completed on 3/14/25 and submitted to the state by the former Administrator revealed Resident #178 was observed on 3/7/25 at 1:30 PM by a nurse aide rubbing his hand near the vaginal area on top of clothing of Resident #163. The incident occurred in the dining room and was witnessed by the nurse aide. Both residents were immediately separated, and Resident #178 was placed on 1:1 supervision pending psychiatric evaluation. Both residents received skin assessments with no negative findings by nursing. Both residents and staff were interviewed. Resident #163 was unable to be interviewed due to advanced dementia and Resident #178 stated he was shooing a fly away from Resident #163. The NP, Physician, police and responsible person for both residents were notified of the incident. Resident #178 was referred to psychiatric services for an evaluation on 3/7/25. Resident #178 was evaluated via telehealth on 3/7/25 and in-person on 3/11/25, there were no medication changes for Resident #178. Resident #178 continued with every hour checks until cleared by psychiatric services and a nurse aide was assigned to the dining area during meals. A telephone interview was conducted on 9/9/25 at 10:08 AM with Resident #163's RP who stated he received a call from the Director of Nursing who informed him of the 3/7/25 incident. He stated that due to Resident #163's advanced dementia she was not aware of and had no insight into what happened. Resident #178's RP was contacted on 9/11/25 at 10:09 AM and was unavailable for interview. The Greensboro police department was contacted on 9/8/25 at 12:16 PM and the officer that responded to call was unavailable for interview. Review of the social service note dated 3/7/25 revealed Resident #178 as well as the former Social Worker spoke with the physician from mental health via a telehealth visit due to the incident where Resident #178 was

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to notify the Resident Representative in writing of the reason for the unplanned transfer/discharge to the hospital and failed to provide the bed hold policy to the Resident Representative for 3 of 4 residents reviewed for hospitalizations (Resident #13, #97, and #2). Resident #13 was admitted to the facility 6/20/25. The admission Minimum Data Set assessment dated [DATE] documented Resident #13 was severely cognitively impaired. Resident #13 was discharged to the hospital 8/20/25 for a change in condition and readmitted to the facility 8/31/25. Review of the medical record revealed no documentation indicating a bed hold policy had been provided to Resident #13 or her Representative. Review of the medical record for Resident #13 revealed documentation for a notice of transfer form that had not been completed. The date for “mailed to representative” was blank. Resident #13's Representative was interviewed by phone on 9/12/25 at 1:07 PM. The Representative reported he had not been provided with a bed hold notice, and no one had spoken to him about a bed hold. Additionally, he had not received a letter of transfer when Resident #13 was hospitalized [DATE]. An interview was conducted with Nurse #7 by phone on 9/10/25 at 1:25 PM. Nurse #7 reported she sent Resident #13 to the hospital on 8/20/25 and described sending the packet with the resident, including a list of her current medications, the most recent nursing notes, demographics, and a transfer sheet. When asked if she sent a bed hold notice with Resident #13, Nurse #7 reported she had not, and thought that was the responsibility of the admissions department. Nurse #7 reported she initiated the transfer notice, but it was not her responsibility to print the form for mailing. The admission Coordinator was interviewed by phone on 9/11/25 at 4:39 PM. The admission Coordinator reported that the facility would accept all residents back to the facility and she had not provided a bed hold statement when a resident was hospitalized . An interview was conducted with the Regional Social Worker on 9/11/25 at 4:51 PM and she reported that due to turnover in the Social Work department, nursing staff started the letter of transfer in the electronic documentation system, and the Social Work department printed and mailed the form. The Regional Social Worker reported Resident #13's letter of transfer had not been printed and mailed to the Resident Representative. 2. Resident #97 was admitted to the facility on [DATE]. (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #97 was cognitively intact. A review of the clinical records indicated that on 8/16/25 Resident #97 was nonresponsive to stimuli. The on-call physician ordered the resident sent to the hospital for evaluation. The review of the facility's records revealed no documentation indicating Resident #97 received the Bed Hold Policy. Unsuccessful attempts were made during the survey to contact the nurse who sent Resident #97 to the hospital. During an interview on 9/11/25 at 4:00 p.m. Nurse #7 stated when a resident was sent to the hospital the facility's nurse on duty compiled a packet to be sent with the resident which consisted of: computer generated information about/for the resident from the resident's medical record (face sheet, list of medications, the completed change of condition form) and NC Notice of Transfer which included the Appeal Rights packet was given to the emergency medical services' staff as they escorted the resident from the building. She stated the Bed Hold Policy was not included in these packets. On 9/11/25 at 4:17 p.m. the Administrator revealed the facility had a Bed Reserve Policy and Voluntary Bed Retention Agreement which were provided to and/or discussed with the resident or the resident's responsible party at the hospital or telephone by the facility's admission Director. During an interview on 9/12/25 at 10:30 a.m. the Admission's Director revealed she was not responsible for providing the facility's Bed Hold Policy to a resident or a resident's responsible party when a resident was discharged to the hospital. Resident #97 did not return to the facility but was admitted to hospice care. 3. Resident #2 was admitted into the facility on 8/2/24. A review of Resident #2's quarterly Minimum Data Set assessment dated [DATE] indicated she was severely cognitively impaired. A review of Resident #2's nursing progress notes indicated that she was transferred to the hospital on 6/14/25 and returned to the facility on 7/1/25. A review of Resident #2's medical record indicated no documentation of the reason for the transfer to the hospital or bed hold information was sent to the Resident Representative. A telephone interview was attempted with Resident #2's representative but they were unavailable. A telephone interview with the previous Social Worker on 9/11/25 at 12:56 PM indicated she was aware all discharges to the hospital required a transfer/discharge form, notification to the ombudsman, and the facility bed hold policy. She stated she was unaware of the process, she just knew someone at the facility, did not say who, would let her know a resident was discharged so she could notify the Ombudsman. The Social Worker reported she was unaware who was responsible for providing the bed hold policy. (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	An interview with the Admissions Coordinator on 9/11/25 at 2:30 PM indicated she visited the hospital frequently and provided the bed hold policy information at that time to either the resident or the Resident Representative. She stated the Social Worker would let her know about discharges and any bed hold policy needs. The Admissions Coordinator was unable to recall if she had visited Resident #2 in the hospital or provided a copy of the bed hold policy. An interview with the Administrator on 9/12/25 at 10:25 AM indicated that she was aware of the need for documentation of transfers and bed hold policy to be sent to the Resident Representative. She stated she started working at the facility in May 2025 and recently became aware that the Admissions Coordinator was not being made aware when a resident was discharged to the hospital by the Social Worker and there were many bed holds not being provided by the facility over the last few months. The Administrator stated the Social Worker was responsible for issuing the transfer/discharge notices.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record reviews, the facility failed to complete annual Minimum Data Set (MDS) assessments within the required 14-day timeframe after the Assessment Reference Date (ARD, the last day of the assessment look-back period) for 2 of 54 residents whose MDS assessments were reviewed (Resident #107 and Resident #126).The findings included: 1. Resident #107 was admitted to the facility on [DATE]. The resident's annual comprehensive Minimum Data Set (MDS) assessment had an Assessment Reference Date (ARD) of 7/30/25. This assessment was signed as completed by the facility's Registered Nurse (RN) MDS Coordinator on 9/3/25. An interview was conducted on 9/10/25 at 3:23 PM with the MDS Coordinator, who was later joined by MDS Nurse #2. During the interview, Resident #107's annual MDS with an ARD of 7/30/25 was reviewed. Upon inquiry, the MDS Coordinator confirmed Resident #107's annual MDS was completed on 9/3/25 and acknowledged this assessment was completed late. An interview was completed on 9/10/25 at 11:30 AM with the facility's Administrator in the presence of the company's [NAME] President (VP) of Operations. During this interview, concerns were discussed related to the resident's MDS having been identified as completed more than 14 days after the assessment's ARD. The Administrator stated that the facility was aware of the issue and had hired two new MDS nurses (the MDS Coordinator and MDS Nurse #2) since May 2025. She was aware the new MDS nurses were behind on completing MDS assessments when they started. 2. Resident #126 was readmitted to the facility 8/13/25. The annual comprehensive Minimum Data Set (MDS) assessment had an Assessment Reference Date (ARD) of 6/26/25. The annual MDS was signed as completed by the Registered Nurse MDS coordinator on 8/15/25. The Care Area Assessment (CAA) was dated 6/26/25 and completed 8/15/25. An interview was conducted on 9/10/25 at 3:23 PM with the MDS Coordinator, who was later joined by MDS Nurse #2. During the interview, the nurses reported they were two months behind on completing MDS assessments when they started their positions at the facility and were still working towards catching up on the assessments. An interview was completed on 9/10/25 at 11:30 AM with the facility's Administrator in the presence of the company's [NAME] President (VP) of Operations. During this interview, concerns were discussed related to several residents' MDS assessments having been identified as completed more than 14 days after the ARD or greater than 120 days after the last MDS assessment was completed. The Administrator reported that the facility was aware of the issue and had hired two new MDS nurses (the MDS Coordinator and MDS Nurse #2) since May 2025. She was aware the new MDS nurses were behind on completing MDS assessments when they started. Upon inquiry, the VP of Operations reported the facility did not have a Plan of Correction (POC) fully implemented regarding the MDS assessments.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record reviews, the facility failed to complete significant change in status Minimum Data Set (MDS) assessments within the required 14-day timeframe after the Assessment Reference Date (ARD, the last day of the assessment look-back period) for 2 of 54 residents whose MDS assessments were reviewed (Resident #14 and Resident #158).The findings included: 1. Resident #14 was admitted to the facility on [DATE]. The resident's significant change in status Minimum Data Set (MDS) assessment had an Assessment Reference Date (ARD) of 6/26/25. This assessment was signed as completed on 8/18/25. An interview was conducted on 9/10/25 at 3:23 PM with the MDS Coordinator, who was later joined by MDS Nurse #2. During the interview, Resident #14's significant change in status MDS with an ARD of 6/26/25 was reviewed. Upon inquiry, the MDS Coordinator confirmed Resident #14's significant change in status MDS was completed on 8/18/25 and acknowledged this assessment was completed late. An interview was completed on 9/10/25 at 11:30 AM with the facility's Administrator in the presence of the company's [NAME] President (VP) of Operations. During this interview, concerns were discussed related to the resident's MDS having been identified as completed more than 14 days after the assessment's ARD. The Administrator stated that the facility was aware of the issue and had hired two new MDS nurses (the MDS Coordinator and MDS Nurse #2) since May 2025. She was aware the new MDS nurses were behind on completing MDS assessments when they started. 2. Resident #158 was admitted to the facility 10/18/24 with diagnoses including dementia and chronic lung disease. Resident #158 was admitted to hospice on 7/31/25. Review of the significant change in status Minimum Data Set (MDS) assessment had an Assessment Reference Date (ARD) of 8/7/25. The assessment was signed as completed by the facility's Registered Nurse MDS Coordinator on 9/8/25. An interview was conducted on 9/10/25 at 3:23 PM with the MDS Coordinator, who was later joined by MDS Nurse #2. During the interview, the nurses reported they were two months behind on completing MDS assessments when they started their positions at the facility and were still working towards catching up on the assessments. An interview was completed on 9/10/25 at 11:30 AM with the facility's Administrator in the presence of the company's [NAME] President (VP) of Operations. During this interview, concerns were discussed related to several residents' MDS assessments having been identified as completed more than 14 days after the ARD. The Administrator reported that the facility was aware of the issue and had hired two new MDS nurses (the MDS Coordinator and MDS Nurse #2) since May 2025. She was aware the new MDS nurses were behind on completing MDS assessments when they started. Upon inquiry, the VP of Operations reported the facility did not have a Plan of Correction (POC) fully implemented regarding the MDS assessments.

