STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345077	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnybrook Rehabilitation Center	25 Sunnybrook Road Raleigh, NC 27610

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with staff, Emergency Medical Services (EMS) staff, Nurse Practitioner, and Medical Director, the facility failed to ensure basic lifesaving support was provided effectively when there was a delay in initiating Cardio Pulmonary Resuscitation (CPR) to a resident who had no signs of life and was a full code (an official directive to perform all necessary life-sustaining measures, including CPR and defibrillation, if a person stops breathing or their heart stops). Additionally, the facility failed to do the following: 1) ensure staff knew how to announce a code blue to obtain assistance when a resident was without signs of life, 2) ensure all emergency equipment, which included an AMBU bag (an AMBU bag is used to ventilate a resident who has stopped breathing so that with each chest compression oxygenated blood will circulate while resuscitation efforts are being conducted) and an Automatic External Defibrillator (AED, a device used to deliver a shock to the heart) was in a place which would not delay effective resuscitation efforts, and 3) immediately notify emergency medical services (EMS) when no signs of life were identified and the code status was confirmed to be a full code. Resident #89's resuscitation efforts were stopped and Resident #89 was pronounced deceased on [DATE] at 2:15 am by EMS. This affected 1 of 1 residents reviewed for CPR (Resident #89). Immediate jeopardy began on [DATE] when staff failed to immediately initiate their CPR protocol to Resident #89 who was a full code and found warm and without breaths or a pulse. Immediate Jeopardy was removed on [DATE] when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity D to ensure education is completed and monitoring systems put in place are effective. The findings included:The facility's policy titled CPR-Cardiopulmonary Resuscitation last revised on [DATE] revealed the center shall provide basic life support, including CPR- Cardiopulmonary Resuscitation when a resident requires such emergency care, prior to the arrival of emergency medical services, subject to physician order, and resident choice indicated in the resident's advance directives. The policy further noted the procedure as follows:1. In the event of cardiac or respiratory arrest, identify code status. If no DNR (Do Not Resuscitate) order exists, or if resident has no obvious clinical signs of irreversible death, initiate CPR. 2. Activate emergency response system by clearly paging over the PA (public address) system, code blue and the area/room number. 3. Use an Automatic External Defibrillator (AED, a device used to deliver a shock to the heart) per manufacturer indications of use as soon as possible when the device is ready for use. Follow the voice and onscreen instructions. 4. Continue CPR until the resident responds, healthcare practitioner arrives and takes over or EMS arrives and takes over. Review of CPR certification records revealed Nurse #8 and Nurse #3 had current CPR training for basic life support (BLS) provider for CPR and AED based on the American Heart Association (AHA) guidelines. The 2025 AHA Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care (CPR & ECC) revealed recognition of cardiac arrest by the healthcare professional for an adult who was unconscious or unresponsive with absent or abnormal breathing was to check for a pulse no longer than 10 seconds and if no definite pulse is felt, should assume person is in cardiac arrest. The (continued on next page)

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

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	NA #6 was interviewed via telephone on [DATE] at 11:19 am who revealed on [DATE] she recalled hearing commotion in the hall and going to see what happened but she did not hear anyone announce a code blue over the speaker or yell it out in the hall. NA #6 stated she went to the room and Nurse #8 was doing CPR and other staff were there so she went back to her work assignment. During an interview on [DATE] at 11:37 am with NA #7 she revealed she was at the nursing station #2 on [DATE], which was close to Resident #89's room when Nurse #8 came and asked for the supervisor on duty. NA #7 stated Nurse #8 appeared very calm and did not report any medical emergency or code blue. NA #7 stated that another NA at the nursing station told her Nurse #3 may be on break and would try to call her on her phone. NA #7 stated she later heard commotion down the hall, she went to the area and saw a code blue and went to get the second crash cart when told the AMBU bag was not on the first cart. NA #7 stated she did not get the AED from the wall when she got the second crash cart. A