STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenbridge Health and Rehabilitation	211 Milton Brown Heirs Road Boone, NC 28607

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review and resident and staff interviews, the facility failed to resolve and communicate the facility's efforts to address concerns and/or suggestions voiced by residents during Resident Council meetings for 10 of 11 months reviewed (February 2025, March 2025, April 2025, May 2025, June 2025, July 2025, August 2025, October 2025, November 2025, and January 2026).Findings included:Review of the Resident Council Minutes for the period February 2025 through January 2026 revealed the following:a. The Resident Council Meeting minutes dated 02/20/25 revealed in part, the section for Old Business noted that showers were not being provided as often as residents would like, food was served late and cold or undercooked, beds were not being made, and residents clothing was not being taken to laundry to wash. The section for Pending Updates noted working with staff to make sure names are written in clothing so it is returned to the correct room with no further information documented. The section for New Business noted residents voiced concerns regarding medications being administered late, showers not being provided, beds not being made, and clothing not being returned.A Resident Council Concern form dated 02/20/25 noted residents complained the food was served raw or burnt on some days, they were served the wrong texture of food, residents wanted a bigger variety of food and better desserts, and food was often served late or cold. The department assigned to address the concern was listed as dietary. There was nothing documented describing what was done to address the concern. At the bottom of the concern form was an illegible signature of the person assigned to address the concern and the date the concern was addressed was blank.A Resident Council Concern form dated 02/20/25 noted residents stated they were not receiving medications on time and Nurse Aides (NAs) were not changing resident beds as often as they should. The department assigned to address the concern was listed as nursing. There was nothing documented describing what was done to address the concern. The concern form was signed by the Director of Nursing (DON) as the person addressing the concern and dated 02/21/25.A Resident Council Concern form dated 02/21/25 noted residents voiced concerns of missing clothing and that staff were not taking their clothing to laundry to be washed. The department assigned to address the concern was listed as laundry. The department's response noted that clothes labeled with residents' names were returned daily and it was the responsibility of nurse aides to bring soiled linens and resident clothing to laundry. The concern form was signed by the Housekeeping/Laundry Supervisor as the person addressing the concern and dated 02/21/25. b. The Resident Council meeting minutes dated 03/27/25 revealed in part, the section for Old Business noted that showers were not happening as often as residents would like, beds were not getting made and residents were missing clothing. The section for Pending Updates noted working with staff to make sure names are written in clothing so it is returned to the correct room with no further information documented. The section for New Business noted meals were not good and were served late and cold.The facility was unable to provide documentation of a Resident Council Concern form filed on behalf of the residents attending the Resident Council Meeting on 03/27/25.c. The Resident Council meeting minutes dated 04/22/25 revealed in part, the section for Old Business noted that meals were often served cold or late and residents were missing clothing. The section for Pending Updates was blank. The section for New Business noted residents voiced they were not being changed often enough, beds were not being (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	made, clothing was not being returned from laundry, and meals were served late.The facility was unable to provide documentation of a Resident Council Concern form filed on behalf of the residents attending the Resident Council Meeting on 04/22/25.d. The Resident Council meeting minutes dated 05/28/25 revealed in part, the section for Old Business noted concerns were voiced regarding residents not being changed often enough, beds were not being made, clothing getting lost in laundry, and meals were served late. The section for Pending Updates was blank. The section for New Business noted concerns were voiced regarding call bells not being answered for long periods of time, rooms were not being cleaned thoroughly, bed sheets were too small to fit the mattress, missing clothing, food portions were too small and/or not appetizing, and sandwiches not provided when requested.A Resident Council Concern form dated 05/28/25 noted concerns regarding small food portions, kitchen staff would not make sandwiches when requested, and food was tough or stale. The department assigned to address the concern was listed as dietary. The department's response to the concern noted the menu was made by the Registered Dietician to ensure all food groups were met and dietary staff were trained on using the proper size of serving utensils. At the bottom of the concern form was an illegible signature of the person assigned to address the concern and dated 05/30/25.A Resident Council Concern form dated 05/28/25 noted a concern regarding rooms not being cleaned thoroughly by housekeeping staff. The department assigned to address the concern was listed as housekeeping. The department's response noted that housekeeping staff removed trash, cleaned bathrooms, dust, swept, and mopped rooms daily. The concern form was signed by the Housekeeping/Laundry Supervisor as the person addressing the concern and dated 06/03/25. A Resident Council Concern from dated 05/28/25 noted concerns regarding bed sheets did not fit the mattress and popped off at the corners, residents were receiving clothing labeled with other residents' names, and clothes shrunk when washed. The department assigned to address the concern was listed as laundry. The department's response noted an order would be placed for larger sized fitted bed sheets, residents clothing was washed in the proper wash cycle and shrinkage could be due to the type of fabric of the garment, and clothes with labeled with residents' names were returned daily. The concern form was signed by the Housekeeping/Laundry Supervisor as the person addressing the concern and dated 06/03/25. e. The Resident Council meeting minutes dated 06/18/25 revealed in part, the section for Old Business noted concerns were voiced regarding residents not being changed often enough, beds were not being made, clothing getting lost in laundry, and meals were served late. The section for Pending Updates was blank. The section for New Business noted concerns were voiced regarding call bells not being answered for long periods of time, rooms not being cleaned thoroughly, bed sheets were too small to fit the mattress, missing clothing, food portions were too small and/or not appetizing, and sandwiches not provided when requested. The facility was unable to provide documentation of a Resident Council Concern form filed on behalf of the residents attending the Resident Council Meeting on 06/18/25.f. The Resident Council meeting minutes dated 07/21/25 revealed in part, the section for Old Business noted concerns were voiced regarding call bells not being answered for long periods of time, rooms were not being cleaned thoroughly, bed sheets were too small to fit the mattress, missing clothing, food portions were too small and/or not appetizing, and sandwiches not provided when requested. The section for Pending Updates was blank. The section for New Business noted concerns were voiced regarding nurses being disruptive at night and call bells were not being answered for long periods of time. The residents also voiced they would like more showers and bed sheets.The facility was unable to provide documentation of a Resident Council Concern form filed on behalf of the residents attending the Resident Council Meeting on 07/21/25.g. The Resident Council meeting minutes dated 08/20/25 revealed in part, the sections for Old Business and Pending Updates were blank. The section for New Business noted concerns were voiced regarding nurse aides being too loud at night and not answering call lights in a timely manner. The residents also voiced they would like food to be served faster and have more towels and bed sheets.The facility was unable to provide documentation of a Resident (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Council Concern form filed on behalf of the residents attending the Resident Council Meeting on 08/20/25.h. The Resident Council meeting minutes dated 09/25/25 revealed in part, the sections for Old Business and Pending Updates were blank. The section for New Business noted concerns were voiced regarding residents not wanting showers at night, nursing staff not answering call lights in a timely manner, and call lights being turned off without staff providing the requested assistance. The facility was unable to provide documentation of a Resident Council Concern form filed on behalf of the residents attending the Resident Council Meeting on 09/25/25.i. The Resident Council meeting minutes dated 10/24/25 revealed in part, the section for Old Business was blank. The section for Pending Updates noted new kitchen manager. The section for New Business noted concerns were voiced regarding too many recurring meals like pizza and sandwiches, food to be served faster, clothing not being returned from laundry, nursing staff not answering call lights in a timely manner, and call lights being turned off before the task was completed.The facility was unable to provide documentation of a Resident Council Concern form filed on behalf of the residents attending the Resident Council Meeting on 10/24/25.j. The Resident Council meeting minutes dated 11/20/25 revealed in part, the section for Old Business noted concerns were voiced regarding over-recurrence of certain foods being served and inconsistent times, call lights not being answered in a timely manner and clothing not being returned from laundry. The section for Pending Updates was blank. The section for New Business noted residents stated the food had gotten better but they still voiced concerns regarding the quality of food, call lights not being answered in a timely manner and clothing not being returned from laundry.The facility was unable to provide documentation of a Resident Council Concern form filed on behalf of the residents attending the Resident Council Meeting on 11/20/25.k. The Resident Council meeting minutes dated 12/30/25 revealed in part, activities were canceled due to a flu and COVID outbreak in the building. The section for Old Business noted the residents agreed the food had gotten better but they still voiced concerns regarding the quality of food, call lights not being answered in a timely manner and clothing not being returned from laundry. The section for Pending Updates noted clothes need to have residents' names in them to be returned and any unlabeled clothing is set aside. There was no New Business noted due to activities being canceled.l. The Resident Council meeting minutes dated 01/29/26 revealed in part, activities had opened back up after being canceled due to a flu and COVID outbreak in the building. There was no Old Business or Pending Updates. The section for New Business noted concerns were voiced regarding call lights not being answered in a timely manner and clothing not being returned from laundry. The residents also voiced they wanted