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record reviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within the required 14-day timeframe after the Assessment Reference Date (ARD, the last day of the assessment look-back period) for 8 of 54 residents whose MDS assessments were reviewed (Residents #31, #10, #92, #7, #109, #78, #52 and #85). 8. Resident #85 was admitted to the facility 9/8/23. Review of the medical record on 9/10/25 revealed the quarterly MDS assessment had an Assessment Reference Date (ARD) of 6/26/25. The assessment was signed as completed by the facility's Registered Nurse MDS coordinator on 8/15/25. An interview was conducted on 9/10/25 at 3:23 PM with the MDS Coordinator, who was later joined by MDS Nurse #2. During the interview, the nurses reported they were two months behind on completing MDS assessments when they started their positions at the facility and were still working towards catching up on the assessments. An interview was completed on 9/10/25 at 11:30 AM with the facility's Administrator in the presence of the company's [NAME] President (VP) of Operations. During this interview, concerns were discussed related to several residents' MDS assessments having been identified as completed more than 14 days after the ARD or greater than 120 days after the last MDS assessment was completed. The Administrator reported that the facility was aware of the issue and had hired two new MDS nurses (the MDS Coordinator and MDS Nurse #2) since May 2025. She was aware the new MDS nurses were behind on completing MDS assessments when they started. Upon inquiry, the VP of Operations reported the facility did not have a Plan of Correction (POC) fully implemented regarding the MDS assessments. The findings included: 1-a) Resident #31 was admitted to the facility on [DATE]. The resident's quarterly Minimum Data Set (MDS) assessment had an Assessment Reference Date (ARD) of 8/7/25. This assessment was signed as completed on 9/6/25. An interview was conducted on 9/10/25 at 3:23 PM with the MDS Coordinator, who was later joined by MDS Nurse #2. During the interview, Resident #31's quarterly MDS with an ARD of 8/7/25 was reviewed. Upon inquiry, the MDS Coordinator reported Resident #31's quarterly MDS was completed on 9/6/25. She confirmed this assessment was completed late. b) Resident #10 was admitted to the facility on [DATE]. The resident's quarterly Minimum Data Set (MDS) assessment had an Assessment Reference Date (ARD) of 7/11/25. This assessment was signed as completed on 8/25/25. (continued on next page)

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	An interview was conducted on 9/10/25 at 3:23 PM with the MDS Coordinator, who was later joined by MDS Nurse #2. During the interview, Resident #10's quarterly MDS with an ARD of 7/11/25 was reviewed. Upon inquiry, the MDS Coordinator reported Resident #10's quarterly MDS was completed on 8/25/25. She confirmed this assessment was completed late. c) Resident #92 was admitted to the facility on [DATE]. The resident's quarterly Minimum Data Set (MDS) assessment had an Assessment Reference Date (ARD) of 8/2/25. This assessment was signed as completed on 9/4/25. An interview was conducted on 9/10/25 at 3:23 PM with the MDS Coordinator, who was later joined by MDS Nurse #2. During the interview, Resident #92's quarterly MDS with an ARD of 8/2/25 was reviewed. Upon inquiry, the MDS Coordinator reported Resident #92's quarterly MDS was completed on 9/4/25. She confirmed this assessment was completed late. d) Resident #7 was admitted to the facility on [DATE]. The resident's quarterly Minimum Data Set (MDS) assessment had an Assessment Reference Date (ARD) of 8/5/25. This assessment was signed as completed on 9/8/25. An interview was conducted on 9/10/25 at 3:23 PM with the MDS Coordinator, who was later joined by MDS Nurse #2. During the interview, Resident #7's quarterly MDS with an ARD of 8/5/25 was reviewed. Upon inquiry, the MDS Coordinator reported Resident #7's quarterly MDS was completed on 9/8/25. She confirmed this assessment was completed late. e) Resident #109 was admitted to the facility on [DATE]. The resident's quarterly Minimum Data Set (MDS) assessment had an Assessment Reference Date (ARD) of 8/10/25. This assessment was signed as having been completed on 9/8/25. An interview was conducted on 9/10/25 at 3:23 PM with the MDS Coordinator, who was later joined by MDS Nurse #2. During the interview, Resident #109's quarterly MDS with an ARD of 8/10/25 was reviewed. Upon inquiry, the MDS Coordinator reported Resident #109's quarterly MDS was completed on 9/8/25. She confirmed this assessment was completed late. f) Resident #78 was admitted to the facility on [DATE]. The resident's quarterly Minimum Data Set (MDS) assessment had an Assessment Reference Date (ARD) of 8/21/25. This assessment was not yet signed as completed as of the date of the review (9/10/25). An interview was conducted on 9/10/25 at 3:23 PM with the MDS Coordinator, who was later joined by MDS Nurse #2. During the interview, Resident #78's quarterly MDS with an ARD of 8/21/25 was reviewed. Upon inquiry, the MDS Coordinator reported Resident #78's quarterly MDS was not completed as of 9/10/25. She confirmed this assessment was 6 days overdue. g) Resident #52 was admitted to the facility on [DATE]. (continued on next page)

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	The resident's quarterly Minimum Data Set (MDS) assessment had an Assessment Reference Date (ARD) of 7/26/25. This assessment was signed as completed on 9/2/25. An interview was conducted on 9/10/25 at 3:23 PM with the MDS Coordinator, who was later joined by MDS Nurse #2. During the interview, Resident #52's quarterly MDS with an ARD of 7/26/25 was reviewed. Upon inquiry, the MDS Coordinator and Nurse #2 reported Resident #52's quarterly MDS was completed on 9/2/25 and confirmed this assessment was completed late. The nurses explained they were two months behind on completing MDS assessments when they started their positions at the facility. They were still working towards catching up on the assessments. An interview was completed on 9/10/25 at 11:30 AM with the facility's Administrator in the presence of the company's [NAME] President (VP) of Operations. During this interview, concerns were discussed related to several residents' MDS assessments having been identified as completed more than 14 days after the ARD. The Administrator stated that the facility was aware of the issue and had hired two new MDS nurses (the MDS Coordinator and MDS Nurse #2) since May 2025. She was aware the new MDS nurses were behind on completing MDS assessments when they started.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review, the facility failed to submit a discharge Minimum Data Set (MDS) assessment within the required timeframe for 2 of 54 residents whose MDS assessments were reviewed (Resident #32 and Resident #13). 1 2. Resident #13 was admitted to the facility 6/20/25 and transferred to the hospital on 8/20/25. The discharge Minimum Data Set assessment dated [DATE] was marked as completed on 9/10/25. An interview was conducted on 9/10/25 at 3:23 PM with the MDS Coordinator, who was later joined by MDS Nurse #2. During the interview, the nurses reported they were two months behind on completing MDS assessments when they started their positions at the facility and were still working towards catching up on the assessments. An interview was completed on 9/10/25 at 11:30 AM with the facility's Administrator in the presence of the company's [NAME] President (VP) of Operations. During this interview, concerns were discussed related to the MDS assessment having been identified as completed late. The Administrator reported that the facility was aware of the issue and had hired two new MDS nurses (the MDS Coordinator and MDS Nurse #2) since May 2025. She was aware the new MDS nurses were behind on completing MDS assessments when they started. The findings included: 1. Resident #32 was admitted to the facility on [DATE] and was discharged to her home on 7/31/25. The resident's electronic medical record (EMR) revealed her history of Minimum Data Set (MDS) assessments included a discharge MDS with an ARD of 7/31/25. This assessment was signed as completed on 9/2/25. An interview was conducted on 9/10/25 at 3:23 PM with the MDS Coordinator, who was later joined by MDS Nurse #2. During the interview, Resident #32's discharge MDS with an ARD of 7/31/25 was reviewed. Upon inquiry, the MDS Coordinator confirmed Resident #32's discharge MDS was completed and submitted on 9/2/25. She reported this assessment was completed late. An interview was completed on 9/10/25 at 11:30 AM with the facility's Administrator in the presence of the company's [NAME] President (VP) of Operations. During this interview, concerns were discussed related to the resident's MDS having been identified as completed more than 14 days after the assessment's ARD. The Administrator stated that the facility was aware of the issue and had hired two new MDS nurses (the MDS Coordinator and MDS Nurse #2) since May 2025. She was aware the new MDS nurses were behind on completing MDS assessments when they started.

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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 staff interviews and record reviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of: 1) Activities of Daily Living (Resident #107); 2) Use of an antibiotic medication (Resident #8), and 3) Brief Interview for Mental Status (BIMS) and Pain assessment interview (Resident #48). This occurred for 3 of 54 residents whose MDS assessments were reviewed.The findings included: 1. Resident #107 was admitted to the facility on [DATE]. The resident's cumulative diagnoses included acute respiratory failure with hypoxia (an inadequate supply of oxygen to the tissues) and non-Alzheimer's dementia. The resident's care plan included the following areas of focus, in part:--Long term care: the resident requires assistance with Activities of Daily Living (ADL) related to advanced age, chronic health conditions and is a Hospice patient (Date Initiated: 2/5/25); --The resident is incontinent of bladder and bowels: inability to control bowel and bladder (Date Initiated: 2/5/25). Resident #107's most recent Minimum Data Set (MDS) assessment was an annual assessment dated [DATE]. The assessment reported the resident had severely impaired cognitive status and was dependent on staff for all her ADLs. The MDS also reported Resident #107 was occasionally incontinent of bladder and frequently incontinent of bowel. An interview was conducted on 9/11/25 at 8:22 AM with MDS Nurse #2. During the interview, MDS Nurse #2 was asked to review Resident's #107's MDS section related to “Bladder and Bowel.” Upon inquiry as to whether the MDS was correct when it indicated the resident as only occasionally incontinent of bladder and frequently incontinent of bowel, the nurse stated it was not. The nurse confirmed the resident was bedbound and the MDS assessment should have indicated the resident was always incontinent of bladder and bowel. An interview was conducted on 9/12/25 at 1:10 PM with the facility's Administrator to discuss the MDS concerns identified. During the interview, the Administrator reported she would expect the MDS assessments to be completed accurately. 2. Resident #8 was admitted to the facility on [DATE]. The resident's cumulative diagnoses included chronic kidney disease and respiratory failure with hypoxia. The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated [DATE]. The MDS section on “Medications” indicated Resident #8 received an antibiotic medication during the 7-day look back period. Resident #8's electronic medical record (EMR) included May 2025 and June 2025 Medication Administration Records (MAR). A review of the MARs revealed no antibiotic medication was administered to the resident during the 7-day look back period for the 6/4/25 quarterly MDS assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 9/10/25 at 3:23 PM with the MDS Coordinator, who was later joined by MDS Nurse #2. During the interview, the MDS Coordinator reviewed Resident #8's EMR and 6/4/25 MDS. Upon review, she confirmed the resident did not receive an antibiotic during the 7-day look back period. An interview was conducted on 9/12/25 at 1:10 PM with the facility's Administrator to discuss the MDS concerns identified. During the interview, the Administrator reported she would expect the MDS assessments to be completed accurately. 3. Resident #48 was admitted to the facility on [DATE] with diagnoses that included gout, diabetes mellitus with diabetic polyneuropathy, contracture of left hand muscle, and hemiplegia and hemiparesis affecting left non dominant side. Resident #48's annual Minimum Data Set (MDS) assessment dated [DATE] was not completed in the areas of cognitive patterns and health conditions. The area under cognitive patterns read “Brief Interview for Mental Status (BIMS)” and “staff assessment for mental status” with the proceeding questions answered with “not assessed, no information”. The area under health conditions read “pain assessment interview” with the proceeding questions answered with “not assessed, no information”. An interview was conducted on 09/12/25 at 3:53 PM with the MDS Nurse #2. She stated she had worked at the facility for approximately one month and that she was trying to get the assessments caught up because the facility went for a period without an MDS person. She verified Resident #48's annual assessment dated [DATE] was not completed in the areas of cognition and pain assessments. She explained that the person who completed the assessment was a traveling MDS person. An interview was conducted on 09/12/25 at 4:12 PM with the Director of Nursing (DON). The DON stated the MDS assessments should be coded accurately to reflect Resident 48's condition.