telephone interview was conducted with NA #2 on [DATE] at 1:55 pm who revealed that on [DATE] she was sitting at the nursing station that was on the other side of the facility sometime after midnight and Nurse #3 ran down the hall and told us there was a code blue. She stated she had not worked with Nurse #8 before and she reported Nurse #8 did not make any announcement over the intercom system about a code blue and she never heard anyone yell code blue until Nurse #3 told her. NA #2 stated she went to the room but by the time she arrived both crash carts were there and Nurse #8 was doing CPR.A telephone interview was conducted on [DATE] at 9:18 am with the EMS Shift Commander who revealed that any delay in initiation of basic life support including notification of 911, placement of the AED, and initiation of quality CPR reduces the chance of survival from a cardiac arrest. The EMS Shift Commander noted that the first intervention when identification of a person that does not have a pulse is to active the 911 notification so the EMS professionals can be dispatched. He stated that the recommendation if there are two people present at the scene is that one person calls 911 and the other person puts on the AED to determine if a shock is required. He stated the AED was a crucial part of the process and should be placed on the person so the heart rhythm could be analyzed as quickly as possible. The EMS Shift Commander stated once the AED determines if a shock was needed the machine directs everyone to stand clear while shock is administered then will direct to continue CPR if needed. The EMS Shift Commander stated that if 911 was called and determined no longer needed the facility could always call back or just let the EMS squad know when they arrive but the delay in notification of 911 slows the arrival of EMS and Paramedics who are able to provide advanced life support measures in the field.An observation of the two facility crash carts and emergency closets where the crash carts and AED were stored was completed on [DATE] at 10:05 am with the Director of Nursing. The two crash carts had all required equipment and the AED was noted to be mounted to the wall in each emergency closet. The typed attestation statement dated [DATE] and signed by the Administrator revealed the facility reviewed the facility cameras to visualize the time lapse of the code blue for Resident #89 in the morning of [DATE]. The Administrator noted that around the hour of 1:00 am Nurse #8 was observed to leave Resident #89's room abruptly to get assistance at the nursing station. The first station she approached did not have anyone available and she quickly proceeded to the second nursing station where she was able to exchange words with NAs that were present. The Administrator further noted that Nurse #3 appeared from down the hall and shortly after both staff members arrived at Resident #89's room. A crash cart was obtained and brought to the room and a staff member had to then retrieve the second crash cart. The Administrator concluded the time lapse was no more than 7 minutes from the start of the event to staff at Resident #89's room. The typed attestation statement, not dated, provided by the Administrator on [DATE] revealed the facility cameras were reviewed and noted that Resident #89 was checked on by NA #1 around 12:45 am. The Administrator stated after discussion with staff regarding this incident further it was determined that Nurse #8 had entered Resident #89's room periodically after 1:00 am. At 1:25 am Nurse #8 approached the nurses station for help, quickly found Nurse #3 and both rushed to Resident #89's room immediately to initiate CPR. The (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	review the policy. The Administrator stated based on the video of the incident on [DATE] it was less than 7 minutes from the time Nurse #8 was seen exiting Resident #89's room and when all staff were back to the room to provide CPR. The Administrator stated that she felt the time frame from when Nurse #8 left Resident #89's room to find Nurse #3 until she returned was not a very long time and she stated that staff reported they were timely in response and most of the staff overheard and acted quickly when they heard the commotion. The Administrator stated she felt the staff managed Resident #89's code blue appropriately. The Administrator was notified of immediate jeopardy on [DATE] at 4:24 pm.The facility provided the following credible allegation of immediate jeopardy removal:Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:During morning Clinical Interdisciplinary Team [IDT] meeting on [DATE], upon review of 24-hour report reflecting nursing notes, the Director of Nursing identified that there was an initial delay in obtaining the Ambu bag and activating EMS, during a Code Blue situation. An investigation was initiated, including staff interviews. The facility failed to ensure basic life support was provided effectively when there was a delay in initiating Cardiopulmonary Resuscitation to Resident # 89. During the early morning hours of [DATE], Resident #89 was evaluated by Nurse #8 and noted without palpable radial pulses, respirations or blood pressure, as per staff interview and medical record review on [DATE]. Nurse #8 left the resident room and checked the Code status of the resident, identifying they were a full code status. Nurse #8 then attempted to call Code Blue overhead, although was unsuccessful, so she yelled out ?Code Blue, HELP!'