a wider variety of foods and both fruit and dessert served with meals.A Resident Council Concern form dated 01/29/26 noted a concern that clothing was not being returned. The department assigned to address the concern was listed as laundry. The department's response noted clothing labeled with residents' names were returned daily. The concern form was signed by the Housekeeping/Laundry Supervisor as the person addressing the concern and dated 01/29/26. A Resident Council Concern form dated 01/29/26 noted a concern that call lights were not being answered in a timely manner. The department assigned to address the concern was listed as nursing. The department's response describing what was done to address the concern, signature of the person addressing the concern and date the concern was addressed were all blank.A Resident Council Concern form dated 01/29/26 noted a concern that residents wanted a bigger variety of food and wanted both fruit and dessert. The department assigned to address the concern was listed as dietary. The department's response describing what was done to address the concern, signature of the person addressing the concern and date the concern was addressed were all blank.A Resident Council group interview was conducted on 03/24/26 at 1:45 PM with Residents #6, #22, #35, #44, #47, #66, #67, #97, #108, #109, and #118 in attendance. In addition, Residents #31, #56, #58, #100, and #111 also attended but did not verbally participate in the group interview. When the group was asked about the concerns voiced during previous Resident Council meetings, Residents #6, #22, #35, #44, #47, #66, #67, #97, #108, #109, and #118 all agreed concerns regarding call bell response times, cold and/or late (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	food and missing clothing were recurring issues that remained ongoing and were brought up at nearly every Resident Council meeting. Resident #35 and Resident #108 both stated Resident Council was never provided any communication regarding what was done or being done to address the concerns and Residents #6, #22, #44, #47, #66, #67, #97, #109, and #118 all voiced agreement with Resident #35 and Resident #108 statements. During an interview on 03/24/26 at 4:07 PM, the Activity Director revealed she attended and recorded the minutes for the Resident Council monthly meetings. The Activity Director explained when residents voiced concerns and/or suggestions during the monthly meetings, she wrote them on a Resident Council Concern form that was given to the appropriate Department Manager to address. She stated once the concern was addressed and returned to her, she typically discussed the resolution during the next scheduled Resident Council meeting. The Activity Director verified that residents attending the Resident Council meetings voiced the same frequent concerns month-to-month such as call lights not being answered, staff turning off call lights but not providing care, and clothing not being returned from laundry. She stated when facilitating the Resident Council meeting, she reviewed old business, discussed resolution to address the concern(s) previously voiced and asked the residents if they felt the matter had been resolved. She stated if the residents mentioned the same concerns again, she would document the concerns as new business and wrote the concerns on another Resident Council Concern form for the Department Manager to investigate. The Activity Director stated it was up to the Department Manager on how the concerns were addressed. During an interview on 03/26/26 at 11:00 AM, the Administrator stated when residents voiced concerns during a Resident Council meeting, the concerns should be documented in the Resident Council minutes and on a Resident Council Concern form to be investigated by the appropriate department. In addition, she stated the concerns voiced the previous month should be discussed as old business at the next Resident Council meeting which would include the processes that were put into place or what was done to address the concern(s), asking the residents attending the meeting if the concerns had improved or resolved and documenting in the minutes that resolution for the concerns was provided and discussed. If the residents reported the concerns had not improved, then the repeated concerns should be documented in the minutes under new business and the Activity Director should ask more specific questions about what specifically did not work with the previous resolution so that the administration team would have more details to use as a constructive tool when developing a new process to address the concern(s). The Administrator reviewed the Resident Council Concern forms from the February 2025, May 2025 and January 2026 Resident Council meetings and expressed that the department responses did not really address the issues that were voiced by the residents. She explained the Activity Director was still new to the position and going forward, she was going to have the Activity Director provide her with a copy of the Resident Council minutes and Resident Council Concern forms following the meeting so that she could review and assist the Activity Director with what she needed to do.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident and staff interviews, the facility failed to implement an effective system to assess residents for the risk of entrapment from bed rails and monitor and document the ongoing need for bed rails. The facility also failed to maintain evidence that the risk and benefits of bed rails were discussed with the resident or resident representative and informed consent was obtained prior to the installation of bed rails for 4 of 4 sampled residents (Residents #11, #53, #61, and #75).Findings Included: a. Resident #11 was admitted to the facility on [DATE]. His cumulative diagnoses included heart failure, acute kidney failure, chronic atrial fibrillation (irregular heart rhythm), and diabetes.Resident #11's electronic medical record revealed a Siderail Data Collection assessment dated [DATE]. The assessment consisted of four subsections, Bed Mobility, Balance, Type of device, Summary, and included the following:Bed Mobility:Has the resident demonstrated poor bed mobility or difficulty moving within the bed or moving to a sitting position on the side of the beds? Yes.Is the resident currently using side rail for positioning, mobility or support? Yes.Has the resident expressed a desire to have side rails raised while in bed? Yes.Comments/Explanation: nothing documented.Balance:Does the resident have difficulty with balance or poor trunk control? Yes.Does the resident have difficulty with postural hypotension? Yes.Is the resident ambulatory? No.Does the resident have a history of falls? No.Comments/Explanation: nothing documented.Type of Device:Identify the type of device being used by resident - side rails are not indicated, assist rails/quarter rails, double full side rails, double half side rails, single full side rails, single half side rails, bed bolsters, or bed against the wall: single half side rails was selected.Summary: Nothing documented.There was no evidence Resident #11 was assessed for risk of entrapment from the bed rails. There were no further Siderail Data Collection assessments completed after 04/25/23. Resident #11's electronic medical record revealed no evidence the risks and benefits of side rail use was discussed with Resident #11 prior to the installation or use of the bed rails. Resident #11's electronic medical record revealed a Nursing Quarterly/Annual/Significant Evaluation assessment dated [DATE] that was divided into two subsections: A. Potential Restraint Type and B. Side Rail Review. In subsection A (Potential Restraint Type) staff selected resident does not have any potential restraints (including alarms or side rails). Per the assessment instructions, that response disabled the remaining questions in both subsection A (Potential Restraint Type) and subsection B (Side Rail Review). The disabled questions in subsection B (Side Rail Review) left unanswered consisted of the following:Right side rail: Full, Half, Quarter, or NoneLeft side rail: Full, Half, Quarter, or NoneAlarm type: Bed alarm, chair alarm, seat belt with alarm, floor mat alarm, wanderguard alarm, other (specify), or noneIndications (if not considered a restraint): Safety, promote independence, assist with bed mobility, or other (specify)CommentsThere was no evidence Resident #11 was assessed for risk of entrapment from the bed rails. There were no Nursing Quarterly/Annual/Significant Evaluation assessments completed prior to or after 01/20/26.The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had intact cognition. He had an indwelling catheter, was always incontinent of bowel and required partial to moderate staff assistance with toileting hygiene. The MDS assessment also noted that Resident #11 was independent with rolling left-to-right, independent with moving from a sitting-to-lying or lying-to-sitting position, and bed rails were not used as a physical restraint.During an observation and interview on 03/23/26 at 11:36 AM, Resident #11 was lying in bed on his left side with his cellphone in hand. Half-length bed rails were observed in the upright position on each side of his bed. Resident #11 explained he was able to use the bed rails for bed mobility.b. Resident #53 was admitted to the facility on [DATE]. Her cumulative diagnoses included fibromyalgia (widespread body pain), (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rheumatoid arthritis, low back pain, Alzheimer's disease with late onset, and dementia.Resident #53's electronic medical record revealed a Siderail Data Collection assessment dated [DATE]. The assessment consisted of four subsections, Bed Mobility, Balance, Type of device, Summary, and included the following:Bed Mobility:Has the resident demonstrated poor bed mobility or difficulty moving within the bed or moving to a sitting position on the side of the beds? Yes.Is the resident currently using side rail for positioning, mobility or support? Yes.Has the resident expressed a desire to have side rails raised while in bed? No.Comments/Explanation: nothing documented.Balance:Does the resident have difficulty with balance or poor trunk control? Yes.Does the resident have difficulty with postural hypotension? No.Is the resident ambulatory? No.Does the resident have a history of falls? Yes.Comments/Explanation: nothing documented.Type of Device:Identify the type of device being used by resident - side rails are not indicated, assist rails/quarter rails, double full side rails, double half side rails, single full side rails, single half side rails, bed bolsters, or bed against the wall: assist rails/quarter rails was selected.Summary: Nothing documented.There was no evidence Resident #53 was assessed for risk of entrapment from the bed rails. There were no further Siderail Data Collection assessments completed after 01/17/24.The significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #53 had severe cognitive impairment. She had impairment on both sides of the lower extremities, was frequently incontinent of bladder and bowel and required partial to moderate staff assistance with toileting hygiene. The MDS assessment also noted Resident #53 was independent with rolling left-to-right, required supervision or touching assistance with moving from a sitting-to-lying or lying-to-sitting position, and bed rails were not used as a physical restraint.Resident #53's electronic medical record revealed a Nursing Quarterly/Annual/Significant Evaluation assessment dated [DATE] that was divided into two subsections: A. Potential Restraint Type and B. Side Rail Review. In subsection A (Potential Restraint Type) staff selected resident does