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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 record review, observations, Resident Representative, and staff interviews, the facility failed to implement a fall mat for fall precautions for 1 of 4 residents reviewed for accidents (Resident #126).The findings included: Resident #126 was readmitted to the facility on [DATE] with diagnoses including dementia and hypertension. The annual Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #126 to be severely cognitively impaired. The MDS documented Resident #126 was dependent on staff for bed mobility. The MDS documented no falls since the previous quarterly MDS completed on 4/2/25. Care plans for Resident #126 last revised on 7/9/25 addressed Resident #126's potential for falling. Interventions included placing a fall mat on the floor on the left side of the bed. Resident #126 was observed on 9/8/25 at 12:03 PM. There was no fall mat on the floor on the left side of the bed. Resident #126 was positioned in the center of the bed, and the bed was in the low position. During the observation, Resident #126's Representative reported that Resident #126 could roll in bed. Another observation of Resident #126 was conducted on 9/10/25 at 11:31 AM. Resident #126 was positioned in the middle of the bed, turned on her left side, and the bed was in the low position. There was no fall mat on the floor on the left side of the bed. The fall mat was in the bathroom, rolled up against the wall. Unit Manager #1 was interviewed 9/10/25 at 11:58 AM. Unit Manager #1 reported she was not aware the fall mat for Resident #126 was rolled up in the bathroom, and it should be on floor as the care plan directed. Unit Manager #1 reported she did not know why the fall mat would have been in the bathroom and maybe a staff member had removed it during care and forgotten to put it back. Nursing Assistant (NA) #12 was interviewed 9/10/25 at 12:08 PM. NA #12 reported Resident #126 was able to roll in bed sometimes. NA #12 reported she had provided care to Resident #126 several times over the past month and was familiar with her care. NA #12 explained Resident #126 bed needed to be low and she required frequent checks, but NA #12 was not aware the fall mat should be on the floor. An interview was conducted by phone with NA #4 on 9/12/25 at 2:09 PM and she reported she provided care to Resident #126 almost every day and she was aware to keep Resident #126's bed low for fall precautions. NA #4 reported she had not seen the fall mat on the floor beside Resident #126's bed. NA #4 reported in the past several months Resident #126 had attempted to get out of bed.The Director of Nursing (DON) was interviewed by phone on 9/12/25 at 4:58 PM. The DON reported he was not aware the fall mat was rolled up in the bathroom and not on Resident #126's floor on the left side of her bed. The DON reported the fall mat should remain on the floor to prevent injuries if Resident #126 were to fall out of bed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident representative, and staff interviews, the facility failed to revise a care plan for 2 of 54 residents reviewed for care plans (Resident #158 and #28). The findings included: 1. Resident #158 was admitted to the facility 10/18/24 with diagnoses including diabetes and chronic lung disease. The significant change Minimum Data Set (MDS) assessment dated [DATE] documented Resident #158 was cognitively intact and had a condition or chronic disease that resulted in a life expectancy less than 6 months. The MDS documented Resident #158 received Hospice services. A. Review of Resident #158's medical record revealed a physician order dated 8/11/25 that changed Resident #158 full code status (full resuscitative efforts to be made in the event of cardiac arrest) to Do Not Resuscitate status (no resuscitative efforts to be provided in the event of cardiac arrest). This order was evident on Resident #158's face sheet in the electronic medical record.Review of the care plan revealed Resident #158's full code status, with interventions to honor Resident #158's code status and review the code status with the resident. There was no care plan that addressed Resident #158's do not resuscitate status. B. A physician order dated 7/29/25 ordered for a Hospice referral. Review of Resident #158's medical record revealed she had been admitted to Hospice 7/31/25. Review of Resident #158's care plan revealed no care plan in place addressing Hospice services. An interview was conducted with the MDS Nurse #1 on 9/10/25 at 3:23 PM. The MDS Nurse #1 reported once the MDS was completed, they would review the care plan and orders with the Interdisciplinary team (IDT) to make revisions. The MDS Nurse #1 reported that the care plans were updated daily during the clinical care meetings, and the care plan revisions were considered a team effort.The Director of Nursing (DON) was interviewed by phone on 9/12/25 at 4:58 PM. The DON reported he was not aware the care plan for Resident #158 had not been updated to reflect her updated code status or her hospice admission. The DON explained that a daily clinical meeting was held with the IDT, which included all departments, including MDS, and the care plans were reviewed and updated as needed. The DON reported he expected the care plans to accurately reflect the needs of each resident.