. When no one immediately responded, Nurse #8 ran to the other nursing station to obtain help from Nurse #3. Nurse #8 asked nurse aides where Nurse #3 was, stating she needed assistance. Nurse #3 appeared at nursing station, Nurse #8 stated, I have a Code!Nurse #8 and Nurse #3 ran back to the residents' room at 1:25am (approximately 2-3 minutes), confirmed pulselessness and lack of respirations, as described in nursing note dated [DATE], as exhibited by no visible rise and fall of chest and initiated chest compressions, as resident was a Full Code status. A nurse aide ran and brought the crash cart to the room as directed. It was identified that an Ambu bag was not noted on the crash cart, and the nurse aide was directed to obtain the second crash cart, which contained an Ambu bag, and was then utilized. Nurse #3 called 911 to activate the EMS system at 1:37am, then returned to the resident's room to again assist with CPR. CPR was in progress by licensed nurses until EMS arrived and took over CPR at 1:45am. CPR continued by EMS staff, until the event was called at 2:15am by EMS, at which time EMS staff stopped CPR. During initial investigation by the Director of Nursing, on [DATE], the only missing item mentioned was the Ambu bag. Upon reinterviews on [DATE], Nurse #8 disclosed to the surveyor that the AED was not brought into Resident #89's room.After being interviewed by the Administrator and Director of Nursing, on [DATE], regarding the Code Blue occurrence, the Administrator informed Nurse #8 that she was being suspended pending the outcome of an investigation into occurrence. Upon being informed of the suspension, Nurse #8 stood up and stated, then I'm not coming back. I quit as of right now.Both crash carts were checked and stocked with all required equipment needed to conduct effective Cardiopulmonary Resuscitation, immediately after Code Blue on [DATE], by the Nurse Manager. On [DATE], the nurse aide who brought the crash cart to the resident room was reeducated to assure their understanding, that when delegated to obtain a crash cart, that always includes the AED. Nurse #3 was reeducated on [DATE] on CPR-Cardiopulmonary policy and procedure, including timely notification/ activation of EMS-911 system. Nurse #8 was reported on [DATE] to the North Carolina Board of Nursing by the facility Administrator.The Director of Clinical Services completed a full-house audit on [DATE], for any CODE Blue events that occurred during the 30 days prior to [DATE], to identify any other potential areas of concern. Audit conducted included active and discharged residents with a ?full code' status, during the stated time period, and included review of MD orders and progress notes. No concerns noted.Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:The Director of (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nursing, who is a Registered Nurse, with a current CPR certification through the American Heart Association, conducted a Code Blue drill on [DATE], with 7a-3p licensed nurses, using a mannequin as the ?resident'. The drill did not identify any concerns.T[TRUNCATED]

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to ensure narcotic lock boxes were permanently affixed to the medication refrigerators in 2 of 2 medication rooms observed for medication storage (Medication room [ROOM NUMBER] and Medication room [ROOM NUMBER]). The findings included:a. On 5/19/26 at 12:38 PM an observation was conducted of Medication room [ROOM NUMBER] with Nurse #1. The observation revealed two black lock boxes in the medication refrigerator. Nurse #1 was observed as she picked up the lock box labeled #2. Lock box #2 was not permanently affixed to the medication refrigerator. Nurse #1 unlocked and opened lock box #2. Lock box #2 contained one card of Marinol (a cannabinoid drug that us used to treat appetite loss, nausea and vomiting) 5 milligrams(mg) with 14 tablets. Further observation revealed the lock box labeled #3 was permanently affixed to the refrigerator. Nurse #1 confirmed that medication lock box #2 should have been permanently affixed to the refrigerator.b. On 5/19/26 at 12:54 PM an observation was conducted of Medication room [ROOM NUMBER] with Nurse #2. The observation revealed two black lock