not have any potential restraints (including alarms or side rails). Per the assessment instructions, that response disabled the remaining questions in both subsection A (Potential Restraint Type) and subsection B (Side Rail Review). The disabled questions in subsection B (Side Rail Review) left unanswered consisted of the following:Right side rail: Full, Half, Quarter, or NoneLeft side rail: Full, Half, Quarter, or NoneAlarm type: Bed alarm, chair alarm, seat belt with alarm, floor mat alarm, wanderguard alarm, other (specify), or noneIndications (if not considered a restraint): Safety, promote independence, assist with bed mobility, or other (specify)CommentsThere was no evidence Resident #53 was assessed for risk of entrapment from the bed rails. There were no Nursing Quarterly/Annual/Significant Evaluation assessments completed prior to or after 01/20/26.Resident #53's electronic medical record revealed no evidence the risks and benefits of bed rail use was discussed with Resident #53 or her representative and informed consent was obtained prior to the installation or use of the bed grab bar. During observations on 03/23/26 at 11:11 AM and 03/24/26 at 3:30 PM, Resident #53 was lying in bed sleeping soundly. A bed grab bar was observed secured to the bedframe and in the upright position on the right side of Resident #53's bed. c. Resident #61 was admitted to the facility on [DATE]. Her cumulative diagnoses included heart failure, chronic obstructive pulmonary disease (progressive lung disease that makes it difficult to breathe) and hypertension.Resident #61's electronic medical record revealed a Siderail Data Collection assessment dated [DATE]. The assessment consisted of four subsections, Bed Mobility, Balance, Type of device, Summary, and included the following:Bed Mobility:Has the resident demonstrated poor bed mobility or difficulty moving within the bed or moving to a sitting position on the side of the beds? Yes.Is the resident currently using side rail for positioning, mobility or support? Yes.Has the resident expressed a desire to have side rails raised while in bed? No.Comments/Explanation: nothing documented.Balance:Does the resident have difficulty with balance or poor trunk control? Yes.Does the resident have difficulty with postural hypotension? No.Is the resident ambulatory? Yes.Does the resident have a history of falls? Yes.Comments/Explanation: nothing documented.Type of Device:Identify the type of device being used by resident - side rails are not indicated, assist (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rails/quarter rails, double full side rails, double half side rails, single full side rails, single half side rails, bed bolsters, or bed against the wall: assist rails/quarter rails was selected.Summary: Nothing documented.There was no evidence Resident #61 was assessed for risk of entrapment from the bed rails. There were no further Siderail Data Collection assessments completed after 04/25/23.Resident 61's electronic medical record revealed a Nursing Quarterly/Annual/Significant Evaluation assessment dated [DATE] that was divided into two subsections: A. Potential Restraint Type and B. Side Rail Review. In subsection A (Potential Restraint Type) staff selected resident does not have any potential restraints (including alarms or side rails). Per the assessment instructions, that response disabled the remaining questions in both subsection A (Potential Restraint Type) and subsection B (Side Rail Review). The disabled questions in subsection B (Side Rail Review) left unanswered consisted of the following:Right side rail: Full, Half, Quarter, or NoneLeft side rail: Full, Half, Quarter, or NoneAlarm type: Bed alarm, chair alarm, seat belt with alarm, floor mat alarm, wanderguard alarm, other (specify), or noneIndications (if not considered a restraint): Safety, promote independence, assist with bed mobility, or other (specify)CommentsThere was no evidence Resident #61 was assessed for risk of entrapment from the bed rails. There were no Nursing Quarterly/Annual/Significant Evaluation assessments completed prior to or after 01/20/26.Resident #61's electronic medical record revealed no evidence the risks and benefits of bed rail use was discussed with Resident #61 and informed consent was obtained prior to the installation or use of the bed grab bar.The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #61 had intact cognition. She was frequently incontinent of bladder, was always incontinent of bowel and required partial to moderate staff assistance with toileting hygiene. The MDS also noted Resident #11 was independent with rolling left-to-right, independent with moving from a sitting-to-lying or lying-to-sitting position and bed rails were not used as a physical restraint.During an observation and interview on 03/23/26 at 11:56 AM, Resident #61 was sitting up in her wheelchair, well-groomed and dressed. Quarter-length bed rails were observed in the upright position on each side of her bed. Resident #61 stated she used the bed rails to reposition herself when lying in bed.d. Resident #75 was admitted to the facility on [DATE]. Her cumulative diagnoses included Parkinson's disease, cerebral infarction (stroke) and dementia. Resident #75's electronic medical record revealed a Siderail Data Collection assessment dated [DATE]. The assessment consisted of four subsections, Bed Mobility, Balance, Type of device, Summary, and included the following:Bed Mobility:Has the resident demonstrated poor bed mobility or difficulty moving within the bed or moving to a sitting position on the side of the beds? Yes.Is the resident currently using side rail for positioning, mobility or support? Yes.Has the resident expressed a desire to have side rails raised while in bed? No.Comments/Explanation: nothing documented.Balance:Does the resident have difficulty with balance or poor trunk control? Yes.Does the resident have difficulty with postural hypotension? No.Is the resident ambulatory? No.Does the resident have a history of falls? Yes.Comments/Explanation: nothing documented.Type of Device:Identify the type of device being used by resident - side rails are not indicated, assist rails/quarter rails, double full side rails, double half side rails, single full side rails, single half side rails, bed bolsters, or bed against the wall: assist rails/quarter rails was selected.Summary: Nothing documented.There was no evidence Resident #75 was assessed for risk of entrapment from the bed rails. There were no further Siderail Data Collection assessments completed after 10/16/23.Resident #75's electronic medical record revealed no evidence the risks and benefits of bed rail use was discussed with Resident #75 or her representative and informed consent was obtained prior to the installation or use of the bed grab bar.The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #75 had severe cognitive impairment. She was frequently incontinent of both bladder and bowel and was dependent on staff assistance with toileting hygiene, rolling left-to-right and moving from a sitting-to-lying or lying-to-sitting position. The MDS assessment indicated bed rails were not used as a physical restraint.Resident #53's electronic medical record revealed a Nursing Quarterly/Annual/Significant Evaluation assessment dated (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenbridge Health and Rehabilitation	211 Milton Brown Heirs Road Boone, NC 28607

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] that was divided into two subsections: A. Potential Restraint Type and B. Side Rail Review. In subsection A (Potential Restraint Type) staff selected resident does not have any potential restraints (including alarms or side rails). Per the assessment instructions, that response disabled the remaining questions in both subsection A (Potential Restraint Type) and subsection B (Side Rail Review). The disabled questions in subsection B (Side Rail Review) left unanswered consisted of the following:Right side rail: Full, Half, Quarter, or NoneLeft side rail: Full, Half, Quarter, or NoneAlarm type: Bed alarm, chair alarm, seat belt with alarm, floor mat alarm, wanderguard alarm, other (specify), or noneIndications (if not considered a restraint): Safety, promote independence, assist with bed mobility, or other (specify)CommentsThere was no evidence Resident #75 was assessed for risk of entrapment from the bed rails. There were no Nursing Quarterly/Annual/Significant Evaluation assessments completed prior to or after 01/20/26.During an observation on 03/23/26 at 11:12 AM, Resident #75 was observed lying in bed in a supine (flat on back with the face and upper body facing upward) position, alert but unable to respond to questioning. Quarter-length bed rails were in the upright position on both sides of the bed.Additional observations on 03/24/26 at 9:30 AM and 03/25/26 at 8:10 AM revealed Resident #75 lying in bed with quarter-length bed rails in the upright position on each side of the bed.During interviews on 03/24/26 at 10:40 AM and 03/25/26 at 10:00 AM, the Director of Nursing (DON) revealed bed rail assessments were completed quarterly and as needed. She explained that in an effort to streamline the process, the corporate office had consolidated multiple nursing assessments into a single Nursing Quarterly/Annual/Significant Evaluation assessment, which included the bed/side rail review. The DON stated she was not aware that the bed/side rail review was not being completed until the issue was brought to her attention by the surveyor and upon review, she realized that by selecting no to the question Is this a restraint? caused the remaining questions for the bed/side rail review section to automatically disable, leading staff to proceed to the next section of the assessment. The DON further stated it was her understanding that informed consent for bed rail use was only required when residents used full bed rails and that informed consent was not necessary if a resident used grab bars, quarter-length bed rails or half-length bed rails. She stated they had not obtained informed consent for bed rail use since they had no resident utilizing full bed rails.During an interview on 03/26/26 at 11:00 AM, the Administrator explained the corporate office attempted to consolidate multiple nursing assessments into a single assessment and no one had realized that the questions for the bed/side rail review were disabled once the restraint question was marked no. She stated informed consents should be obtained per the regulatory guidelines. The Administrator further stated she felt the breakdown was due to oversight and nursing staff getting used to the new streamlined assessment process.