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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** Based on observations, record review, and resident, family, ombudsman, and staff interviews, the facility failed to provide incontinence care (Resident #162), failed to assist with a meal (Resident #107and Resident #162), and failed to provide nail care and assistance with facial hair (Resident #85) to residents who were dependent on staff for assistance. This was for 3 of 13 residents reviewed for activities of daily living (ADL) (Residents #85, #107, #162). 1. a. Resident #162 was admitted to the facility on [DATE] and had cumulative diagnoses that included dementia, contracture of right and left hands, dysphagia, and aphasia. Resident #162's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated she was non-verbal. The Staff Assessment of Cognition completed by staff indicated Resident #162 had short- and long-term memory problems and her Cognitive Skills for Daily Decision Making was severely impaired. Resident #162 had functional limitation in range of motion to one side of her upper extremity and to both sides of lower extremities. She was dependent on staff for all ADL and was always incontinent with bowel and bladder. Resident #162 also had a stage 4 pressure ulcer to her sacrum. Resident #162's active care plan included the focus area of an Activity of Daily Living (ADL) self-care deficit. The interventions included she required 2-person assistance with transfers and bed mobility. Resident #162 also had an active care plan with a focus area of bowel and bladder incontinence which included the intervention Resident #162 required 2-person assistance with toileting, check and change briefs frequently and as needed, and provide toileting hygiene with brief changes. Another focus area included Resident #162 had a stage 4 pressure ulcer to her sacrum. The interventions included to assess Resident #162 for risk of skin breakdown, assist the resident to turn and reposition often, and to keep her skin as clean and dry as possible. An interview with the Ombudsman was conducted on 09/04/25 at 3:44 PM. The Ombudsman stated she came to the facility on [DATE] for a visit and when she walked by Resident #162's room on 06/12/25 around 3:00 PM she observed a lunch tray sitting on the bedside table beside Resident #162's bed untouched. The Ombudsman stated she told the nurse who then told the Director of Nursing (DON). The Ombudsman explained that the DON informed her that they were short staffed and that was why Resident #162's meal tray was untouched at her bedside. She continued to explain that as of 3:00 PM on 06/12/24, Resident #162 had not been offered or assisted with lunch. Nurse #9 provided direct care to Resident #162 on 06/12/25 from 7:00 AM until 7:00 PM. She was not available for interview during the survey period. A phone interview was conducted on 09/11/25 at 1:44 PM with the previous DON. She stated it was brought to her attention by the Ombudsman on 06/12/25 at approximately 3:30 PM that Resident #162's lunch tray was still in her room on the bedside table and that it had not been touched, and it did not appear that staff had attempted to assist Resident #162 with her lunch. The DON stated they had several call outs on 06/12/25 and the NA who was assigned Resident #162 did not ask for assistance by other staff members and forgot to go back and assist Resident #162 with her lunch. Corrective action was rendered. The DON indicated that administrative staff were assisting in answering call lights and providing care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 09/12/25 at 2:27 PM with NA #8. She verified she was the direct care NA for Resident #162 on 06/12/25. She explained that the Ombudsman did locate Resident #162's lunch tray in her room and that it had not been touched since the trays were passed out. She stated it was around 2:00 PM, not 3:30 PM, and she could not recall what time the trays were passed out. She then stated she did not forget to assist Resident #162 with her lunch; she was just the last person she had to feed that day and she was doing the best she could do because they were short staffed. NA #8 could not recall how many residents she had to care for on 06/12/25. She further explained that she did not ask for assistance with feeding or changing Resident #162 because everyone was busy. She indicated when they were short staffed it was difficult to get her tasks done, she would be running late, but the tasks would get done. An interview was conducted on 09/12/25 at 4:12 PM with the DON. He stated the NAs were to make sure the residents were changed and fed in a timely manner. The DON further explained that staffing had been a problem, and they were using a lot of agency staff. b. Review of the grievance log revealed a concern dated 08/20/25 at 5:25 PM written by the Wound Nurse who observed Resident #162 saturated from head to toe in urine and still had night clothes on. The roommate stated Resident 162 had not been cleansed or repositioned all day. The Wound Nurse added Resident 162's linens were soiled, she needed to be changed, and the resident had a stage 4 pressure ulcer. A phone interview was conducted on 09/11/25 at 10:52 AM with the Wound Nurse. She stated when she went in Resident #162's room to do her wound care Resident#162's brief and bedding were soaked with urine. A phone interview was conducted on 09/11/25 at 11:00 AM with NA #9. She verified she was the direct care NA for Resident #162 on 08/20/25. She explained Resident #162 required 2 people for bed mobility and there were no staff members seen in the hall to assist her with performing Resident #162's incontinence care on 08/20/25. Incontinence care was provided however there was normally a delay with completing it. NA #9 confirmed she did one round on Resident #162 after breakfast at approximately 9:45 AM at which time she provided incontinence care, however she did not do another round on her because she did not have any help to safely provide care until approximately 5:30 when the Wound Nurse notified the DON. An interview was conducted on 09/11/25 at 11:16 AM with Unit Manager #1. She stated she recalled the situation when Resident #162 was observed saturated with urine by the Wound Nurse on 08/20/25. She explained the Wound Nurse notified her Resident #162's brief and sheets were soaked with urine. Unit Manager #1 stated she did speak to the NA who told her she had not provided incontinence care to Resident #162 yet because she was behind with her tasks. The Unit Manager also indicated the NAs provided the care; however, it was delayed. An interview was conducted on 09/11/25 at 4:07 PM with the DON. He stated he did recall the Wound Nurse reporting Resident #162's brief, sheets, and blankets being saturated with urine. 2) Resident #107 was admitted to the facility on [DATE] from a hospital. The resident's cumulative diagnoses included acute respiratory failure with hypoxia (an inadequate supply of oxygen to the tissues) and non-Alzheimer's dementia. The resident's weight history included an initial weight of 128.3 pounds (#) obtained on 2/13/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's physician's orders included a diet order dated 1/30/25 for a regular diet with dysphagia pureed textures and nectar thick liquids. The resident's weight obtained on 5/2/25 was 115.6#. Resident #107's care plan included the following areas of focus, in part:--Long term care: the resident requires assistance with Activities of Daily Living (ADL) related to advanced age, chronic health conditions and is a Hospice patient (Date Initiated: 2/5/25). The planned interventions included: provide assistance with feeding for meals (Date Initiated 5/13/25). The resident's most recent Minimum Data Set (MDS) assessment was an annual assessment dated [DATE]. The assessment indicated Resident #107 had severely impaired cognitive status. She had no behaviors nor rejection of care. The resident was reported as being dependent on staff for all her ADL (including eating). The resident's weight history did not include June or July weights. However, a weight obtained on 8/18/25 indicated Resident #107 weighed 111.0#. The resident's Care Area Assessments (CAAs) included “Nutritional Status.” A CAA worksheet dated 9/3/25 noted the following, in part: “…requires assist when eating…Wts [Weights] are not normally monitored per hospice protocol…” Upon the family's request, an interview was conducted with Resident #107's family member on 9/9/25 at 2:30 PM. During the interview, the family member expressed concerns about the resident's weight loss of approximately 17# over the last 18 months or so. She acknowledged the resident was on Hospice but stated Resident #107 “was not actively dying.” The family member reported Resident #107 was totally dependent on staff for all her needs and she felt strongly that the resident was not always being fed her meals. Meal rounds conducted on 9/10/25 for breakfast and lunch revealed Resident #107 was provided with staff assistance for her meals. Based on the observations, she had a fair to good intake. On 9/11/25 at 8:13 AM, Resident #107 was observed from the hallway as Nurse Aide (NA) #5 sat next to her bed and attempted to feed her the breakfast meal. The NA was overheard as he called the hall nurse into the room to tell her the resident was not wanting to eat. The nurse was observed as she went into the room and encouraged the resident to try to eat and drink. An interview was conducted on 9/11/25 at 12:55 PM with NA #5. Upon inquiry, the NA reported that once Resident #107 got started eating her breakfast earlier that morning, she ended up having a fair to good intake. An observation made on 9/11/25 at 12:56 PM revealed Resident 107's lunch tray was not present in her room. The resident's lunch tray was located among the meal trays that had already been served and returned to a meal cart. The observation of Resident #107's lunch tray revealed the meal had not been touched. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/11/25 at 1:13 PM, no residents on the hall (other than Resident #107) remained to be assisted with his/her meal. NA #5 was then asked about the resident's lunch meal tray. The NA stated he thought someone else had fed the resident. When told where Resident #107's meal tray was located, NA #5 went to the meal cart, observed her meal tray, and confirmed no one tried to feed Resident #107. The NA was observed as he removed the lunch tray from the cart and proceeded into Resident 107's room to assist her with the meal. On 9/11/25 at 2:00 PM, NA #5 requested an interview. The NA appeared excited as he pulled out his phone, stating he wanted to share a picture of Resident #107's lunch plate. The picture showed the resident consumed nearly 100% of the food provided. When the NA was asked what would have happened if the lunch tray on the meal cart had not been brought to his attention, he stated, “She wouldn't have gotten fed her lunch at all.” A follow-up interview was conducted on 9/12/25 at 11:00 AM with NA #5. Upon inquiry, NA #5 reported he fed the resident her dinner last evening (9/11/25) and she ate very well. He showed a picture of her meal plate, revealing she consumed almost 100% of the meal. During this interview, NA #5 was asked as to how staff were assigned to help the residents who required assistance with their meal. The NA stated, There's no communication. He reported that because this resident's lunch tray had been moved from one cart to another cart on 9/11/25, he mistakenly assumed someone had fed her. An interview was conducted on 9/12/25 at 11:20 AM with the facility's Director of Nursing (DON) related to the concern of the resident's 9/11/25 lunch meal tray not being served to her without surveyor intervention. The DON stated his expectation was that every resident who needed assistance with feeding would be fed. An interview was conducted on 9/12/25 at 1:10 PM with the facility's Administrator. During the interview, the observation made of staff failing to assist Resident #107 with her lunch meal on 9/11/25 was discussed. The Administrator stated that all residents requiring assistance with meals should be assisted. She reported the facility's process needed to be reviewed to ensure NAs knew who they were assigned to assist with each meal. 3. Resident #85 was readmitted to the facility 2/28/24 with diagnoses including stroke and hemiplegia (paralysis on one side of the body from a stroke). The most recent Quarterly Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #85 to be cognitively intact. The MDS documented Resident #85 had limited range of motion on one side of his body, upper and lower limbs. Resident #85 was documented to require set-up assistance for personal hygiene (including shaving), and he was dependent on staff for bathing. A review of the care plan for Resident #85 with a revision date of 3/3/25 addressed his need for assistance with activities of daily living (ADLs) but did not include specific interventions for the provision of bathing and personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #85 was observed on 9/8/25 at 11:02 AM. His facial hair was thick, covering his cheeks, chin, neck, and was greater than ¼ inch in length. The free edge of the fingernail for all 10 of Resident #85's fingernails extended greater than ¼ inch past the tips of his fingers and there was dark material noted under the free edge of the nails on the right hand. Resident #85 was interviewed at the time of the observation, and he reported he was able to shave his face with an electric razor if he was set up for the task by a nursing assistant (NA). Resident #85 reported he had asked the NAs (unknown) to set up his electric razor to shave himself, but no NA staff had set him up with the electric razor to shave. Resident #85 clarified he needed the razor brought to him, and he needed to be sitting up with a mirror to shave. When asked about his long fingernails, Resident #85 reported that because of his stroke, he was unable to clip his fingernails and needed someone to do that for him. Resident #85 reported he had asked several (unknown) NAs to have his nails trimmed, but no one had done that for him. Resident #85 reported he felt frustrated because he could not maintain his normal level of grooming. Resident #85 was observed on 9/10/25 at 11:18 AM. His facial hair and fingernails were unchanged from the observation from 9/8/25 at 11:02 AM. Resident #85 was interviewed at the time of the observation, and he reported a NA had brought him one washcloth “a while ago” and told him to wash his face and body it with it. He showed one dry washcloth and that he didn't have water, soap, or a towel to wash. NA #10 was interviewed when she returned to Resident #85's room on 9/10/25 at 11:24 AM. NA #10 reported she had been assigned to Resident #85 “a few times” and she had left Resident #85 with one washcloth to protect his privacy while he was using the urinal. NA #10 reported she had planned to return to Resident #85's room to assist him with a bath. When asked about his facial hair and his fingernails, NA #10 agreed that both were long and needed trimming. When asked if she had offered to provide shaving and nail care to Resident #85, NA #10 reported that she had never offered him shaving or nail trimming. Resident #85 was observed again on 9/10/25 at 3:39 PM. Resident #85's facial hair had been shaved, but his fingernails remained in the same condition as the observations on 8/8/25 and 9/9/25. Regarding the status of Resident #85's nails, which remained untrimmed and the debris from under the free edge of the nail uncleaned, Resident #85 reported in an interview, “She (NA #10) left and said she would try to do it later.” NA #10 was interviewed again on 9/10/25 at 3:45 PM and she reported she would cut Resident #85's fingernails “later, after dinner.” Nurse #6 was interviewed 9/10/25 at 3:53 PM at Resident #85's bedside and she agreed that Resident #85's nails were too long and should have been trimmed. Unit Manager (UM) #1 was interviewed on 9/11/25 at 3:24 PM and she reported she had not noticed Resident #85's facial hair or long nails. UM #1 explained that she did daily rounds to check on residents, but she was not checking to ensure that care and ADLs, including facial shaving and nail care, were being completed. UM #1 reported she was mostly concerned with residents being clean, dry, and fed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Director of Nursing (DON) was interviewed by phone on 9/12/25 at 4:58 PM. The DON reported he was not aware Resident #85 had facial hair was greater than ¼ inch in length, and the free edge of his fingernails were greater than ¼ inch past the tips of his fingers or there was dark material noted under the nails. The DON explained that agency staff were providing care, and the facility had been working with the agency staff to improve the quality of care. The DON reported he expected ADL care to be provided to residents, including shaving and nail care.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and resident and staff interviews, the facility failed to provide a record of an activity assessment and provide an ongoing resident centered activities program that included activities to meet the interests of a resident who did not participate in activities outside of his room for 1 of 1 resident reviewed for activities (Resident #3). Resident #3 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction (stroke) affecting his right dominant side. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #3 was cognitively intact; and his activity preferences included books, music, animals, and being outside. Review of the care plan dated 6/20/25 revealed Resident #3 preferred to participate in self-directed activities such as reading books, watching television programs in his room. The interventions included review with the resident his self-directed preferences, as needed. During an observation and interview on 9/8/25 at 1:43 p.m., Resident #3 was awake reclining in bed in his private room. The lights and television were in the off position. When asked, the resident stated he did not attend out of room activities by choice. He revealed he enjoyed reading but after his stroke it was difficult to hold and turn the pages of a book with one hand (the resident demonstrated his inability to move his right arm and leg but was able to open and close his right hand). The resident revealed the activity he missed most was coloring pictures with pencils and all of his finished pictures were in an album at his home. He indicated he was unaware if the facility had art supplies available to him because no one had talked to him about his activity interests and if the facility was able to provide supplies to assist with his activity preferences. On 9/12/25 at 11:58 a.m., an interview was conducted with the Activity Director (AD). She stated she worked at the facility for three weeks and had 2 part-time assistants and 1 full-time assistant. The AD revealed on 9/6/25 she initiated a one-on-one visit program with residents who refused to attend out of room activities and Resident #3 was visited on Sunday 9/7/25 for fifteen minutes. The AD revealed she was unable to locate a completed Activity Assessment of Resident #3's activity preferences and one should have been completed at the time of the resident's admission. She indicated she was unaware the resident was interested in coloring and reading but would immediately begin working with the resident and the rehabilitation department in finding ways to accommodate the resident's activity interests due to his hemiplegia and hemiparesis.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and record reviews, the facility failed to monitor a resident's vital signs and neurological status (referring to an evaluation of an individual's brain and nervous system functions) after sustaining an unwitnessed fall for 1 of 7 residents reviewed for the provision of care in accordance with professional standards (Resident #8). The findings included:Resident #8 was admitted to the facility on [DATE]. The resident's cumulative diagnoses included respiratory failure with hypoxia (an inadequate supply of oxygen to the tissues), generalized muscle weakness, unsteadiness on feet, and difficulty in walking.A quarterly Minimum Data Set (MDS) assessment dated [DATE] was reviewed for the resident. Resident #8 was assessed as having intact cognition.The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated [DATE]. The assessment reported that the resident was understood and could understand others with clear comprehension but did not provide an assessment of the resident's cognitive status. The MDS indicated Resident #8 was independent with toileting, dressing, personal hygiene, bed mobility, sit to stand and chair to bed to chair transfers. She required set-up or clean-up assistance with eating and supervision or touching assistance with bathing and walking 10 feet. No falls were reported since her previous assessment.Resident #8's care plan included the following area of focus, in part:--The resident is at risk for falls related to psychiatric medication use and occasional incontinence (Date Initiated: 7/6/24; Revision on: 7/11/25). The planned interventions included: non-skid socks while out of bed (Date Initiated 7/6/24); place bed in lowest position while resident is in bed (Date Initiated: 7/6/24); place common items within reach of the resident (Date Initiated: 7/11/25).Resident #8 filed a grievance with a Care Concern on 8/22/25. The facility provided a Grievance Summary of this concern for review. The Grievance Details read as follows: [Resident #8] stated that on August 21, 2025, around 11:30 am she had a fall and landed on the floor mat. She called for help, and the CNA [Certified Nurse Aide] and Unit Manager came in helped her off the floor and put her on the side of the bed. They told her that they would send the Nurse in to have a look at her, and she is stating that no one came back, and she is wanting to have this looked into as to why no one followed up.A review of the list of Unwitnessed Fall Incidents provided by the facility revealed no unwitnessed falls were reported for Resident #8 during the month of August 2025.An interview was conducted on 9/8/25 at 12:45 PM with Resident #8. During the interview, the resident reported she experienced a fall approximately 3 weeks ago. Resident #8 stated she was upset because after the fall, the nurse never came in to see her, follow up with her, or report the fall. A telephone interview was conducted on 9/11/25 at 7:50 PM with NA #2. NA #2 was identified as a Nurse Aide (NA) who worked on Resident #8's hall during first shift (7:00 AM - 7:00 PM) on 8/21/25. During the interview, the NA recalled Resident #8's unwitnessed fall that occurred on 8/21/25. The NA stated because the resident was not within reach of her call light when she fell, she hollered out for help. Both the NA and the Unit Manager went to help her. NA #2 stated that the Unit Manager initially assessed the resident before they transferred her onto the bed and her vital signs were taken. The NA reported Resident #8 didn't seem to be hurt at that time. The NA heard the Unit Manager say she was going to tell the hall nurse about the fall so the nurse could follow up and check on the resident. When asked, NA #2 reported she did not recall the hall nurse's name but recognized and identified this nurse as having worked on the first shift of 9/11/25.An interview was conducted on 9/11/25 at 3:11 PM with Unit Manager #1. During the interview, the Unit Manager confirmed she and NA #2 responded to Resident #8's calls for help after she had an unwitnessed fall on 8/21/25. She described the resident as sitting on her butt in an upright position when she entered the room. The Unit Manager reported she did an initial assessment of Resident #8 and took her vitals. The resident reported no pain and had no apparent injuries. The Unit Manager and NA assisted the resident back to bed. Upon leaving the room, she recalled the hall nurse came down the hall and the Unit Manager then told her about the unwitnessed fall. The Unit Manager reported she told the hall nurse to be sure to do neurological checks (also called neurochecks, are an assessment of an individual's nervous system functions which includes motor and sensory responses and level of consciousness) on the resident, notify Resident #8's family and physician of the fall, and complete the Risk Management tasks (referring to the reporting and documentation of the fall). When asked, Unit Manager #1 reported she recalled the name of the NA (NA #2) who responded to the resident's call for help after the fall but could not recall the name of the hall nurse who was on duty that day. When asked what her thoughts were regarding the lack of follow up being completed, the Unit Manager

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations and resident and staff resident interviews, the facility failed to provide supervision for a resident who was assessed as requiring both supervision and use of a smoking apron to promote safety while smoking. This deficient practice occurred for 1 of 16 residents reviewed for accidents (Resident #7)The findings included:Resident #7 was admitted to the facility on [DATE] from a hospital. The resident's cumulative diagnoses included a history of a stroke with hemiplegia/hemiparesis (complete paralysis to partial weakness), and unspecified psychosis not due to a substance or known physiological condition.The resident's most recent Minimum Data Set (MDS) assessment was a quarterly assessment dated [DATE]. The assessment indicated Resident #7 had intact cognition. The MDS indicated Resident #7 had a functional impairment of range of motion on one side of his upper and lower extremities. The resident was reported as being independent with eating but required substantial to maximum assistance for bed mobility, sit to stand, and chair to bed to chair transfers. Resident #7 was totally dependent on staff for toileting, bathing, dressing, and personal hygiene.Resident #7's care plan included the following area of focus, in part:--The resident prefers to smoke cigarettes (Date Initiated: 8/27/25). The planned interventions included: may smoke independently (Date Initiated: 8/27/25); supervise with smoking (Date Initiated: 9/2/25); and smoking apron (Date Initiated: 9/2/25).The resident's electronic medical record (EMR) included one Smoking-Safety Screen dated 9/2/25 and conducted by the facility's Director of Nursing (DON). This smoking assessment reported Resident #7 had a problem with dexterity and required the use of a smoking apron/blanket for safety. The assessment score was a 10, and noted a score of 5 or greater was indicative of requiring supervision with smoking. Under the topic of Care Plan, each box was checked on the Smoking - Safety Screen form to include all Care Plan Interventions listed. These interventions included: educate on facility smoking policy, may smoke independently, Occupational Therapy referral as needed, smoking apron, smoking assessment as needed, and supervise with smoking.An interview was conducted on 9/10/25 at 9:32 AM with Resident #7. During the interview, the resident confirmed he was a smoker and reported that late yesterday a facility staff member (not identified) told him he needed to be supervised when he went out to smoke. When asked if specific times were now designated when he can go out to smoke, he said, No. The resident was asked if he wore a smoking apron when he smoked in the courtyard. He stated, No and added that there weren't any smoking aprons available in the courtyard until this morning. Observations and interviews were conducted on 9/10/25 at 10:15 AM of the courtyard utilized as the facility's smoking area. Five (5) residents were in the smoking courtyard with one Nurse Aide (NA) #4 supervising. An interview was conducted on 9/10/25 with NA #4 on 9/10/25 at 10:17 AM. During the interview, the NA stated someone was always supposed to be out in the smoking area to supervise the smokers. When asked about the smoking aprons, the NA reported the facility just began using smoking aprons the day before (on 9/9/25). At that time, the NA was asked how she knew which residents were safe smokers, which required supervision, and which residents should wear a smoking apron to promote safety. NA #4 pointed to a list of Supervised Smokers located on a nearby table. Resident #7's name was observed to be on this list of Supervised Smokers. The NA reported she understood that all smokers requiring supervision needed to wear a smoking apron. An interview was conducted on 9/10/25 at 11:30 AM with the Administrator in the presence of the [NAME] President (VP) of Operations. During the interview, the Administrator was asked about the recent changes related to smoking that were implemented at the facility on 9/9/25. The Administrator and VP explained that during a recent mock survey, inconsistencies in the implementation of the facility's smoking practices were identified. Since the mock survey, smoking assessments have been conducted on all residents and the smokers were identified as either independent smokers or those that required supervision. Smoking aprons were ordered and received last week. Use of the smoking aprons began yesterday (9/9/25). The Administrator and VP reported the facility's smoking policy was discussed during each resident's smoking assessment and these changes were again reviewed with the residents on 9/9/25. The contradiction documented on Resident #7's smoking assessment (and care plan) which indicated the resident could smoke independently yet was required to smoke with supervision was addressed. The Administrator responded by stating that the smoking assessment (and care plan) should have indicated a smoker was either an independent or a supervised smoker. Upon inquiry, the VP of Operations reported the facility did not have a plan of correction (POC) in place related to smoking because the facility was still in the process of