boxes in the medication refrigerator. Nurse #2 was observed as she picked up the lock box labeled #1. Lock box #1 was not permanently affixed to the medication refrigerator. Nurse #2 unlocked and opened lock box #1. Lock box #1 contained one card of Marinol 5 mg with 5 tablets and Marinol 10 mg with 9 tablets, and three vials of Ativan 2 milligrams per milliliter (2mg/ml). Nurse #2 confirmed that the medication lock box should have been permanently affixed to the refrigerator. Nurse #2 stated the facility had recently replaced the refrigerators due to needing more storage space. Nurse #2 stated she did not have the key to lock box #4 but demonstrated the lock box was not permanently affixed to the refrigerator.An interview was conducted with the Director of Nursing (DON) on 05/21/2026 at 3:04 PM. She stated the facility should have immediately bolted the narcotic boxes to the medication refrigerator when they were exchanged. The DON stated the medication refrigerators had been exchanged a couple of weeks ago and she was not aware that narcotic lock boxes were not bolted to the inside of the refrigerator. An interview was conducted on 05/21/2026 at 3:04 PM with the Administrator. She indicated she expected that the narcotic boxes would have been immediately affixed to the medication refrigerator. The Administrator stated she was not aware that the narcotic lock boxes had not been affixed to the medication refrigerator.

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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 record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of Level II Preadmission Screening and Resident Review (PASRR) for 1 of 1 resident reviewed for PASRR (Resident #3).The findings included:Resident #3 was admitted to the facility on [DATE] with diagnoses which included unspecified bipolar disorder and major depressive disorder recurrent. Review of Resident #3's electronic medical record revealed a Level II PASRR Determination Notification dated 4/04/22 which noted Resident #3's nursing home placement was appropriate. The Minimum Data Set (MDS) annual assessment dated [DATE] noted Resident #3 was not currently considered by the state Level II PASRR process to have a serious mental illness. An interview was conducted with MDS Nurse #1 on 5/20/26 at 2:29 p.m. MDS Nurse #1 confirmed that Resident #3 had a Level II PASRR Determination Notification located in the electronic health record and the resident should have been coded for the Level II PASRR on the assessment. MDS Nurse #1 stated she must have missed the document in Resident #3's electronic health record when she completed the annual MDS assessment. During an interview with the Administrator on 5/21/26 at 2:09 p.m. she revealed MDS Nurse #1 was responsible for accurately coding Resident #3's MDS assessment related to the Level II PASRR. The Administrator stated MDS Nurse #1 should have coded Resident #3 for a Level II PASRR based on the documentation that was in the health record.

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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 and staff interviews, the facility failed to develop a person-centered care plan in the area of a Level II Preadmission Screening and Resident Review (PASRR) for 1 of 1 resident reviewed for PASRR (Resident #3). The findings included: Resident #3 was admitted to the facility on [DATE] with diagnoses which included unspecified bipolar disorder and major depressive disorder recurrent. Review of Resident #3's electronic medical record revealed a Level II PASRR Determination Notification dated 4/04/22 which noted Resident #3's nursing home placement was appropriate.The Minimum Data Set (MDS) annual assessment dated [DATE] noted Resident #3 was not currently considered by the state Level II PASRR process to have a serious mental illness. Resident #3's care plan which was last reviewed on 4/17/26 revealed no care plan related to the Level II PASRR Determination. An interview was conducted with MDS Nurse #1 on 5/20/26 at 2:29 p.m. MDS Nurse #1 confirmed that Resident #3 had a Level II PASRR determination and that it was required to have a care plan. MDS Nurse #1 stated Resident #3 had a previous care plan in place for the Level II PASRR, but it was resolved on 12/05/24. MDS Nurse #1 stated she could not say why the previous care plan may have been resolved but assumed it was accidentally checked to resolve it at that time. MDS Nurse #1 stated she did not have a care plan in place for Resident #3's Level II PASRR because she did not see the Level II PASRR Determination Notification in the resident's health record when she completed the 1/15/26 MDS assessment. During an interview with the Administrator on 5/21/26 at 2:09 p.m. she revealed MDS Nurse #1 was responsible to ensure that Resident #3's care plan was in place to reflect the Level II PASRR status.