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews and interviews with staff, Nurse Practitioner, Pharmacy Director and Medical Director, the facility failed to have effective systems in place for acquiring a scheduled medication when nursing staff failed to request a prescription from the Nurse Practitioner to avoid a gap in medication administration when refilling a controlled medication which resulted in Resident #56 missing 4 days of the medication. This deficient practice occurred for 1 of 1 resident reviewed for pharmacy services (Resident #56).The findings included:Resident #56 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus and neuropathy (condition characterized by damage, disease, or dysfunction of one or more nerves, often causing pain, numbness, tingling, or muscle weakness).Review of Resident #56's physician orders revealed an order dated [DATE] for Lyrica (used to treat nerve pain from diabetes) 25 milligrams (mg) one capsule by mouth one time a day for neuropathy.Review of Resident #56's Medication Administration Record (MAR) for [DATE] revealed the Lyrica was scheduled to be administered at 9:00 AM but was not administered on [DATE], [DATE], [DATE] and [DATE]. Further review of the MAR revealed each day was coded with a 9 which indicated to see progress notes.Review of Resident #56's progress note dated [DATE] was written by Nurse #4 indicated the Lyrica was on order.Review of Resident #56's progress note dated [DATE] was written by Nurse #3 indicated the Lyrica was on order.Review of Resident #56's progress note dated [DATE] was written by Nurse #3 indicated the Lyrica was on order.Review of Resident #56's progress note dated [DATE] was written by Nurse #5 indicated the Lyrica was on order.A telephone interview was conducted with Nurse #4 on [DATE] at 1:03 PM. The Nurse confirmed that she worked first shift on [DATE] and did not have the Lyrica available to give to Resident #56 for his 9:00 AM medication administration. The Nurse explained that she reordered the medication from the pharmacy and reported it to the Weekend Supervisor who told Nurse #4 that they were aware and it was being addressed.An interview was conducted with the Weekend Supervisor on [DATE] at 2:00 PM who confirmed that she worked on [DATE] and explained that she did not recall being notified by Nurse #4 that Resident #56 was out of his Lyrica medication.A telephone interview was conducted with Nurse #3 on [DATE] at 12:32 PM who confirmed that she did not have Resident #56's Lyrica 25 mg to administer on [DATE] and [DATE]. Nurse #3 stated that she requested a refill for the Lyrica on [DATE] from the Unit Manager and still did not have the medication to administer on [DATE] and [DATE]. Nurse #3 explained that she called the pharmacy to see if Resident #56 had a prescription on hand so that she could pull the Lyrica from the Pyxis (a backup supply of medications), but the pharmacy did not have a prescription on hand for the Lyrica therefore she could not pull the Lyrica from the Pyxis. Nurse #3 continued to explain that she informed the Unit Manager on [DATE] that Resident #56 was out of his Lyrica 25 mg capsules and notified the Unit Manager again on [DATE] that she still did not have Resident #56's Lyrica and she could not pull it from the Pyxis. On [DATE] at 9:30 AM an interview was conducted with Nurse #5 who explained that she did not have Resident #56's Lyrica 25 mg to administer to him that morning ([DATE]). The Nurse stated she reported it to Unit Manager #1 who indicated she would take care of it. Review of a progress note dated [DATE] at 12:05 PM and written by the Unit Manager #1 revealed the pharmacy was notified again of Resident #56's Lyrica 25 mg capsules. The pharmacy stated the prescription on file had expired with no further refills. The Nurse Practitioner was notified and prescription sent to the pharmacy with follow up confirmation call. The medication will be delivered on the next run. The next dose was not due until 9:00 AM on [DATE].An interview was conducted with Unit Manager #1 on [DATE] at 10:15 AM who explained that the process to reorder medication was for the nurses to call the pharmacy for refills and the pharmacy would either send the medication or let her know that they needed a new prescription. She continued to explain that most of the time the full-time nurses would (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	let the Unit Manager know that the pharmacy needed a new prescription for a medication, but the agency nurses did not know how to do that. She stated she was constantly educating the agency nurses how to do that but by the time she got the agency nurse educated to the process they were gone, and another one came in and the cycle started all over. The Unit Manager stated she tried to look for the upcoming refills herself, but she did not always have time to do that. She explained that she was informed on Monday [DATE] that they were out of Resident #56's Lyrica 25 mg capsules and when she called the pharmacy, she was told that they would send the medication down in the next delivery. When she was told on Tuesday [DATE] that they still did not have the Lyrica she called the pharmacy again and the pharmacy told her that they needed a prescription before they could send the Lyrica. When the Unit Manager was asked why the nurses did not pull the Lyrica from the Pyxis, she explained that if the resident did not have a current prescription for the medication, then the pharmacy would not give them a code to pull the medication from the Pyxis. The Unit Manager stated she received a prescription notice from the pharmacy on [DATE] and she sent it to the Nurse Practitioner, but the pharmacy did not send the medication, and she did not know why they did not send the medication. She reported the pharmacy did allow the facility to pull the Lyrica from the Pyxis on [DATE] because they had the prescription by that time. The Unit Manager stated they needed a new system to obtain the controlled medications from the pharmacy to prevent the residents from running out since the facility utilized so many agency nurses.During an interview with the Nurse Practitioner on [DATE] at 12:12 PM the Nurse Practitioner explained that he received emails from the facility when it was time to reorder controlled medications and he would send the prescriptions to the pharmacy. The Nurse Practitioner reported that if there was a lag in receiving the medications it was between when he sent the new prescriptions to the pharmacy and when the pharmacy delivered the medications to the facility. The Nurse Practitioner stated he checked his emails for refills multiple times a day, 7 days a week. He reported the last request for Resident #56's Lyrica was that morning on [DATE].An interview was conducted with Resident #56 on [DATE] at 1:08 PM. The resident was sitting on the side of his bed eating his lunch. Resident #56 was asked if he knew that he did not get the pain medication for four days in a row and the Resident replied, No, they give me something for pain if I need it.A telephone interview was conducted with the Pharmacy Director on [DATE] at 1:12 PM who explained that the last refill of Resident #56's Lyrica 25 mg capsules was delivered on [DATE] of 30 capsules and the most recent refill of Lyrica 25 mg capsules was sent on [DATE] which required a new prescription. She stated if the facility did request an early refill, then the pharmacy would have needed a new prescription for an early refill, and she could not find where that was requested. The Pharmacy Director stated if the facility followed the procedure, then there was no reason why they would have run out of Resident #56's Lyrica 25 mg capsules.An interview was conducted with the Director of Nursing (DON) on [DATE] at 12:13 PM. The DON explained that she found out about the nurses running out of Resident #56's Lyrica while she was investigating another issue. The DON stated she knew that the facility needed to develop another system to prevent the nurses from running out of the residents' medications.An interview was conducted with the Medical Director on [DATE] at 2:29 PM who explained that she was not notified that Resident #56 was not given his Lyrica 25 mg daily on [DATE], [DATE], [DATE] and [DATE] but the facility may have notified the Nurse Practitioner. The Medical Director stated running out of the resident's medications should never happen.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to obtain consent and inform the resident or Responsible Party in advance of the risks and benefits of psychotropic medications prior to initiation for 1 of 5 residents reviewed for unnecessary medications (Resident #4).The findings included:Resident #4 was admitted to the facility on [DATE] with diagnoses that included Lewy Body Dementia (a progressive neurological disorder caused by abnormal protein deposits (Lewy bodies) in the brain, affecting thinking, movement, behavior, and mood).The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 had severe cognitive impairment. He displayed no behavioral symptoms and received antidepressant medications during the MDS assessment look-back period.Review of the December 2025 Medication Administration Record for Resident #4 revealed an active physician order dated 12/04/25 for risperidone (antipsychotic medication) 0.5 milligrams 1 tablet by mouth two times a day for mood disorder. Review of Resident #4's electronic medical record revealed no documentation that Resident #4's Responsible Party was informed in advance of the risks and benefits of initiating risperidone 0.5 mg and consented to the treatment.Interviews were conducted with the Social Worker and the Social Worker Assistant simultaneously on 03/25/26 at 8:59 AM. They both reported that they started in August 2025 and were not responsible for obtaining the informed consents for the psychotropic medications. The Social Workers explained that the Nurse Practitioner was responsible for obtaining informed consent for the psychotropic medications for the residents.During an interview with the Nurse Practitioner (NP) on 03/27/26 at 9:49 AM the NP explained that he was informed that it was his responsibility to review the psychotropic medications and before the last Social Worker left, he was getting a pile of forms every month that he had to sign but that stopped when the last Social Worker left. He continued to explain that when he rounded on the residents, he reviewed medications in general and not just the psychotropic medications and documented that in his progress notes. The NP stated that he was not obtaining informed consents before psychotropic medications were initiated.An interview was conducted with the Director of Nursing (DON) on 03/27/26 at 11:53 AM. the DON explained that when psychotropic medications were initiated the Social Worker notified the NP of the need to obtain informed consent for the new psychotropic medication. The DON indicated that the system failed when the last Social Worker left and unfortunately that system stopped when the Social Worker left. The DON reported the NP would again be responsible for obtaining consent for psychotropic medications.