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and resident, staff and physician interviews, the facility failed to change a dressing for a peripherally inserted central catheter (PICC- is a type of longer intravenous catheter that goes into a larger vein close to the heart) line as ordered by the provider. The deficient practice occurred for 1 of 1 resident reviewed for parenteral/IV fluids (Resident #112). Findings included:Resident #112 was admitted to the facility on [DATE] with diagnoses of congestive heart failure, diabetes, chronic kidney disease, and cellulitis.Review of physician orders revealed an 8/27/25 order for meropenem (antibiotic) 1 gram intravenously three times a day for infection. An admission Minimum Data Set (MDS) assessment on 8/27/25 noted Resident #112 was cognitively intact. An admission care plan noted focus areas for congestive heart failure, chronic kidney disease, diabetes, falls, cellulitis, antibiotic therapy and central line care.Review of physician orders revealed an 8/28/25 order for a peripherally inserted central catheter line dressing change on admission, then every 7 days on day shift and as needed.A review of Resident #112's Medication Administration Record (MAR) for September 2025 revealed an order for PICC line dressing changes, to be changed on admission, then every 7 days on day shift, and as needed. The MAR did not specify what dates the dressing changes needed to be completed on. The PICC line dressing change was documented as having been completed by Nurse #4 on 9/3/25. On 9/11/25 at 10:20 AM, an interview and observation of Resident #112's September 2025 MAR with Nurse #4 was conducted. Nurse #4 confirmed that on 9/3/25, her initials were documented as having changed the line dressing but stated she had made an error, and she had not changed the peripherally inserted central catheter line dressing on 9/3/25. On 9/8/2025 at 12:02 PM an observation and interview with Resident #112 were conducted. Resident #112 was observed with a PICC line in her upper right arm with an antibiotic infusing as ordered. The dressing over the insertion site was clean, dry, intact and was hand-labeled in black ink 8/25. The Resident said the special IV was for her antibiotics and she did not remember when the dressing was last changed. On 9/10/2025 at 09:48 AM Resident #112 was observed in her room, awake, lying in bed watching television. Resident #112 was observed with a PICC line in her upper right arm and the dressing over the insertion site was clean, dry, intact and was hand-labeled in black ink 8/25.In an interview with Resident #112's primary nurse, Nurse #3 on 9/10/25 at 9:55 AM, Nurse #3 said this was only her second day working at the facility and her first day working the day shift. Nurse #3 said she did not know Resident #112 yet and was not yet familiar with the Resident's orders so she did not know when the Resident's peripherally inserted central catheter line dressing should be changed.In a joint interview with the Administrator and the Director of Nursing (DON) on 9/10/25 at 11:45 AM, both the Administrator and the DON said the expectation was that when a physician wrote an order for a peripherally inserted central catheter line dressing to be changed every week, the order should be carried out by nursing staff as ordered. On 9/10/25 at 12:00 PM an interview with the Nurse Practitioner was conducted. The Nurse Practitioner stated that if he wrote an order for a peripherally inserted central catheter line dressing to be changed weekly, he expected it to be changed as ordered. An observation of Resident #112's peripherally inserted central catheter line dressing on 9/10/25 at 3:30 PM revealed the line dressing remained unchanged with the same hand-written label of 8/25. During an interview on 9/11/25 at 10:20 AM Nurse #4 confirmed that she changed the PICC line dressing that morning (9/11/25) and stated the dressing she removed was dated 8/25. A telephone interview with the Medical Director was conducted on 9/11/25 at 12:19 PM. The Medical Director said that the peripherally inserted catheter line dressing change should be completed every seven days as ordered to help prevent infection and maintain the integrity of the catheter.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and staff and family interviews, the facility: failed to obtain an order for oxygen administration (Resident #121 and Resident #131), failed to administer supplemental oxygen at the prescribed rate (Resident #13) and failed to post cautionary signage for oxygen in use (Resident #13). These practices affected 3 of 3 residents reviewed for respiratory services (Residents #121, #131 and #13). The findings included: Resident #131 was admitted to the facility on [DATE]. A review of Resident #131's diagnosis revealed a diagnosis of “other forms of dyspnea.” A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #131 was cognitively intact. The resident was not documented as receiving oxygen during the assessment period. Resident #131's active care plan, last reviewed on 07/29/25, did not include a care plan for oxygen therapy. A review of Resident #131's August 2025 and September 2025 physician orders did not include an order for oxygen therapy. A review of the Resident #131's September 2025 medication administration record and treatment administration record no orders for oxygen therapy. A review of the standing orders for the facility indicated for shortness of breath, check pulse oximeter (ox) level and assess breath sounds. If the pulse ox level is less than 90% administer two liters of oxygen via nasal canula, obtain the resident's medical history, and notify the on-call provider. A review of the 600 hall Medical Communication Book from 08/01/25 through 9/10/25 revealed there was no communication to the medical provider related to shortness of breath or a pulse ox level less than 90% for Resident #131. A review of the Resident #131's September 2025 nursing progress notes revealed indication of shortness of breath or pulse ox level less than 90%. An observation was conducted at 11:20am on 09/08/25 of Resident #131. The observation revealed the resident lying in bed with an oxygen concentrator placed at the right side of the bed with the nasal canula and tubing lying over his stomach. The oxygen concentrator was turned on at the time of observation. An observation was conducted at 8:45am am on 09/09/25 of Resident #131. The observation revealed the resident lying in bed with an oxygen concentrator placed on the right side of the bed with the nasal canula and tubing lying on the floor. The oxygen concentrator was turned on at the time of observation. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up observation and interview were conducted at 8:30am on 09/10/25 with resident #131. The observation revealed the resident lying in bed with an oxygen concentrator placed on the right side of the bed with the nasal canula and tubing lying over his stomach. The resident stated he used oxygen at night and sometimes throughout the day. The resident also stated he had been using oxygen for a while, but he could not remember the exact date he started. The oxygen concentrator was turned on at the time of observation. An interview was conducted at 10:40am on 09/10/25 with Nurse #6. She stated when she came in that morning Resident #131 was receiving oxygen via the nasal canula through his nose at around 7:30am or 7:40am. She stated she had not worked with Resident #131 before and could not recall how long he had been receiving oxygen. Nurse #6 reviewed the physician orders during the interview and confirmed there were no active orders for oxygen. She stated the facility had standing orders for oxygen. Nurse #6 reviewed the facility's standing orders. The nurse then reviewed the 600 Hall Medical Communication Book and confirmed there was no communication to the medical provider related to shortness of breath or a pulse ox level less than 90% for Resident #131. She stated she did not receive any information related to the resident experiencing shortness of breath or a pulse ox reading less than 90%. An interview was conducted at 11:20am on 09/10/25 with Unit Manager. Unit Manager #1 stated she was not aware the resident did not have physician orders for oxygen therapy. The Unit Manger reported she had seen an oxygen concentrator in the resident's room but was not aware of how long he had been receiving oxygen. At the time of the interview Unit Manger #1checked the resident's medical records for an active order for oxygen therapy. The Unit Manager then confirmed there were no oxygen therapy orders for Resident #131. An interview was conducted at 11:25am on 09/10/25 with the facility's Assistant Director of Nursing (ADON) to discuss the findings for Resident #131. The ADON stated when she returned to work after being off for a month (specific date unidentified), the oxygen concentrator was in Resident #131's room. She stated she was not aware the resident had no active orders for oxygen therapy or how long the resident had been receiving oxygen. She stated if the oxygen was administered as a standing order once the need resolved the oxygen concentrator should have been removed from the resident's room. At time of the interview the ADON reviewed documentation back to July 2025 with the after hour provider service records and saw no communication pertaining to Resident #131experiencing any shortness of breath or a pulse ox reading less than 90%. An interview was conducted at 11:30am on 09/10/25 with the facility's Director of Nursing (DON) to discuss the findings for Resident #131. The DON stated he had seen Resident #131 receiving oxygen since he started working at the facility on 08/15/25 but was not aware the resident had no physician order for oxygen therapy. An interview was conducted at 11:40am on 09/10/25 with the facility's Nurse Practitioner (NP) to discuss the findings for Resident #131. The NP stated the oxygen concentrator should not have been in Resident #131's room. The NP stated the resident had no diagnosis that required oxygen therapy. He stated if Resident #131 required oxygen therapy it should be documented in the medical record. 2. Resident #121 was admitted to the facility on [DATE] with diagnoses that included second degree atrioventricular block (electrical signals between the heart's chamber are partially blocked , leading to irregular heartbeats) and unspecified dementia. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #121 was cognitively intact, and she was not assessed as using oxygen. On 9/8/25 at 11:01 AM an observation and interview were conducted with Resident #121 and her Representative. An oxygen concentrator was at the bedside with tubing and a nasal cannula connected. The Representative stated Resident #121 used oxygen mostly at night and when she got short of breath with chest tightness. Resident #121 agreed she mostly used oxygen at night. An oxygen in use sign was posted at the Resident's door. A review of the active orders for Resident #121 for the month of September 2025 did not reveal an order for oxygen usage. An order dated 9/10/25 read check oxygen saturation nightly and as needed if the resident expressed a need for oxygen or shortness of breath. On 9/10/25 at 4:14 PM Medication Aide #1 was interviewed and stated Resident #121 had been using oxygen for the past three months. He indicated she typically used it in the evenings and when she went to bed, and she applied it herself. On 9/11/25 at 12:50 PM the Physician Assistant (PA) was interviewed and stated he was not surprised Resident #121 was receiving oxygen because several months ago she was treated for pneumonia, and the oxygen must have been left over from an order given at that time. He indicated the facility had called him on 9/10/25 to request an order for oxygen, but he stated he informed the caller the resident needed oxygen saturation levels to support the order first before he would write an order for oxygen. He stated he did not give an order for oxygen, and the resident should not have a concentrator at the bedside. The Director of Nursing (DON) was interviewed on 9/12/25 at 2:45 PM and verified Resident #121 did not have an order for oxygen administration. He stated the facility did have standing orders for oxygen, but he was unable to locate the information or a protocol. 3. Resident #13 was admitted to the facility 6/20/25 with diagnoses including chronic respiratory failure and congestive heart failure. A care plan dated 7/1/25 addressed Resident #13's need for oxygen therapy with interventions included to administer oxygen as ordered and assess for signs and symptoms of respiratory complications. The admission Minimum Data Set assessment dated [DATE] assessed Resident #13 to be severely cognitively impaired. Resident #13 was assessed to use oxygen therapy. Physician orders for Resident #13 were reviewed and an order dated 9/6/25 specified the continuous administration of oxygen at 2 liters per minute by nasal cannula. Resident #13 was observed on 9/9/25 at 8:54 AM. The oxygen concentrator was observed to be administering oxygen at 3.5 liters per minute by nasal cannula and there were no cautionary signs posted for oxygen in use. Resident #13 was observed on 9/10/25 at 8:24 AM. The oxygen concentrator was observed to be administering oxygen at 3.5 liters per minute by nasal cannula and there were no cautionary signs posted for oxygen in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Unit Manager (UM) #2 was asked to observe the oxygen concentrator flow rate on 9/10/25 at 8:29 AM and she reported Resident #13 should have oxygen administered at 2 liters per minute. UM #2 reported a Medication Aide was responsible for administering medication for Resident #13, but the nurse in charge of the Medication Aide should have checked the flow rate of the oxygen and corrected the rate to 2 liters per minute. UM #2 reported that nursing staff were responsible for the oxygen cautionary signs, and an oxygen cautionary sign should have been posted on Resident #13's doorway. UM #2 did not know why the sign was not posted. An interview was conducted with Nurse #6 on 9/10/25 at 3:53 PM. Nurse #6 reported she was responsible for overseeing the Medication Aide and checking the oxygen flow rates for residents. Nurse #6 reported she was not aware of Resident 13's oxygen flow rate was 3.5 liters per minute. Nurse #6 was unable to recall if she had checked the oxygen flow rate on 9/8 or 9/10/25 for Resident #13. The Nurse Practitioner was interviewed on 9/11/25 at 12:20 PM and he reported that while the delivery of oxygen at 3.5 liters per minute had not harmed Resident #13, the nurse should check all oxygen concentrators for the correct oxygen delivery rate and post oxygen cautionary signs on the door to the resident's room. The Director of Nursing (DON) was interviewed by phone on 9/12/25 at 4:58 PM. The DON reported that a nurse was assigned to oversee the Medication Aide and part of the nurses' responsibility was checking oxygen flowrates. The DON reported he expected all nurses to ensure all oxygen flow rates were accurate to the physician orders. The DON reported any resident using oxygen should have a cautionary oxygen sign on their door, and he did not know why Resident #13 did not have a sign. The DON reported he expected all residents using oxygen to have a cautionary sign posted.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, Resident interviews as well as staff and Nurse Practitioner interviews, the facility failed to provide pain management during a painful dressing change procedure. Resident #136 had a chronic unstageable pressure ulcer on his left heel requiring regular dressing changes. During an ordered dressing change, Resident #136 was observed to exhibit signs of pain which included facial grimacing, increased breathing rate, shifting of position and verbal expressions of the dressing change procedure being painful and was not provided pain management. The deficient practice occurred in 1 of 4 residents reviewed for pressure ulcers (Resident #136).Findings included:Review of records revealed a hospital Discharge summary dated [DATE] which indicated that Resident #136 fell at home and fractured his left femoral neck (the part of the thigh bone that connects to the hip socket) and his right fifth metatarsal (a bone in the foot) and needed emergent surgery to repair the thigh bone fracture. Surgical intervention for the foot fracture was not indicated. Resident #136 had other medical diagnoses of paroxysmal atrial fibrillation, coronary artery disease, congestive heart failure, abdominal aortic aneurysm, hypertension, dementia and an unstageable pressure ulcer on his left heel. Resident #136 was admitted to the facility on [DATE] for rehabilitation services following his fall. A 7/24/25 admission Minimum Data Set (MDS) assessment revealed that Resident #136 had moderate cognitive impairment. A revised care plan dated 8/21/25 revealed focus areas for atrial fibrillation, congestive heart failure, hypertension, diuretics complications monitoring, fractures, pressure ulcers, falls, impaired skin integrity and pain riskReview of records revealed physician orders which included:An 8/12/25 order for hydrocodone-acetaminophen 5-325mg, one (1) tablet by mouth every 6 hours as needed for pain.An order dated 8/13/25 indicated that the left heel wound was to be cleansed with topical cleansing solution 0.125% and pat dried. Fluffed gauze, moistened with cleansing solution, was to be placed to the wound and covered with dry dressing, then wrapped with gauze and compression wrap bandage every day shift and as needed. In an observation and interview with Resident #136 on 9/8/25 at 12:39 PM, the Resident was awake and alert. He responded appropriately to questions and was pleasant and conversant. Resident #136 was sitting up in his wheelchair with both feet resting on the floor. He was wearing a non-skid sock on his right foot, and his left foot was covered with a wrap dressing which was intact. No odors were discerned from his left foot dressing. Resident #136 said he gets dressing changes for his foot every day and even a couple times a day if it gets dirty.On 9/10/25 at 10:36 AM, an interview with Resident #136's nurse, Nurse #3, was conducted. Nurse #3 said she did not know the Resident yet as she was new and had not finished her rounding or given medications yet. Nurse #3 said she was not yet familiar with the Resident's dressing change orders.On 9/10/25 at 10:40 AM, a second interview with Resident #136 was conducted. Resident #136 said his left foot was not healing, that he fell at home and ever since then, the wound on his heel wouldn't get better. Resident #136 said that his left foot hurts really bad any time they move it or do my dressing changes. They do my dressing changes a couple of times per day but I don't have a lot of pain otherwiseAt 10:46 AM on 9/10/25, an interview with Nurse #3 and Unit Manager #2 and an observation of Resident #136's dressing change were conducted. Unit Manager #2 said she did not know Resident #136 or his wound care orders because she was only filling in for the day but his dressing had not been changed yet for the day. Resident #136 was observed awake, sitting up in his wheelchair, his legs were uncrossed with both of his feet resting on the floor. Resident #136 was calm and conversant prior to the dressing change. Immediately prior to the dressing change, the Surveyor asked Nurse #3 and Unit Manager #2 if the Resident may need pain medication prior to the start of his dressing change. Nurse #3 and Unit Manager #2 said the Resident usually did not have a lot of pain during his dressing changes and so he was not pre-medicated for pain prior to the initiation of the dressing change. There was no witnessed pain assessment for Resident #136 immediately prior to the dressing change. Unit Manager #2 stepped outside of the room to a treatment cart and returned wearing gloves and carrying dressing change supplies. Unit Manager #2 sat down on the floor in front of Resident #136 and laid a clean gauze pad on the bare room floor to her left side and set the dressing change supplies on the gauze pad. Nurse #3 stood at the left side of the Resident's wheelchair and elevated Resident #136's left leg and held it in the elevated position. Unit Manager #2, from a seated floor position, then proceeded to remove the existing outer wrap from Resident 136's left leg and foot. Resident #136 grimaced his face and said, oh goodness, that hurts. The Resident then closed his eyes tightly and grimaced his face again and proceeded to take several deep breaths in quick succession. Unit Manager #2