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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 and staff interviews, the facility failed to revise the person-centered care plan in the area of elopement risk and use of a wander/elopement alarm bracelet for 1 of 25 residents whose care plans were reviewed (Resident #54).The findings included:Resident #54 was admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder bipolar type and Alzheimer's Disease. Resident #54 was hospitalized on [DATE] and returned to the facility on [DATE]. The elopement risk assessment dated [DATE] revealed Resident #54 was at risk for elopement. Resident #54 had an active physician order for an alerting bracelet (elopement alarm bracelet) located on the left ankle, check functionality every day shift, check placement every shift. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #54 had severe cognitive impairment and was coded for inattention and disorganized thoughts that were continuously present. Resident #54 was coded for wandering which occurred daily and the use of a wander/elopement alarm daily. The care plan which was last reviewed on 3/11/26 revealed there was no care plan or interventions in place for Resident #54's risk for elopement or use of the wander/elopement alarm bracelet. An interview was conducted with MDS Nurse #1 on 5/21/26 at 1:14 p.m. who revealed she was responsible for Resident #54's comprehensive care plan. MDS Nurse #1 reported she should have initiated the care plan for the elopement risk and use of the wander/elopement alarm bracelet when the care plan was last reviewed but she just missed it. The Director of Nursing (DON) was interviewed on 5/21/26 at 1:58 pm. The DON stated that MDS Nurse #1 was responsible for Resident #54's comprehensive care plan and should have started the care plan for the wander/elopement alarm bracelet and risk for elopement when the care plan was reviewed. During an interview on 5/21/26 at 2:08 pm the Administrator stated that MDS Nurse #1 was responsible for resident care plans and the care plan should reflect the current resident status.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, family member and staff interviews, the facility failed to ensure a resident was transported for a scheduled orthopedic appointment and instead transported a different resident to the appointment for 1 of 1 resident reviewed (Resident #95). Findings: Resident #95 was admitted on [DATE] with diagnoses that included heart failure and difficulty walking.The admission Minimum Data Assessment (MDS) dated [DATE] revealed Resident #95 was moderately cognitively impaired.Resident #95 was discharged from the facility on 2/26/26.During an interview with the Medical Records Staff #1 on 5/20/26 at 3:26 p.m. she stated that she prepared Resident #95 for his appointment on 2/25/26 and sat him by the reception area to wait for his driver. Medical Records Staff #1 stated that later in the day she learned that a mix up had occurred and Resident #95 did not go for his appointment. She stated that Driver #1 went to Resident #95's room and picked up Resident #45 who was Resident #95's roommate and took him to the appointment. Medical Records Staff #1 further stated that Resident #45 was sent back by the doctor's office because he was not Resident #95. During a telephone interview on 5/19/26 at 9:15 a.m. Resident #95's Family Member stated that on 2/25/26 at 2:00 p.m. Resident #95 had an orthopedic appointment and that she arrived for this appointment ahead of time and waited for Resident #95 to arrive. The Family Member stated that Resident #95 never arrived and instead Resident #95's roommate (Resident #45) showed up for the appointment and did not have an appointment and was sent back to the facility after the doctor's office discovered it was not Resident #95 at the appointment. She stated she attempted to speak with the Scheduler at the facility without success. During an interview with Resident #45 on 5/19/26 at 2:29 p.m. he revealed that he went for an appointment early this year that was not his, but the driver brought him back. He stated that it was a short ride to the doctor's office.During an interview with Driver #1 from the transportation company on 5/21/26 at 3:11 p.m. he revealed that he arrived at the facility on 2/25/26 at 1:00 p.m. to take Resident #95 for his appointment. He stated