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, the facility failed to ensure a written grievance decision included all required components and to provide a written grievance decision to 1 of 1 resident reviewed for grievances (Resident #67). Findings included:Resident #67 was admitted to the facility on [DATE].A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #67 was cognitively intact.A grievance form dated 3/5/26 was completed by the Social Worker (SW) on behalf of Resident #67 and indicated Resident #67 had concerns regarding the attentiveness of night shift staff and not being changed during the night or check on every two hours. The form documented education was going to be provided by the Staff Development Coordinator (SDC). The form did not document the following: how the grievance was investigated, a summary of pertinent findings/conclusions regarding the resident's concern, a statement as to whether the grievance was confirmed or not confirmed, or the date the written grievance decision was provided to Resident #67. An interview was conducted with Resident #67 on 3/23/26 at 3:25 PM. Resident #67 reported she still had an issue with incontinence care not being provided routinely on night shift. She stated she had reported her concerns about care on the night shift during a care plan meeting but did not remember the date. Resident #67 said she did not know if her concern about care on night shift had been addressed or if anything had been done. She stated she was never informed verbally of the grievance decision and had never received or been offered a written grievance decision from the facility about this concern.An interview was conducted with the SW on 3/26/26 at 9:39 AM. The SW reported she had completed the grievance form on 3/5/26 for Resident #67 because she had mentioned a concern about care on night shift during a care plan meeting. The SW explained she was responsible for managing grievances. She indicated when a resident or family member reported a concern to her, she completed a grievance form and then assigned the grievance to the appropriate department to address. The SW reported that at the time the resident and/or family member told her their concerns, she told them what she planned to do to address their concern and wrote that on the grievance form. She stated then she made a copy of the grievance form and gave it to the appropriate department to address. The SW indicated she verbally followed up with the assigned department about the grievance to ensure they had addressed it. The SW stated she did not go back and document on the grievance form after talking to the assigned department about how the grievance was investigated, what was found, what was done to address the grievance, or how it was resolved. The SW stated she did not follow up with the individual who filed the grievance on how their grievance was investigated, what was found, how it was addressed by the assigned department, or what the resolution was. The SW was not sure why she did not do those things and indicated she did not know it was a requirement. The SW said she did not provide a written copy or notification of how the grievance was resolved to the party who filed the grievance because she did not know she was supposed to. The SW reported she did not follow up and provide information to Resident #67 regarding how her grievance from 3/5/26 was investigated or what the resolution was.An interview was conducted with the Administrator on 3/26/26 at 5:37 PM. The Administrator stated grievances should be completed when a resident or family member had a concern. She reported the SW was responsible for managing facility grievances. She indicated that once the grievance was investigated and addressed by the appropriate department, it should be documented on the form with dates of how/ when it was investigated, what the findings/ conclusion were, what was done to correct the concern, and what the resolution of the grievance was. She stated the individual who made the grievance should be notified and offered a written copy of the grievance resolution. The Administrator stated it should be documented on the grievance form who was notified of the resolution and the date they were notified. The Administrator stated she was not aware the SW was not doing that.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) evaluation for a resident with a serious mental health disorder for 1 of 2 residents reviewed for PASRR (Resident #81).Findings included:A PASRR Determination Notification letter dated 08/29/23 revealed Resident #81 had a Level I PASRR with no expiration date.A review of the North Carolina PASRR Level I screen dated 08/29/23 revealed that major depressive disorder and bipolar disorder were not documented on the North Carolina PASRR Level 1 screen.Resident #81 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy, vascular dementia, anxiety disorder, major depressive disorder, and bipolar disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #81 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Resident #81's active psychiatric/mood disorder diagnoses were documented as non-Alzheimer's dementia, anxiety disorder, depression (other than bipolar) and bipolar disorder. He received antianxiety medications during the MDS assessment period. A psychiatry initial consultation note dated 07/11/25 revealed psychiatry was consulted to review Resident #81's psychotropic medications (medications used to treat mental health disorders). Resident #81 had diagnoses that included dementia, insomnia, depression, anxiety, and bipolar disorder. The provider recommended no changes to Resident#81's buspirone (antianxiety) 5 milligrams that was taken once in the morning and once in the evening.The facility was unable to provide documentation that a request for a Level II PASRR evaluation had been submitted for Resident #81.During an interview on 3/25/26 at 12:25 PM, the admission Coordinator revealed he did not have access to the North Carolina Medicaid Uniform Screening Tool (NC MUST) to verify if a resident had a PASRR. He stated the hospital had initiated the PASRR screening process for new residents. He confirmed the Social Work Assistant had access to NC MUST and provided him with the PASRR Determination Notification letter for new residents. The admission Coordinator also confirmed that Resident #81 had a Level I PASRR assigned before admission to the facility.An interview was conducted with the Social Worker and Social Work Assistant on 3/25/26 at 12:25 PM. The Social Work Assistant stated the hospital had initiated the PASRR screening process. She looked up a potential resident's PASRR in NC MUST (screening tool used to refer and manage PASRR evaluations) and provided the admission Coordinator with a copy of the PASRR Determination Notification letter. The Social Work Assistant stated she did not verify a new resident's diagnosis before she provided the admission Coordinator with the PASRR Determination Notification letter. She confirmed she had not been informed by the clinical team to submit a request for a Level II PASRR evaluation for Resident #81.An interview with the Administrator on 03/25/26 at 1:57 PM revealed residents were discussed in daily clinical team meetings and if it was determined that a resident needed a Level II PASRR evaluation the Social Work Assistant would be responsible for requesting the Level II PASRR evaluation. The Administrator acknowledged a request for a level II PASRR evaluation should have been submitted for Resident #81 due to Resident #81's mental health diagnoses.

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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 reviews, staff, resident, Pharmacy Consultant and Nurse Practitioner (NP) interviews, the facility failed to ensure medications were administered as prescribed by the physician when Nurse #4 administered Adderall (a central nervous system stimulant containing amphetamine and dextroamphetamine) to Resident #95 that was prescribed for Resident #59. In addition, Nurse #6 administered 100 milligrams (mg) of Lyrica (used to treat nerve pain from diabetes) to Resident #56 instead of the prescribed 50 mg Lyrica at bedtime. This deficient practice affected 2 of 3 residents reviewed for medication errors (Resident #59 and Resident #56).The findings included:1. Resident #59 was admitted to the facility on [DATE] with diagnoses that included attention deficit hyperactivity disorder (ADHD).Review of Resident #59's admission Minimum Data Set assessment dated [DATE] revealed his cognition was moderately impaired.Review of Resident #59's physician orders dated 02/20/26 for Adderall XR (extended release) 10 milligrams (mg) capsules give two capsules by mouth in the morning for ADHD.Resident #95 was admitted to the facility on [DATE] with diagnoses that included urinary retention, metabolic encephalopathy and hypertension.Review of Resident #95's admission Minimum Data Set assessment dated [DATE] revealed his cognition was severely impaired.A Medication Variance Report dated 03/11/26 at 10:01 AM completed by Unit Manager #1 revealed Nurse #4 reported administering Adderall XR 20 milligrams to Resident #95. The Resident had a very similar name to another Resident located two doors down. The Nurse stated she was interrupted by a staff member asking her a question during the medication pass and she inadvertently entered the wrong room. Resident #95 noticed the medications and before taking any additional pills he stated, these don't look like my pills. Nurse #4 immediately collected the remaining pills and went to review the orders. The Nurse immediately reported the medication error as per the facility policy. The Director of Nursing (DON) and Nurse Practitioner (NP) have both been notified. A Name Alert has been put in place for both residents. Staff were reminded to utilize the five rights of medication administration with each resident. This Resident will be monitored closely for adverse reactions.An interview was conducted with Nurse #4 on 03/26/26 at 10:55 AM. Nurse #4 explained that on 03/11/26 she was administering the morning medications when she was distracted by a therapist and inadvertently gave Resident #95 medications that belonged to Resident #59. She stated their names were very similar. The Nurse reported that Resident #95 started taking the medications and telling her that they were not his medications at the same time and before she could get him to stop taking the medications he had taken Adderall. She stated she compared the remaining pills to Resident #59's Medication Administration Record and medication cards and determined that it was Adderall that Resident #95 took before she got the medicine cup from the Resident. She stated she immediately reported the medication error to Unit Manager #1 who informed the Nurse Practitioner while Nurse #4 obtained the Resident's vital signs and monitored him multiple times throughout the shift. Nurse #4 stated Resident #95 did not have any adverse side effects from receiving the Adderall. She included that the facility put a Name Alert sign on the two residents' doors.Review of Resident #95's blood pressure and heart rate on 03/11/26 at 10:08 AM and taken by Nurse #4 were blood pressure 136/80 and heart rate 90 beats per minute. The blood pressure and heart rate taken on 03/11/26 at 10:27 PM was blood pressure 122/76 and heart rate was 78 beats per minute.Review of the Nurse Practitioner's progress note dated 03/11/26 at 10:45 AM revealed the NP was notified by nursing that Resident #95 was accidentally given another patient's medication, just one dose of Adderall. This was meant for the resident across the hallway who has a very similar name to Resident #95. The NP indicated she found Resident #95 seated in his wheelchair and he was in good spirits. He denied feeling any anxiety, chest pain, shortness of breath, no other concerning signs or symptoms. We are monitoring his blood pressure and his heart rate throughout the day today. Plan: Patient is stable, no harm has come to Resident #95 from this medication error. Continue with all treatments and plans of care unless (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	otherwise noted above.An interview was conducted with Resident #95 on 03/26/26 at 10:30 AM. The Resident was smiling and conversant. Resident #95 was asked about taking the wrong medication and he explained that he remembered taking the wrong medication when the Nurse gave him the medication and he knew that there were more pills in the cup than he normally took but he took them anyway. He stated he told the Nurse that those were not his pills and by the time the Nurse told him not to take the pills, he had taken one of them. Resident #95 stated they took his vital signs and checked on him often and he was fine. He stated, it did not bother me at all.On 03/26/26 at 2:13 PM an interview was conducted with the Pharmacy Consultant who explained that after Resident #95 received Resident #59's Adderall by mistake the facility should have monitored his blood pressure and heart rate which they did, and they were within normal limits for his age so she would not consider the medication error a significant medication error. The Pharmacy Consultant stated Resident #95 did not have any negative side effects from receiving the wrong medication.During an interview with the Nurse Practitioner on 03/27/26 at 9:31 AM, the NP explained that he was notified by Unit Manager #1 about the medication error made by Nurse #4 on 03/11/26. The NP reported that he was told that Nurse #4 inadvertently gave Resident #95 Adderall that belonged to Resident #59. The NP continued to explain that he saw Resident #95 that morning and he was not having any adverse side effects from the Adderall and he gave the staff a verbal order to monitor him and take his blood pressure and heartrate and to call him if they needed to, but he did not get a call about Resident #95.On 03/27/26 at 10:00 AM an interview was conducted with Unit Manager #1 who explained that on 03/11/26 Nurse #4 came to her and reported that she was interrupted during her medication pass, and she mistakenly gave Resident #95 medication that belonged to Resident #59. Nurse #4 stated she stopped Resident #95 from taking the medications when she realized what she had done but she knew that he took the Adderall XR 20 mg. The Unit Manager continued to explain that she reported the medication error to the DON and the NP who gave a verbal order to monitor Resident #95's blood pressure and heart rate which they did throughout the day, and Resident #95 was fine. She reported the facility made Name Alert signs on red paper to put on the doors that would alert the nurses of similar names and make them be aware that Resident #95 and Resident #59 had similar names.During an interview with the Director of Nursing (DON) on 03/27/26 at 12:02 PM, the DON stated that the medication error involving Resident #95 was brought to her attention by Unit Manager #1 who explained that Nurse #4 was interrupted during the medication pass and she gave Resident #95 another resident's medications (Adderall) that had a name similar to Resident #95. She continued to explain that Unit Manager #1 notified the Nurse Practitioner who saw Resident #95 that day and gave a verbal order to monitor the Resident and check his vital signs. The DON stated Resident #95 did not have any adverse side effects from taking the Adderall. The DON reported the root cause of the medication error was the two residents' names being similar, so they made Name Alert signs and posted them on the residents' doors to prevent a medication error from occurring again.2. Resident #56 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus and neuropathy.Review of Resident #56's physician orders revealed an order dated 12/04/25 for Lyrica (used to treat nerve pain (neuropathic pain) from diabetes) 25 milligrams (mg) one capsule by mouth one time a day for neuropathy.Review of Resident #56's physician orders revealed an order dated 12/31/25 for Lyrica 50 mg one capsule by mouth at bedtime for neuropathy.Review of Resident #56's annual Minimum Data Set assessment dated [DATE] revealed his cognition was moderately impaired.Review of Resident #56's declining count sheet for Lyrica 25 mg capsules revealed the last Lyrica capsule was removed on 03/19/26 at 9:31 AM.Review of Resident #56's declining count sheet for Lyrica 50 mg capsules revealed that on 03/19/26 at 9:00 PM, 2 capsules were subtracted from the count of 22 capsules leaving 20 capsules remaining.Review of the Resident #56's March 2026 Medication Administration Record (MAR) revealed Lyrica 50 mg capsule was given at 9:00 PM on 03/19/26 by Nurse #6. Further review of the March 2026 MAR indicated Nurse #7 held the 9:00 AM dose of Lyrica 25 mg.Review of a Medication Variance Report dated 03/20/26 at 10:02 AM and written by Unit Manager (UM) #1 revealed Nurse #7 reported (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that Resident #56 was accidentally given 100 mg of Lyrica instead of the prescribed dose of 50 mg for the 9:00 PM scheduled time on 03/19/26. Resident #56 has had no ill effects thus far. The Resident awakened for breakfast and per his usual routine laid back down after eating. Will monitor closely. The Nurse Practitioner and family were both notified. The staff were reminded to always check MAR with medication card to ensure proper medication dosing. Resident #56 was assessed; his vital signs were stable. He is alert and baseline confused.Review of a typed statement by the Administrator on 03/20/26 revealed the Weekend Supervisor notified the Administrator that a medication error had occurred with Resident #56. A phone call to the Director of Nursing was placed with the Weekend Supervisor present. The Supervisor reported to the Director of Nursing what was reported to her and the Director of Nursing instructed her to report the medication error to the Nurse Practitioner, complete a full assessment of Resident #56 and to complete an incident report and highlight the medication cards.Review of a written statement from Unit Manager #1 dated 03/20/26 revealed Nurse #7 reported that Resident #56 was accidentally given Lyrica 100 mg at bedtime on 03/19/26 by Nurse #6. The AM dose (03/20/26) was held. Resident #56 awakened easily for breakfast, answers questions appropriately and voiced no complaints. The Resident was monitored closely throughout the day. The Nurse Practitioner and family were notified. The Nurse Practitioner was in to assess Resident #56 as well. Nursing was reminded to always check MAR with medication card to ensure proper medication dosing. Attempted to contact Nurse #6 but no answer. Director of Nursing was notified.Review of the Nurse Practitioner's progress note dated 03/20/26 at 9:00 AM revealed he was notified by nursing of a medication error that Resident #56 accidently received a higher dose of Lyrica than was prescribed for him. The Resident was awake and alert, in his wheelchair accompanied by his family in the hallway. He is doing quite well, smiling and interacting. His family denies noticing any concerning symptoms. Assessment Plan: to monitor more closely today including his vital signs.Review of Resident #56's progress note dated 03/20/26 at 7:48 PM and written by Unit Manager #1 revealed Resident #56 showing no adverse reactions to Lyrica 100 mg given at bedtime on 03/19/26. Alert, answers questions when spoken to and no voiced complaints.An interview was conducted with Nurse #7 on 03/25/26 12:59 PM who confirmed that she worked on first shift on 03/20/26. The Nurse explained that she counted controlled medications with Nurse #6 during shift change on the morning of 03/20/26 and there were no discrepancies with the counts. When Nurse #7 went to pull Resident #56's Lyrica 25 mg capsule for his 9:00 AM medication administration, there were no 25 mg Lyrica in the drawer and no declining count sheet either. The Nurse continued to explain that there was Lyrica 50 mg capsules for Resident #56 in the drawer and when she reviewed the declining count sheet for the 50 mg capsules, she discovered that Nurse #6 had removed 2 capsules from the 50 mg supply of Lyrica on 03/19/26 at 9:00 PM. Nurse #7 stated that when she discovered the medication error she immediately notified the Weekend Supervisor who notified the Administrator and the Director of Nursing who instructed them to monitor Resident #56 and check his vital signs. The Nurse stated she took Resident #56's vital signs and he appeared sleepy during the morning, but the Nurse was informed by Unit Manager #1 that it was Resident #56's normal routine to lay down after breakfast and sleep. The Nurse stated that the Unit Manager advised her not to give Resident #56 his Lyrica 25 mg that was due on 03/20/26. When the Nurse was asked if she documented the Resident's vital signs she reported she thought she did, but she may not have but insisted that Resident #56's vital signs were within normal limits every time she took them. The Nurse stated that Resident #56 was seen by the Nurse Practitioner that morning on 03/20/26. Nurse #7 reported that the management highlighted Resident #56's Lyrica 50 mg medication card to draw the nurses' attention to the dosage.On 03/27/26 11:01 AM an interview was conducted with the Weekend Supervisor who explained that she was notified on the morning of 03/20/26 by Nurse #7 that Nurse #6 had mistakenly given Resident #56 2 Lyrica 50 mg capsules for the bedtime medication administration on 03/19/26. Nurse #7 discovered the error during her morning medication pass on 03/20/26. The Supervisor stated both she and Nurse #7 went to assess Resident #56 and obtained (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his vital signs and they were within normal limits. The Supervisor stated she went to the Administrator who called the Director of Nursing on the phone and explained what happened. The Director of Nursing instructed her to assess the Resident which she already had and to highlight the medication cards and write PM on the Lyrica 50 mg card so that it was noticeable for the nurses to see when pulling the medication. The Director of Nursing also instructed her to notify the Nurse Practitioner as well and the Nurse Practitioner assessed Resident #56 as well. The Supervisor stated about an hour after her being notified of the medication error, Resident was observed to be awake and out of bed and she did not observe any side effects of the medication error.An interview was conducted with Unit Manager #1 on 03/27/26 at 10:05 AM who explained that she came in on the morning of 03/20/26 and was notified by Nurse #7 that on 03/19/26 Resident #56 was given two 50 mg Lyrica instead of the one 50 mg dose that was prescribed to be given at bedtime by Nurse #6. The Unit Manager continued to explain that Resident #56 was drowsy which was not unusual for him because he received Lyrica twice a day and used to be on 100 mg of Lyrica at bedtime until recently when it was lowered. She stated she notified the Nurse Practitioner who instructed her to hold the morning dose on 03/20/26 and the Nurse Practitioner was into assess Resident #56 that morning as well and gave her a verbal order to monitor the Resident throughout the day. The Unit Manager reported she checked on Resident #56 several times that day and she did not observe any ill side effects from receiving the Lyrica 100 mg dose. She stated she highlighted the 50 mg Lyrica medication card, so it was more noticeable when the nurses were pulling the medications. The Unit Manager stated she tried to interview Nurse #6, but the Nurse did not return her calls. The Unit Manager reported the Nurse Practitioner did not provide a written order to hold the morning dose of Lyrica, but that he verbally told her to hold the Lyrica.Multiple attempts were made to interview Nurse #6 who made the medication error on 03/19/26, but the attempts were unsuccessful. An interview was conducted with the Nurse Practitioner on 03/27/26 at 10:20 AM who explained that he was notified of the medication error on Resident #56 when he was given a double dose of Lyrica 50 mg and assessed the Resident that morning on 03/20/26. The Nurse Practitioner stated Resident #56 was awake and talkative with him and he did not observe any adverse reactions from the medication error. He stated he gave a verbal order for the staff to monitor the Resident and notify him if there were any changes and to hold the morning dose of Lyrica. He stated he was not notified of any changes with Resident #56.During an interview with the Director of Nursing (DON) on 03/27/26 at 12:13 PM the DON explained that she was notified via telephone on the morning of 03/20/26 about the medication error made by Nurse #6 on the evening of 03/19/26. It was discovered by Nurse #7 when the Nurse was administering Resident #56's morning medications and found that Nurse #6 had signed out for two 50 mg Lyrica instead of one 50 mg Lyrica. The DON stated she thought Nurse #6 was trying to make 50 mg by giving two 25 mg, but she pulled the two capsules from the 50 mg card by mistake. She stated she was unable to verify that because Nurse #6 has refused to return her phone calls and she had not been back to work at the facility. The DON reported Resident #56 was assessed by the Nurse Practitioner and the Nurses throughout the shift and had no adverse side effects from the medication. In fact, she stated that the Resident used to be on Lyrica 100 mg and the dose was lowered. The DON explained that she directed the staff to highlight the directions on her two Lyrica medication cards so that the specific dosage could be determined by the nurses.