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident, and staff interviews, the facility failed to provide sufficient nursing staff to provide activity of daily living (ADL) assistance to residents who required extensive to total care with toilet hygiene and eating (Resident #162). This affected 1 of 13 sampled residents. 1. a. Resident #162 was admitted to the facility on [DATE] and had cumulative diagnoses that included dementia, contracture of right and left hands, dysphagia, and aphasia. Resident #162's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated she was barely/rarely understood and her cognitive skills were severely impaired. Resident #162 had functional limitation in range of motion to one side of her upper extremity and to both sides of lower extremities. She was dependent on staff for all ADLs and was always incontinent with bowel and bladder. Resident #162 also had a stage 4 pressure ulcer to her sacrum. An interview with the Ombudsman was conducted on 09/04/25 at 3:44 PM which stated she came to the facility on [DATE] for a visit. She indicated when she walked by Resident #162's room on 06/12/25 around 3:00 PM she observed a lunch tray sitting on the bedside table beside Resident #162's bed untouched. The Ombudsman stated she told the nurse who then told the Director of Nursing (DON). The Ombudsman explained that the DON informed her that they were short staffed and that was why Resident #162's meal tray was untouched at her bedside. She continued to explain that as of 3:00 PM on 06/12/24, Resident #162 had not been offered or assisted with lunch. Nurse #9 provided direct care to Resident #162 on 06/12/25 from 7:00 AM until 7:00 PM. She was not available for interview during the survey period. A phone interview was conducted on 09/11/25 at 1:44 PM with the previous DON. She stated it was brought to her attention by the Ombudsman on 06/12/25 at approximately 3:30 PM that Resident #162's lunch tray was still in her room on the bedside table and that it had not been touched, and it did not appear that staff had attempted to assist Resident #162 with her lunch. The DON stated they had several call outs on 06/12/25 and the NA who was assigned Resident #162 did not ask for assistance by other staff members and forgot to go back and assist Resident #162 with her lunch. Corrective action was rendered. The DON indicated that administrative staff were assisting in answering call lights and providing care.An interview was conducted on 09/12/25 at 2:27 PM with NA #8. She verified she was the direct care NA for Resident #162 on 06/12/25. She explained that the ombudsman did locate Resident #162's lunch tray in her room and that it had not been touched since the trays were passed out. She stated it was around 2:00 PM, not 3:30 PM, and she could not recall what time the trays were passed out. She then stated she did not forget to assist Resident #162 with her lunch; she was just the last person she had to feed that day and she was doing the best she could do because they were short staffed. NA #8 could not recall how many residents she had to care for on 06/12/25. She further explained that she did not ask for assistance with feeding or changing Resident #162 because everyone was busy. She indicated when they were short staffed it was difficult to get her tasks done, she would be running late, but the tasks would get done. She then stated sometimes the showers may not get done but the residents did get a quick bed bath. An interview was conducted on 09/12/25 at 4:12 PM with the Director of Nursing. He stated that it was his expectation that the facility had a sufficient number of nursing staff to meet the needs of the residents b. Review of the grievance log revealed a concern dated 08/20/25 at 5:25 PM written by the Wound Nurse who observed Resident #162 saturated from head to toe in urine and still had night clothes on. The roommate stated Resident 162 had not been cleansed or repositioned all day. The Wound Nurse added Resident 162's linens were soiled, she needed to be changed, and the resident had a stage 4 pressure ulcer.An interview was conducted on 09/08/25 at 4:08 PM with NA #10. She stated she had worked for the facility since April 2025, and the facility did not always have enough staff available to help the residents with their care needs. NA #10 explained she typically had 26 residents assigned to her on 1st shift (7 AM-7 PM), and if she worked the 700 hall then she had up to 40 residents. She then stated that when she had that many residents assigned to her, she couldn't get baths or showers done. NA #10 continued to explain that the shower sheet at the nurse's station did not match what's on the computer. She indicated showers on the weekend didn't always get done because there were not enough staff. NA #10 also indicated the last time she had 40 residents assigned to her was in August, although she was unable to recall the exact day or shift.A phone interview was conducted on 09/11/25 at 10:52 AM with the Wound Nurse. She stated on 08/20/25 at 5:25 PM when she went to perform wound care on Resident #162's her brief and bedding were soaked with urine. She reported the situation to the DON, and he advised her to complete a grievance form which she did. She

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on record review and staff interviews, the facility failed to accurately report staffing for 5 of 5 daily posted sheets reviewed (5/1/25, 6/14/25, 7/4/25, 8/10/25, and 9/1/25).The findings included: The following posted nurse staffing sheets were reviewed: 5/1/25, 6/14/25, 7/4/25, 8/10/25, and 9/1/25.a. The posted nurse staffing sheet dated 5/1/25 indicated 5 Registered Nurses (RNs), 2 Licensed Practical Nurses (LPNs) and 5 Nursing Assistants (NAs) were working the day shift (7:00 AM to 3:00 PM). The nursing schedule had 2 RNs, 2 LPNs, and 11 NAs working that shift. The posted nurse staffing sheet indicated that 4 RNs and 3 LPNs were working the evening shift (3:00 PM to 11:00 PM). The nursing schedule had 1.5 RNs and 2.5 LPNs working that shift. The posted nurse staffing sheet indicated 2 RNs, 1.5 LPNs, and 5 NAs were working the night shift (11:00 PM to 7:00 AM). The schedule had 1 RN, 3 LPNs, and 10 NAs working that shift. b. The posted nurse staffing sheet dated 6/14/25 indicated 0.5 RN and 6.5 NAs were working day shift that date. The schedule showed 1 RN and 10 NAs were working day shift. The posted nurse staffing sheet indicated 1. 5 RNs, 4.5 LPNs, and 10.5 NAs were working the evening shift. The nursing schedule had 1 RN, 3 LPNs, and 7.5 NAs working that shift. The posted nurse staffing sheet indicated that 2.5 LPNs and 4 NAs were working the night shift that date. The nursing schedule had 2 LPNs and 6 NAs working the night shift. c. The posted nurse staffing sheet dated 7/4/25 indicated 1 RN, 2 LPN, and 5.5 NAs were working day shift that date. The nursing schedule had 2 RNs, 4 LPNs, and 11 NAs working day shift. The posted nurse staffing sheet indicated that 2.5 RNs and 11 NAs were working evening shift. The nursing schedule had 4 RNs, and 5.5 NAs working evening shift. The posted nurse staffing sheet had 1.5 RNs, 1.5 LPNs, and 5.5 NAs working the night shift that date. The nursing schedule had 3 RNs, 2 LPNs, and 10 NAs working night shift. d. The posted nurse staffing sheet dated 8/10/25 indicated 2 RN and 3.5 LPNs were working evening shift that date. The nursing schedule had 3.5 RNs and 4 LPNs working that shift. e. The posted nurse staffing sheet dated 9/1/25 indicated 10 NAs were working the night shift that date. The schedule had 11.5 NAs working that shift. An interview was conducted with the Scheduler on 9/11/25 at 9:21 AM. The Scheduler reported she had been in the position for 1 month and she was responsible for adjusting the schedule of nurses and NAs, as well as correcting the posted nurse staffing sheet. The Scheduler described correcting the posted nurse staffing sheet during the day from 8:00 AM to 5:00 PM when staff called out of work, or she had to add staff. The Scheduler reported she would take the posted nurse staffing sheet and the schedule the following day, check the schedule against time sheets and make corrections to the nursing schedule and the posted nurse staffing sheet. The Scheduler indicated during the weekend, she would return to the facility to make corrections to the posted nurse staffing sheet, as well as final corrections on Monday of each week. The Scheduler reported she did not know if any of the nursing staff had been trained to adjust and correct the posted nursing staff sheet. The Scheduler reported she had changed the posted nurse staffing sheet to indicate the 2 shifts the facility used (7:00 AM to 7:00 PM day shift, and 7:00 PM to 7:00 AM night shift) to make the posted nurse staffing sheet more accurate. The Administrator was interviewed by phone on 9/12/25 at 4:58 PM and she reported she expected the posted nurse staffing sheets to accurately reflect the facility staffing.