that he did not know Resident #95 and stated that the facility gave him the wrong resident, and he only discovered he had the wrong resident when he arrived at the appointment. Driver #1 revealed that when he arrived at the facility he went to the nursing station and could not remember who gave him paperwork for the appointment for Resident #95 and he proceeded to Resident #95's room and found Resident #45 seated by the door to Resident #95's room. Driver #1 stated that he called out Resident #95's name, and Resident #45 responded and he asked Resident #45 if he was ready to go to his appointment and the resident responded yes. Driver #1 stated that the resident did not have footrests on his wheelchair and the nurses located the footrests and continued talking among themselves and did not notice he had left with Resident #45 instead of Resident #95. Driver #1 stated that when they arrived at the appointment Resident #45 stated his name and that's when they discovered he had brought the wrong resident to the appointment and not Resident #95. Driver #1 revealed that he returned Resident #45 to the facility and reported an error to nursing staff and to his manager. During an interview with the Manager of the transportation company on 5/20/26 at 3:55 p.m. he revealed that a mistake happened on 2/25/26 and Resident #95 missed his appointment because Driver #1 took the wrong resident for the appointment. The Manager stated Driver #1 arrived at the facility and received the paperwork for the appointment and proceeded to Resident #95's room to pick him up but instead picked up Resident #45 and took him to the appointment. The Manager stated that they have now changed company policy, and that a driver must first review appointment paperwork with nursing staff and make sure they have the right resident before leaving for an appointment. Record review of an email from the Manager of the transportation company dated 5/20/26 at 4:31 p.m. revealed that the transportation company had conducted client verification training for its drivers and changed their resident pick-up process to make sure clients were confirmed before leaving the building for appointments. During an interview with previous Administrator on 5/21/26 at 8:39 a.m. she stated (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the transportation driver made a mistake and took the wrong resident to an appointment. She stated that the driver went to the resident's room and took the wrong resident. The Administrator stated that they did an investigation and discussed the incident with the transport company and nursing staff to make sure the mix up does not occur again. An interview was conducted on 5/21/26 at 1:52 p.m. with the Administrator and she stated that the facility had new policy where nursing staff were expected to validate residents before being sent out for appointments to ensure the driver has the correct resident for the correct appointment.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review and staff interviews, the facility failed to post accurate licensed and non-licensed nurse staffing data for 14 of 30 days reviewed for sufficient staffing (4/20/26, 4/24/26, 4/25/26, 4/26/26, 4/27/26, 4/28/26, 4/30/26, 5/01/26, 5/02/26, 5/03/26, 5/04/26, 5/11/26, 5/12/26, and 5/17/26). The findings included:1. A review of the posted daily staffing data sheets and the daily nursing staff schedule from 4/18/26 through 5/17/26 revealed the following for licensed nursing staff:a. A review of the posted daily staffing data sheets for the 6:45 am to 3:15 pm shift revealed the licensed nursing staff was not recorded accurately for the following days:4/25/26- the posted daily staffing data sheet noted one (1) Registered Nurse (RN) and 3 Licensed Practical Nurses (LPNs); the daily staff schedule recorded no RN and 2 LPNs.4/30/26- the posted daily staffing data sheet noted 5 LPNs; the daily staff schedule recorded 4 LPNs.5/01/26- the posted daily staffing data sheet noted 5 LPNs; the daily staff schedule recorded 4 LPNs.5/03/26- the posted daily staffing data sheet noted 5 LPNs; the daily staff schedule recorded 4 LPNs.5/12/26- the posted daily staffing data sheet noted one (1) RN and 4 LPNs; the daily staff schedule recorded no RN and 4 LPNs.b. A review of the posted daily staffing data sheets for the 2:45 pm to 11:15 pm shift revealed the licensed nursing staff was