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident, staff, Wound Physician Assistant (PA), Hospice, and Physician interviews, the facility failed to complete assessments for 3 of 3 residents reviewed for pressure ulcers (Resident #14, Resident #83, and Resident #48). In addition, the facility failed to initiate wound treatment for Resident # 14's pressure ulcer at the onset. Findings included: a. Resident #14 was admitted to the facility on [DATE]. His diagnoses included hemiplegia (paralysis or weakness on one side of the body) and hemiparesis (decreased control and strength on one side of the body) following unspecified cerebrovascular disease (stroke) affecting left non-dominant side.A care plan dated 10/30/25 and last revised on 2/2/26 indicated there was potential for pressure ulcer development related to contractures, limited mobility, and bed bound. The care plan goal was for Resident #14 pressure ulcer to show signs of healing and remain free from infection. The care plan interventions included administering treatments as ordered, to monitor/document/ report any changes in skin status, turn/ reposition at least every 2 hours, pressure reducing device on bed, and weekly treatment documentation to include measurement of each area of skin breakdowns width, length, depth, type of tissue and exudate.An order dated 5/15/25 read, apply protective foam dressing to sacrum. Check placement daily, every day shift for high-risk area. The order was discontinued on 10/30/25.An order dated 10/17/25 read, Air Mattress Overlay every day and night shift for maintenance. The order was discontinued on 11/26/25.A significant change Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #14 had moderate cognitive impairment. The MDS documented that he was at risk of developing pressure ulcers. The MDS indicated he did not have unhealed pressure ulcers.The electronic medical record documented he was admitted to Hospice services on 11/4/25.A Braden scale (tool used to identify an individual's risk of developing pressure ulcers) dated 1/20/26 indicated Resident #14 was very high risk for skin breakdown. There were no previous Braden Scale assessments documented in his medical record.Review of Resident 14's medical record revealed there were no weekly skin assessments documented in his medical record prior to 1/13/26.Facility shower sheets for Resident #14 dated 11/11/25 and 11/14/25 documented sacral pressure injury written on the bottom of the form. The shower sheets did not include the name of who had completed them.An interview was conducted on 3/25/26 at 12:23 PM with the Assistant Director of Nursing (ADON). She recalled completing a bed bath for Resident #14 and completing the shower sheet on 11/11/25. She could not recall if there was a dressing to his sacrum or if the area was open. The ADON said she thought from what she had documented on the shower sheet that there would have been a dressing in place. She reported if there had not been a dressing in place she would have documented differently. The ADON said she did not remember talking to anyone about the wound. She said if she did not talk to anyone about the wound it would have been because she thought it was already being taken care of by wound care. The ADON stated she thought there must have been a dressing in place to his sacrum because she did not recall ever seeing Resident #14's actual pressure ulcer. The ADON said she was helping with giving Resident #14 a bed bath not assessing his wound so she would not have removed the dressing to his sacrum to look at the wound if there was one in place.It could not be determined who completed the shower sheet from 11/14/25.Hospice notes from 11/4/25 through 11/18/25 were reviewed and did not include documentation of Resident #14 having a pressure ulcer to his sacrum.There was no evidence of treatment orders or treatments provided for a sacral pressure ulcer for Resident #14 from 11/11/25 to 11/18/25.A weekly wound assessment dated [DATE] completed by the Wound Care Nurse documented Resident #14 had a stage 3 pressure ulcer to his sacrum. The wound assessment indicated 11/18/25 was the date of onset for the wound. The wound length was 2.5 centimeters (cm), the width was 2 cm, and the depth was 0.2 cm. The assessment indicated there was granulation (new tissue) tissue, yellow/ brown eschar (dead tissue), and a small amount of drainage present to the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound.A treatment order dated 11/18/25 read: Cleanse sacrum with saline wash, apply foam dressing, change every three days. A hospice note dated 11/20/25 by Hospice Nurse #2 read: facility staff notified this nurse that patient has a pressure injury to sacrum. Patient provided wound care by facility staff wound care nurse.An interview was conducted with Hospice Nurse #1 on 3/25/26 at 1:39 PM. She saw Resident #14 on 11/4/25 and completed his hospice admission. She stated she did not look at the skin on his buttocks during the visit because he was having issues with pain and had told her not to. She reviewed the hospice notes for Resident #14 and stated hospice became aware of his sacral pressure ulcer on 11/20/25.An interview was conducted with Hospice Nurse #2 on 3/26/26 at 11:47 AM. She saw Resident #14 on 11/5/25 and 11/20/25. She recalled Resident #14 was adamant about not letting her turn him, so she did not assess the skin on his buttocks.An interview was conducted with Hospice Nurse #3 on 3/25/26 at 1:09 PM. She was Resident #14's routine Hospice Nurse and had started seeing him on 11/17/25. She reported the facility's preference was to manage and do Resident #14's wound care. She could not recall exactly when Resident #14's sacral wound was identified but indicated his sacral pressure ulcer was first noted in the hospice notes on 11/20/25. She was not sure how frequently the facility did skin assessments but said the facility notifies hospice if they find a new skin concern.An interview was conducted with the Hospice Nurse Aide (NA) on 3/25/26 at 1:29 PM. She reported she was the routine Hospice NA for Resident #14 and typically came to the facility weekly and gave him a bed bath during her visits. She recalled 11/12/25 was the first time she saw Resident #14 after his admission to hospice on 11/4/25. She remembered he had an existing wound on his sacrum when she saw him on 11/12/25. She stated she knew it was existing because he already had a dressing on his buttocks when she saw him on 11/12/25. The Hospice NA said she regularly spoke to the Wound Nurse and the Hospice Nurse about Resident #14 but did not think the wound to his buttocks was something to report because he had a dressing in place and she thought it was an existing wound and not new. She said the dressing to his buttocks looked like a foam dressing.An interview was conducted with the Wound Care Nurse on 3/24/26 at 11:14 AM. She recalled Resident #14's sacral pressure ulcer and stated the date she first documented on his wound (11/18/25) was the date the wound was identified, and his wound was a stage 3 pressure ulcer when it was first identified. She stated someone had reported the wound to her, but she could not remember who it was. She recalled he had previous stage 2 pressure ulcer to his sacrum but said it had healed. The Wound Nurse stated she had kept a protective dressing on his sacrum after his previous pressure ulcer healed for a long time until she had felt comfortable stopping it. She thought Resident #14's wound may have been found before it was a stage 3 pressure ulcer if routine skin assessments had been completed. The Wound Nurse stated that Resident #14's wound was currently a stage 4 pressure ulcer.An interview was conducted with Unit Manager (UM) #2 on 3/25/26 at 4:30 PM. She was the UM for the 100/200 side were Resident #14 resided. UM #2 explained the process for identifying new skin issues prior to January 2026. She reported that the NAs completed skin checks when they gave a resident a bath/ or shower and were supposed to complete a shower sheet. She explained the NAs were supposed to mark on the shower sheet if there were any skin abnormalities seen and then give the shower sheet to the floor nurse to review. UM #2 indicated she did not review the shower sheets. She stated if there was a skin concern the floor nurse was supposed to notify the Wound Nurse and the Wound Nurse would come and assess the area. She said if the Wound Nurse was not at the facility, then the floor nurse was responsible for assessing the wound, implementing a treatment, and entering the order for the treatment. UM #2 reported Braden Scale assessments were completed for residents on admission and then quarterly, every 3 months. She stated the nurse who did the residents admission assessment completed the Braden Scale on admission. She explained that the UM's were responsible for completing the Braden Scale assessment for residents quarterly. She reported about a year ago the facility transitioned to a new combined quarterly nursing assessment which contained the Braden Scale assessment with all the other required quarterly assessments combined into one. She stated Resident #14 did not have a (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Braden Scale assessment completed in 2025 because that was when the facility transitioned to using the new combined quarterly nursing assessment and thought that was why Resident #14's Braden Scale assessments being completed were missed. She did not recall exactly when Resident #14's sacral wound was found or anyone mentioning it to her before it was identified on 11/18/25. UM #2 thought that if there had been routine skin assessments completed by a nurse for Resident #14 his sacral wound would have been identified earlier before it was a stage 3 pressure ulcer.An observation was completed of Resident #14's wound with the Wound PA and Wound Nurse on 3/25/26 at 11:40 AM. Resident #14's sacral wound was measured and assessed by the Wound PA. The pressure ulcer was circular in shape over the sacrum with no odor or signs of infection present. There was moderate serous (clear/ yellow fluid) drainage. The wound measured 1.5 cm in length, 1.5 cm in width, and 0.4 cm deep with undermining (hidden pocket under the wound edges that mean the wound is wider than the visible wound opening) identified using the clock method (a standardized way to describe and measure a wound imaging a clock face over the wound) at 12:00, 3:00, and 9:00 of 1 cm and undermining at 6:00 of 0.5 cm.An interview was conducted with the Wound PA on 3/25/26 at 11:45 AM. The Wound PA stated today (3/25/26) was the first time he had seen Resident #14's sacral pressure ulcer. He explained he had seen him in the past, but it had been about a year ago before he was admitted to hospice. He said Resident #14 should have had skin assessments completed at least weekly. He thought skin assessments should be completed by a nurse and not an NA due to the level of acuity, nursing background for assessment, and so the nurse could put a treatment in place if it was needed.An interview was conducted with the Physician on 3/26/26 at 1:25 PM. She said Resident #14 did not like to be touched and wanted to be left alone. She said he refused care and she thought that he would develop a pressure ulcer no matter what was done for him. The Physician thought skin assessments for residents should be completed by a nurse