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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. (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and staff interviews, the facility failed to: discard expired medications on 1 of 3 medication carts observed (Medication Cart #1) and 1 of 2 Medication Rooms (Medication room [ROOM NUMBER]); Failed to remove loose and unsecured pills of various shapes, sizes and colors on 2 of 3 medication carts (Medication Cart #1 and Medication Cart #4); and failed to store medication in accordance with the manufacturer's storage instructions on 1 of 3 medication carts (Medication Cart #1). The findings included:1. An observation was conducted on 09/10/25 at 2:00pm of the Medication (Med) Cart #1 in the presence of Medication Aide (MA) #2. The observation revealed the following medications were stored on the med cart:a. One bubble-pack card containing four 0.4 milligrams (mg) tablets of nitroglycerin (a medication used to prevent and treat chest pain) with no resident identification.An interview was conducted with MA #2 on 09/10/25 at 2:00pm. When asked, MA #2 confirmed that the medication should be labeled with the minimum information required, including the name of the resident.b. According to the manufacturer, intact (unopened) bottles of latanoprost (a medication used to treat glaucoma) should be stored under refrigeration at 36 degrees Fahrenheit (F) to 46 F.An unopened bottle of 0.005% latanoprost eye drops dispensed from the pharmacy on 08/31/25 for Resident #6 was stored on the med cart. A blue pharmacy auxiliary sticker placed on the bottle read, Keep in Refrigerator Until Open.An interview was conducted with MA #2 on 09/10/25 at 2:00pm. When asked, MA #2 confirmed the auxiliary sticker placed on the container of latanoprost indicated the eye drops should be stored in the refrigerator.c. One unidentified tan capsule with marking 215 found in the bottom of the last drawer on the med cart.An interview was conducted with MA #2 on 09/10/25 at 2:00pm. When asked, MA #2 confirmed that the medication should be labeled with the minimum information required, including the name of the resident.d. One open stock bottle of 600mg Calcium Carbonate (a medication used to treat heart burn, acid indigestion, and upset stomach). The stock bottle originally contained 150 tablets (with approximately 60 tablets remaining in the bottle) and was observed to have a manufacturer expiration date of August 2025. An interview was conducted with MA #2 on 09/10/25 at 2:00pm. When asked, MS #2 confirmed that the medication should be labeled with the minimum information required, including the name of the resident. 2. An observation was conducted on 09/10/25 at 2:15pm in the Medication room [ROOM NUMBER]. The observation revealed the following medications were stored in the refrigerator:a. One large clear plastic bag labeled one (1) gram (g)/1000 milliliters (ml) Meropenem (used to treat bacterial infections) with a pharmacy dispensed date of 08/18/25 and an expiration date of 08/28/25 with six individual containers labeled 1g/1000 ml Meropenem with a pharmacy dispensed date of 08/18/25 and an expiration date of 08/28/25 for Resident #101. A blue pharmacy axillary sticker placed on the large bag and the six individual containers read, Refrigerate.A second large clear plastic bag labeled 1g/1000ml Meropenem with a pharmacy dispensed date of 08/25/25 and an expiration date of 09/04/25 with eight individual containers labeled 1g/1000ml Meropenem with a pharmacy with a dispense date of 09/04/25 for Resident #101. A blue pharmacy axillary sticker placed on the large bag and the eight individual containers read, Refrigerate.An interview was conducted with MA #2 on 09/10/25 at 2:15pm. When asked, MA #2 confirmed that the medication had an expiration date of 08/25/25 and 09/04/25. She also stated the expired medication should have been sent back to the pharmacy.3. An observation was conducted on 09/10/25 at 2:30pm of Med Cart #4 in the presence of Nurse #6. The observation revealed the following medications were stored on the med cart: a. One small round white tablet with marking ZC41 found in the first drawer of the med cart. b. One small round white tablet with marking 90T found in the second drawer of the med cart. c. One small oval tan tablet with marking HP24 found in the second drawer of the med cart. An interview was conducted on 09/10/25 with Nurse #6 at 2:30pm. When asked, Nurse #6 confirmed that the loose tablets of medication should be labeled with the minimum information required, including the name of the resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to: prevent cross-contamination of dishware during the operation of the dishwashing machine; ensure dietary staff's personal belongings were not stored in the food preparation area; maintain food service equipment clean and free from debris; and store dishware clean and dry. These deficient practices had the potential to affect residents residing in the facility.1. During the initial tour of the kitchen on 9/8/25 at 11:20 a.m., Dietary Staff #1 was observed wearing plastic gloves as she scraped the excess food debris and placed the dirty dishware on a dish rack in preparation for cleaning in the dishwashing machine. The Dietary Staff #1 crossed to the opposite side of the machine and removed a rack of clean glassware without removing the soiled gloves and washing her hands. She placed the rack of glassware onto a preparation table for use during the lunch tray line service. Dietary Staff #1 revealed she had been working at the facility for three days and had not received any training on cross-contamination. She was not aware she was to remove her gloves and wash her hands after handling soiled dishware. On 9/8/25 at 11:30 a.m., the Dietary Manager stated Dietary Staff #1, a new employee, had only been working in the kitchen for three days. The Dietary Manager had not completed Dietary Staff #1's training because he had been busy trying to ensure residents received their meals on time. 2. On 9/8/25 at 11:40 a.m. a large, pink travel mug was observed on the bottom shelf of a food preparation table in the kitchen. Dietary [NAME] #1 stated the mug belonged to one of the dietary staff. On 9/8/25 at 11:45 a.m., a dietary staff was observed entering the kitchen and placing a large travel mug on the bottom shelf of a preparation table after sipping from the straw inserted in the mug. During the meal tray service in the kitchen on 9/8/25 at 12:00 p.m., a small 3-shelf cart was observed next to the trayline service with plate covers stacked on the top shelf, large blue travel mug on the second shelf, one large pink travel mug, one large can of kidney beans, and one bushel of plastic flowers were on the bottom shelf of the cart. 3. During the tour of the kitchen on 9/8/25 at 11:42 a.m., there was a thick, black grease build-up covering the stove top and dried dark stains on the front and sides of the stove. The interior of the double convection ovens also contained thick, dark grease buildup. The interior of the double-sided plate warmer had dried brown/yellow stains. There were clean plates observed in the warmer. On 9/12/25 at 2:31 p.m., the Dietary Manager stated Sundays were scheduled as the deep cleaning day in the kitchen, including equipment. He revealed he last cleaned the ovens on 8/30/25. 4. During an observation of the meal service trayline in the kitchen on 9/10/25 at 12:08 p.m., there were seven wet and dirty (dried food particles) divided plates stacked on the meal service trayline. During an interview on 9/12/25 at 2:31 p.m. the Dietary Manager stated the Registered Dietitian conducted audits of the kitchen every Monday on sanitation, safety, dating and labelling of foods.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review, observations, resident, staff and physician interviews, the facility failed to maintain accurate medical records for a peripherally inserted central catheter (PICC) line dressing change (Resident #112), intravenous antibiotic medication (Residents #101), and for assessing and documenting blood sugars and the administration of insulin (Resident #82). This was for 3 of 3 resident reviewed for resident records (Resident #112, #101, and #82). Findings included: Resident #112 was admitted to the facility on [DATE] with a peripherally inserted central catheter line. An admission Minimum Data Set (MDS) assessment on 8/27/25 noted Resident #112 was cognitively intact. Review of physician orders revealed an 8/28/25 order for a peripherally inserted central catheter line dressing change on admission, then every 7 days on day shift and as needed. On 9/8/2025 at 12:02 PM an observation and interview with Resident #112 was conducted. Resident #112 was observed with a right upper arm peripherally inserted central catheter line, with an antibiotic infusing as ordered. The dressing was clean, dry, intact and was hand-labeled in black ink 8/25. The Resident said the special IV was for her antibiotics and she did not remember when the dressing was last changed. On 9/10/2025 at 09:48 AM Resident #112 was observed in her room, awake, lying in bed watching tv. Her right upper arm peripherally inserted central catheter line was clean, dry and intact with the same dressing hand-labeled in black ink 8/25. A review of Resident #112's Medication Administration Record (MAR) for September 2025 revealed a last documented dressing change as having occurred on 9/3/25 and was documented by Nurse #4. On 9/11/25 at 10:20 AM, Nurse #4 confirmed that she saw the previous dressing was dated 8/25. Nurse #4 confirmed that her initials were present on Resident #112's MAR as having changed the line dressing on 9/3/25 but stated she had made an error, and she had not changed the peripherally inserted central catheter line dressing on 9/3/25. In a joint interview with the Administrator and the Director of Nursing (DON) on 9/10/25 at 11:45 AM, both the Administrator and the DON said documentation should be accurate. On 9/10/25 at 12:00 PM an interview with the Nurse Practitioner was conducted. The Nurse Practitioner stated the documentation should be accurate and complete. A telephone interview with the Medical Director was conducted on 9/11/25 at 12:19 PM. The Medical Director said that all documentation should be accurate and complete. 2. Resident #101 was admitted on [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An active physician's order dated 08/02/25 and renewed on 08/07/25 revealed Resident #101 had an order to receive meropenem (an antibiotic used to treat severe bacterial infections) intravenous (IV) solution reconstituted 1 gram intravenously every 8 hours. The August 2025 Medication Administration Record (MAR) for Resident #101 was reviewed and revealed 2 occurrences indicating the meropenem antibiotic was not administered for the following dates: 08/17/25 at 4:00 PM and 08/22/25 at 12:00 AM. An interview was conducted on 09/13/25 at 2:00 PM with Nurse #1. She verified she worked on 08/17/25. She stated she did administer Resident #101's IV medication on 08/17/25 at 4:00 PM. She explained she forgot to sign the MAR. A phone interview was conducted on 09/11/25 at 10:52 AM with the Wound Nurse. She verified she worked on 08/22/25 at 12:00 AM. She stated she knew she administered the IV antibiotic for Resident #101 but that she could not remember why she didn't sign the MAR. She indicated it was an oversight. The Physician's Assistant was interviewed on 9/12/25 at 12:50 PM he stated he was aware the MAR was not signed as being administered. He explained medications should have been accurately documented. The Director of Nursing was interviewed on 9/12/25 at 2:42 PM and stated nurses were supposed to document on the MAR after administering IV antibiotics. The DON verified he was aware of the missed signatures on the MAR. 3. Resident #82 was admitted on [DATE] with diagnoses that included type II diabetes and cognitive communication deficit. An active physician's order dated 5/28/25 and renewed on 8/5/25 revealed Resident #82 had an order to receive 8 units of Novolin R (insulin regular human); inject 8 units subcutaneously two times a day related to type II diabetes with hyperglycemia. Hold if not eating meal; hold for blood glucose less than 150. The August 2025 Medication Administration Record (MAR) for Resident #82 was reviewed and revealed 5 occurrences indicating Resident #82's blood sugar was not assessed, and the Novolin R insulin was not administered for the following dates: 8/2/25 at 11:30 AM, 8/28/25 at 4:00 PM, and 8/30/25 at 4:00 PM. On 9/12/25 at 12:00 PM Nurse #1 was interviewed and verified she had worked the dates of 8/2/25, 8/28/25, and 8/30/25. She stated she did not recall having missed checking Resident #82's blood sugars or giving him insulin on the missing dates, and she was uncertain why her initials were not recorded on the MAR. The Physician's Assistant was interviewed on 9/12/25 at 12:50 PM and stated medications should have been administered and accurately documented as ordered. The Director of Nursing was interviewed on 9/12/25 at 2:42 PM and stated nurses were supposed to document on the MAR after checking a resident's blood sugar and administering insulin.