not recorded accurately for the following days:4/27/26- the posted daily staffing data sheet noted 5 LPNs; the daily staff schedule recorded 4 LPNs.c. A review of the posted daily staffing data sheets for the 10:45 pm to 7:15 am shift revealed the licensed nursing staff was not recorded accurately for the following days:4/24/26- the posted daily staffing data sheet noted 3 LPNs; the daily staff schedule recorded 2 LPNs.5/11/26- the posted daily staffing data sheet noted 3 LPNs; the daily staff schedule recorded 2 LPNs.5/12/26- the posted daily staffing data sheet noted 4 LPNs; the daily staff schedule recorded 3 LPNs.5/17/26- the posted daily staffing data sheet noted 3 LPNs; the daily staff schedule recorded 2 LPNs.2. A review of the posted daily staffing data sheets and the daily nursing staff schedule from 4/18/26 through 5/17/26 revealed the following for non-licensed nursing staff:a. A review of the posted daily staffing data sheets for the 7:00 am to 3:00 pm shift revealed the non-licensed nursing staff was not recorded accurately for the following days:4/25/26- the posted daily staffing data sheet noted 8 Nurse Aides (NAs); the daily staff schedule recorded 7 NAs.5/02/26- the posted daily staffing data sheet noted 9 NAs; the daily staff schedule recorded 8 NAs.5/03/26- the posted daily staffing data sheet noted 10 NAs; the daily staff schedule recorded 8 NAs.5/04/26- the posted daily staffing data sheet noted 11 NAs; the daily staff schedule recorded 10 NAs.b. A review of the posted daily staffing data sheets for the 3:00 pm to11:00 pm shift revealed the non-licensed nursing staff was not recorded accurately for the following days:4/24/26-the posted daily staffing data sheet noted 8 NAs; the daily staff schedule recorded 7 NAs.4/25/26- the posted daily staffing data sheet noted 8 NAs; the daily staff schedule recorded 6 NAs.4/26/26- the posted daily staffing data sheet noted 8 NAs; the daily staff schedule recorded 6 NAs. 4/28/26- the posted daily staffing data sheet noted 9 NAs; the daily staff schedule recorded 8 NAs.5/03/26- the posted daily staffing data sheet noted 10 NAs; the daily staff schedule recorded 8 NAs.5/04/26- the posted daily staffing data sheet noted 10 NAs; the daily staff schedule recorded 9 NAs. 5/11/26- the posted daily staffing data sheet noted 9 NAs; the daily staff schedule recorded 7 NAs.5/12/26- the posted daily staffing data sheet noted 8 NAs; the daily staff schedule recorded 7 NAs.c. A review of the posted daily staffing data sheets for the 11:00 pm to 7:00 am shift revealed the non-licensed nursing staff was not recorded accurately for the following days:4/20/26 the posted daily staffing data sheet noted 6 NAs; the daily staff schedule recorded 5 NAs. 4/24/26 the posted daily staffing data sheet noted 6 NAs; the daily staff schedule recorded 4 NAs.4/25/26- the posted daily staffing data sheet noted 6 NAs; the daily staff schedule recorded 4 NAs.4/26/26- the posted daily staffing data sheet noted 6 NAs; the daily staff schedule recorded 5 NAs.5/11/26- the posted daily staffing data sheet noted 7 NAs; the daily staff schedule recorded 6 NAs.A telephone interview was conducted on 5/20/26 at 3:39 pm with the previous Scheduler, who was responsible for the (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	facility staff posting and scheduling until a week prior to the survey. She reported that she no longer worked at the facility and would not answer any questions related to the staffing sheets. An interview was conducted with the Director of Nursing (DON) on 5/21/26 at 1:54 pm. The DON stated she had just begun managing the staff posting and scheduling within the last week since the previous Scheduler had left the position at that time. The DON stated the previous Scheduler had not been adjusting the staff posting when changes were needed. The Administrator was interviewed on 5/21/26 at 2:02 pm and revealed the DON had taken over the scheduling responsibilities during the previous week since the previous Scheduler's employment was ended with the facility a week ago. The Administrator explained the previous Scheduler was employed by the facility up to the week prior to the survey and would have been responsible for the staff posting during her employment. The Administrator stated she was not sure why the previous Scheduler did not correct the staff posting when the changes occurred.