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F 0850 Level of Harm - Potential for minimal harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on staff interviews, the facility failed to employ a full-time, qualified social worker. This had the potential to affect all residents. The facility census was 130 at the time of the survey.The findings included: An interview was conducted by phone with Social Worker (SW) #1 9/10/25 at 3:31 PM. SW #1 reported she was no longer employed by the facility and her last day at work was 8/15/25. An interview was conducted on 09/10/25 at 3:47 PM with the Administrator and she reported SW #1 left in August 2025. The Administrator reported the facility had not filled the position and the Social Work department assistant was not a qualified Social Worker. The Administrator reported the regional Social Worker was not qualified as a Social Worker. The Administrator explained that the [NAME] President of Operations had been assisting the Social Work department, and she was a qualified Social Worker. During an interview with the [NAME] President of Operations on 09/10/25 at 4:12 PM she explained that she was assisting the facility Social Work department, but she was not the full-time Social Worker. The [NAME] President explained she was aware the facility was required to have a full-time qualified Social Worker, and they were conducting interviews to fill the position.

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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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, record review, and staff interviews, the facility failed to implement their infection control policy when they failed to dispose of a soiled brief left on a resident's nightstand after performing incontinence care for 1 of 18 residents reviewed for activities of daily living (Resident #84). The facility also failed to implement their infection control policy regarding handwashing while providing ostomy care for 1 of 2 residents reviewed for ostomies (Resident #9). In addition, the facility failed to implement their infection control policy regarding handwashing and enhanced barrier precautions while providing wound care for 1 of 4 residents reviewed for pressure ulcers (Resident #9). This deficient practice occurred for 2 of 15 staff members observed for infection control practices (Nurse #9 and Nurse Aide #11).The findings included:1. The infection prevention and control sub policy entitled #702 Regulated Medical Waste read in part: The Center maintains a current standard of practice regarding regulated medical waste. Regulated waste is defined as waste considered to be capable of producing an infectious disease. Examples of regulated waste include. human body fluids or items contaminated with human blood or body fluids.The infection prevention and control sub policy entitled #402 Standard Precautions read in part: . ensure single use items are discarded properly. On 9/8/25 at 2:29 PM an interview and observation were conducted with Resident #84 in his room. A wet brief was observed sitting on the resident's nightstand while he was lying in bed. Resident #84 stated Nurse Aide #11 (NA) changed him when he was wet, approximately 45 minutes before the interview. He stated the NA told him she had something else to do and walked out of his room after putting the wet brief on his nightstand and had not returned to dispose of it. Nurse Aide #11 walked into Resident #84's room during the interview and stated, I meant to get a bag for that. She walked into the resident's bathroom and retrieved the trash can and disposed of the wet brief. NA #11 stated she did not intend to leave the wet brief lying on the resident's nightstand then took the trash can and walked out of the room.Unit Manager #1 was interviewed on 9/8/25 at 3:35 PM and stated NA #11 should not have placed a wet brief on Resident #84's nightstand at all. She stated the NA should have disposed of the wet brief in a trash bag and removed it from the resident's room once the incontinence care was completed. She also indicated NA #11 should have disinfected the nightstand before leaving Resident #84's room as well, and she would have the NA complete that task. On 9/9/25 at 12:19 PM the Director of Nursing (DON) was interviewed and stated NA #11 should not have placed a wet brief on Resident #84's nightstand, and she should have taken a trash bag into the resident's room to dispose of the brief once she completed incontinence care and removed the trash bag from the resident's room once care was finished.The Infection Preventionist (IP) nurse was interviewed on 9/12/25 at 10:50 PM and stated it was inappropriate to place a soiled brief on a resident's nightstand or any of the resident's furniture. She indicated placing a wet brief on a surface in the room was an infection control hazard, and all soiled briefs should be disposed of in the trash.2a. The infection prevention and control sub-policy #401 entitled Handwashing Requirements, with an effective date of 2/6/2020, read in part:Hand hygiene can consist of handwashing with soap and water or use of an alcohol-based hand rub. The following is a list of some situations that require hand hygiene: . before and after direct patient contact, before and after assisting a patient with toileting, before and after changing a dressing, after any contact with potentially contaminated materials (used wound/treatment dressings). Change gloves during patient care when moving from a contaminated body site to a clean body site.On 9/11/25 at 1:18 PM Nurse #9 was observed as she provided ostomy and wound care for Resident #9. Nurse #9 washed her hands and donned a pair of clean gloves after entering Resident #9's room. She explained the ostomy appliance change procedure to Resident #9, removed the resident's ostomy appliance, and discarded it in the trash. The nurse removed her soiled gloves, washed her hands, then donned clean gloves. Nurse #9 cleaned the resident's peristomal (area of skin surrounding a stoma) area, removed her gloves, discarded them in the trash, and washed her hands. Nurse #9 did not don another pair of clean gloves. She used her bare hands to measure the stoma (a surgically created opening on the abdomen that allows waste from the bowel to exit the body) then removed a pair of scissors from her pocket to cut the wafer to the correct size and applied the new wafer and pouch to Resident #9's colostomy site. Nurse #9 then placed the scissors used to cut the ostomy wafer back in her pocket without cleaning them and washed her hands. 2b. The facility's infection prevention and control sub-policy #406 for enhanced barrier precautions entitled Enhanced Barrier Precautions (EBPs), with an effective date of 3/26/2024, read in part:Employees providing high-contact care activities will follow enhanced barrier precautions for patients who meet the criteria. EBPs require the use of gowns and gloves

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. Building B. Wing	09/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blumenthal Health and Rehabilitation Center	3724 Wireless Drive Greensboro, NC 27455

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to include documentation in the medical record of education regarding the benefits and potential side effects of the Influenza and pneumococcal vaccines and failed to include documentation in the medical record for the acceptance or declination of the vaccinations for 3 of 5 residents reviewed for influenza and pneumonia vaccines (Resident #13, Resident #53, and Resident #132). The findings included: a. Resident #13 was admitted to the facility on [DATE]. A review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #13 was severely cognitively impaired, and the Influenza and Pneumococcal vaccines were not offered. A review of Resident #13's electronic medical record indicated the resident's family had refused the influenza and pneumonia vaccines for Resident #13. There was no information in the medical record that indicated Resident #13, or her family, was provided education regarding the benefits and potential side effects of the influenza or pneumonia vaccines. A vaccine consent form provided by the facility had a checkmark beside decline the flu vaccine and decline the pneumonia vaccine sections. However, the consent form only had the word verbal written on the signature line for the resident or representative to sign. There was no name of the family member who declined, a date for when the word verbal was written, and the document was undated. b. Resident #53 was admitted to the facility on [DATE]. A Review of the comprehensive Minimum Data Set assessment dated [DATE] revealed Resident #53 was moderately cognitively impaired, and the influenza and pneumonia vaccines were offered and declined. A review of Resident #53's electronic medical record indicated the influenza and pneumonia vaccines were declined. A vaccine consent form provided by the facility had a checkmark beside the decline the flu vaccine and decline the pneumonia vaccine sections. However, there was no signature or date on the form. No family member was listed on the form, and the document was undated. On 9/11/25 at 10:13 AM Resident #53 was interviewed and stated she was not offered the flu and pneumonia vaccines since being at the facility. She stated, I would not have refused those vaccines because I have asthma, and those vaccines are very important. c. Resident #132 was admitted to the facility 7/29/25. A review of the comprehensive Minimum Data Set assessment dated [DATE] revealed Resident #132 was cognitively intact, and the influenza and pneumonia vaccines were offered and declined. A review of Resident #132's electronic medical record revealed there was no information in the medical record stating the Resident or their legal representative had declined the flu and pneumonia vaccines, and the record did not state the resident had been provided education regarding the benefits and potential side effects of the influenza and pneumonia vaccines. The facility was unable to provide documentation the resident, or their legal representative gave consent or declined the vaccinations. The Infection Preventionist (IP) was interviewed on 9/12/25 at 12:50 PM and explained she offered residents influenza and pneumonia vaccines upon admission to the facility as well as on an individual basis. She stated after speaking with the resident she would check their vaccine preference then write the word verbal on the consent form. The IP indicated not all residents were able to sign their names, but if the resident wished to sign their vaccine consent form, then they could sign beside the word verbal she had written. The IP stated she was unsure why Resident #132 did not have information in his electronic medical record about his vaccine or education status. She further stated she mailed a copy of the vaccine consent form to the address on file for Resident #13's Representative. An interview was conducted with the Director of Nursing (DON) in conjunction with the Administrator on 9/12/25 at 2:45 PM. The DON explained he had only been at the facility for three weeks, but all residents should be offered the influenza and pneumonia vaccines, and the consent forms should be signed by the resident or their representative. The DON stated a record of the education provided to the residents or their representatives should be maintained in the electronic medical record. The Administrator stated she agreed the residents should be offered the influenza and pneumonia vaccines and be able to sign their vaccine consent forms

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. (continued on next page)

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident, and staff interviews, the facility failed to document if the Covid-19 immunization was administered or if education was provided in the medical record regarding the benefits and potential side effects of the COVID-19 vaccines. This occurred for 3 of 5 residents reviewed for COVID-19 immunizations (Resident #15, Resident #53, and Resident #132). In addition, the facility was unable to provide evidence of Covid-19 immunization status or if education had been provided for 2 of 5 staff members (Staff #13 and Staff #14).The findings included:a. Resident #13 was admitted to the facility on [DATE]. A review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #13 was severely cognitively impaired, and the Covid-19 immunization was not offered. A review of Resident #13's electronic medical record indicated the resident's family, who was unnamed, had refused the Covid-19 immunization on behalf of Resident #13. Further review revealed there was no information in the medical record that indicated Resident #13, or her family, was provided with education regarding the benefits and potential side effects of the Covid-19 immunization. A vaccine consent form provided by the facility had a checkmark beside decline the Covid-19 immunization section. However, the consent form dated 7/1/25 only had the word verbal written on the signature line for the resident or representative to sign. There was no name of the family member who may have declined where the word verbal was written, and the Infection Preventionist's (IP's) name was listed as the facility's representative. Attempts to contact Resident #13's family members were unsuccessful. b. Resident #53 was admitted to the facility on [DATE]. Resident #53 was listed as her own responsible party in the electronic medical record. A Review of the comprehensive Minimum Data Set assessment dated [DATE] revealed Resident #53 was moderately cognitively impaired, and the Covid-19 immunization was offered and declined. A review of Resident #53's electronic medical record indicated the Covid-19 immunization was declined. A vaccine consent form provided by the facility had a checkmark beside the section to decline the Covid-19 immunization was listed. However, there was no signature or date on the form. On the resident signature line, the word verbal was written, and the IP's name was listed as the facility representative. On 9/11/25 at 10:13 AM Resident #53 was interviewed and stated she was not offered the Covid-19 immunization since being at the facility. She stated she would not have refused the vaccine due to having a history of asthma. c. Resident #132 was admitted to the facility on [DATE]. A review of the comprehensive Minimum Data Set assessment dated [DATE] revealed Resident #132 was cognitively intact, and the Covid-19 immunization was offered and declined. A review of Resident #132's electronic medical record revealed there was no information in the medical record that the resident or their legal representative had declined the Covid-19 immunization, or if the resident had been provided education regarding the benefits and potential side effects of the Covid-19 immunization. The facility was unable to provide documentation that the resident or their legal representative gave consent or declined the immunization. Attempts made to interview Resident #132 were unsuccessful. d. The facility was unable to provide evidence of Covid-19 immunization status or if education had been provided for Staff member #13 or Staff member #14 when requested for review. The Administrator stated the facility did not have information on file for either staff member when she presented immunization history for the staff members requested for review on 9/12/25 at 10:00 AM. The Infection Preventionist was interviewed on 9/12/25 at 12:50 PM and explained she offered residents the Covid-19 immunization upon admission to the facility as well as on an individual basis. She stated after speaking with the resident she would check their immunization preference then write the word verbal on the consent form. The IP indicated not all residents were able to sign their names, but if the resident wished to sign their vaccine consent form, then they could sign beside where she had written the the word verbal. The IP stated she was unsure why Resident #132 did not have information in his electronic medical record about his immunization or education status. She further indicated Covid-19 immunizations were not offered to the staff by the facility, but she did keep a record of the staff members' immunization status. The IP indicated she mailed a copy of the vaccine consent form to the address on file for Resident #13's representative. She stated she thought the records for Staff member #13 and Staff member #14 might be missing because of all the changes that had taken place at the facility, including the change in ownership of the facility. An interview was conducted with the Director of Nursing (DON) 9/12/25 at 2:45 PM. The DON explained he had only been at the facility for three weeks, but all residents should be offered Covid-19 immunization, and the consent forms should be signed by the residents or their representatives. The DON