at a minimum of weekly. She said it was okay for NAs to look at the resident's skin when doing care and report to the nurse if they saw something but that an NA could not assess. The Physician stated that logically doing skin assessments routinely would help identify wounds earlier before they developed to a stage 3 or 4 pressure ulcer. She was not sure how often the Braden Scale assessment should be done but said the facility should be doing them to identify risk factors and add interventions if a resident was at risk for skin breakdown.An interview was conducted with the Director of Nursing (DON) on 3/26/26 at 4:33 PM. The DON reported in November 2025 during the time Resident #14's wound was identified he had declined and Hospice had thought he was transitioning to actively dying. The DON reported Hospice had been focused on comfort measures and pain. She stated Resident #14 had refused a lot of motion and movement. The DON was not sure what happened were Resident #14's wound was not identified and assessed earlier by a nurse. The DON said she thought maybe someone placed a dressing on the wound but then failed to report it to the Wound Nurse and then everyone saw a dressing was in place and assumed the wound had already been reported and had a treatment in place.b. Resident #83 was admitted to the facility on [DATE]. His diagnoses included Type-2 Diabetes Mellitus with diabetic neuropathy (pain, tingling, numbness of the hands/ feet) and peripheral angiopathy (complication of diabetes causing damage to blood vessels), stage 3 (full thickness wound that extends into the fatty tissue) pressure ulcer, and unstageable pressure ulcer (full thickness wound were the base is covered by dead tissue).A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #83 was cognitively intact. The MDS indicated he did not have behaviors or rejection or care. The MDS documented that he did not have a pressure ulcer, but he was at risk of developing pressure ulcers.A care plan dated 1/24/24 and last revised on 3/4/26 was in place for Diabetes Mellitus type-2. The care plan stated diabetic complications include neuropathy, history of diabetic foot ulcers, and delayed wound healing. The care plan goals were for Resident #83 to not have complications related to diabetes. The interventions included inspecting feet daily for open areas, sores, pressure areas, blisters, edema, or redness, and to check all of body for breaks in skin and treat promptly as ordered by doctor.A Braden scale assessment dated [DATE] indicated Resident #83 was low risk for (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	skin breakdown. There were no additional Braden Scale assessments documented in his medical record until 12/19/25. Review of Resident 83's medical record revealed there were no weekly skin assessments documented in his medical record prior to 1/15/26.A weekly wound assessment dated [DATE] indicated on 11/11/25 a pressure ulcer to Resident #83's left plantar (bottom of the foot) was identified. The wound measured 1.5 cm in length, 1 cm in width, and 0.2 cm in depth. The assessment indicated the wound was a suspected deep tissue injury with 100% maroon discolored intact skin present. The wound assessment indicated Resident #83 also had a pressure ulcer to his right plantar that was unstageable. The wound to his right plantar measured 4 cm in length, 4 cm in width, and 0.2 cm in depth and was covered 100% by black eschar (dead tissue).A treatment order dated 11/12/ 25 read, cleanse left plantar with saline wash, apply betadine, and cover with foam dressing daily. The order was discontinued on 11/19/25A treatment order dated 11/12/25 read, cleanse right plantar with saline wash apply betadine and cover with foam dressing daily. The order was discontinued on 2/4/26.A Wound PA note dated 11/12/25 indicated Resident #83 had been seen for a deep tissue pressure injury to his left foot and an unstageable pressure injury to his right foot. The note stated that Resident #83's feet lay on the foot of the bed causing this. The note indicated it had been discussed to remove the foot board.A weekly wound assessment dated [DATE] indicated Resident #83's left plantar was a stage 3 pressure ulcer and measured 1 cm in length, 1 cm in width, and 0.2 cm in depth. The assessment indicated the treatment was changed to the left plantar pressure ulcer. The right plantar pressure ulcer remained unstageable with 100 % black eschar and measured 3.5 cm in length, 3.5 cm in width, and 0.2 cm in depth. A treatment order dated 11/19/25 read, cleanse left plantar with saline wash, apply alginate and cover with foam dressing every Monday, Wednesday, Friday. The order was discontinued 11/26/25.An order dated 11/27/25 read cleanse with saline wash. Apply betadine and cover with foam dressing every day shift. The order was discontinued on 11/7/26.A Wound PA note dated 1/7/26 indicated Resident #83's left plantar pressure ulcer was healed. The note indicated his right foot plantar pressure ulcer remained unstageable and covered by 100 % black eschar. The right foot pressure ulcer measured 3 cm in length, 2.5 cm in width, and 0.2 cm in depth. The note indicated the wound was stable but not improved. The treatment was to paint the wound daily with betadine.An observation of Resident #83's wound was completed with the Wound PA and Wound Nurse on 3/25/26 at 11:10 AM. His left plantar foot was observed with a circular open wound. There were no signs of infection, odor, or drainage present.An interview was conducted with the Wound PA on 3/25/26 at 11:15 AM. The Wound PA stated he had seen Resident #83 since the wounds to his foot were identified in November 2025. He reported Resident #83 was not compliant, had poor hygiene, refused to shower, and refused care if he did not want something. He said Resident #83's left foot wound had already healed. He reported the right foot pressure ulcer had been an unstageable area until this week when the eschar came off. He said the pressure ulcer to his right foot was now a stage 3. He said Resident #83 stayed in bed all the time and his feet lying against the footboard was what caused him to develop pressure ulcers to his feet. The Wound PA said, with Resident #83 being diabetic the facility should have been looking at his skin and checking his skin, including his feet at least once a week to identify any skin areas early.An interview was conducted with Resident #83 on 3/26/26 at 10:45 AM. He stated that before he developed the wounds to his feet staff did not check his feet or his skin routinely. Resident #83 said he would have been fine with the nurse doing a once over to check his skin and his feet once a week. He said he could not check his own feet because his knees did not bend. Resident #83 reported he did not have feeling or sensation in his feet because of neuropathy and had not been aware his feet were against the footboard or that he had the wounds on the bottom of his feet.An interview was conducted with the Wound Nurse on 3/24/26 at 3:51 PM. She recalled the pressure ulcers to Resident #83's feet were identified on 11/11/25. She stated he had a pressure ulcer on his right and left plantar, but the one he had on his left foot had healed. She indicated the pressure ulcers on the bottom of his feet were from where he had his feet up against the foot board. She said Resident #83 had diabetes and (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could not feel his feet and was not aware his feet were against the footboard or he had the wounds. She did not remember who specifically had told her about Resident #83's wounds.An interview was conducted with UM #1 on 3/25/26 at 9:16 AM. She recalled an NA had found the wounds on Resident #83's feet and came and got her. She stated she went and looked at the wounds and then went directly to get the Wound Nurse to assess the wounds. She said Resident #83 only allowed a bed bath once a week. She reported that the NAs looked at his skin when they did a bed bath. She did not think nurses were doing formal skin assessments during the time his wounds were identified or prior to January 2026. She said NAs did skin checks, completed shower sheets when they did a shower/ bath, and were supposed to mark on the shower sheet if there were any new skin issues. She explained starting in January 2026 the Wound Nurses were responsible for doing resident weekly skin assessments until the second Wound Nurse had left about a month ago. She said the Wound Nurse was still responsible for the skin assessments currently, but it was going to be transitioning because the Wound Nurse did not have time to do all the skin assessments with her other duties. UM #1 said there was not a formal schedule for skin assessments currently, just that they had to be completed weekly. She explained she looked in the residents' charts when it was close to the end of the week and if she did not see a skin assessment completed for that week by the Wound Nurse then she would do it. UM #1 said the Braden Scale assessments were supposed to be done on admission, quarterly, and as needed if a resident had a decline or a new pressure ulcer. She stated that the Braden Scale assessment was part of the admission assessment and completed by the nurse who did the admission. She stated the quarterly Braden Scale assessments were done by the UMs. She reviewed Resident #83's skin assessments in his electronic medical record and acknowledged he had a skin assessment documented on 1/5/26 and 1/23/26 but no additional skin assessments were completed. UM #1 said she was not sure why there were no additional skin assessments documented for Resident #83. She reviewed the Braden Scale assessments for Resident #83 and was not sure why he had not had a Braden Scale assessment completed for the period between 3/5/25 and 12/19/25. An interview was conducted with the Physician on 3/26/26 at 1:25 PM. She said the nurses should have been looking at Resident #83's feet and skin to check for wounds. She thought if they had been checking his skin routinely, they would have found the areas on his feet sooner. The physician said maybe because Resident #83 was so with it the staff had assumed he could tell them if something was wrong but that had not been the case.An interview was conducted with the DON on 3/26/26 at 4:33 PM. The DON thought that if routine skin assessments had been completed for Resident #83, they could have seen he was developing a wound and put an intervention in place. She said Residents with diabetes should have their feet checked for wounds at least weekly with the weekly skin assessment and that the assessment should be completed by a nurse.c. Resident #48 was admitted to the facility on [DATE]. Her diagnoses included hemiplegia (paralysis or weakness on one side of the body) and hemiparesis (decreased control and strength on one side of the body) following cerebral infarction (stroke) affecting left nondominant side, pressure ulcer of other site stage 4 (full-thickness wound that extends through the skin to exposed muscle, tendon (tissue that connects muscle to bone), or bone), peripheral vascular disease (progressive disorder involving the narrowing or blockage of blood vessels in the legs).A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #48 was cognitively intact. The MDS indicated she did not have behaviors or rejection of care. The MDS documented that she did not have a pressure ulcer, but she was at risk of developing pressure ulcers. The MDS documented she had functional limitations in range of motion to upper and lower extremity on one side. A care plan dated 8/24/24 and last revised on 2/18/26 was in place for potential for pressure injury development. The care plan goals included to be free from redness, blisters, or discoloration. The care plan interventions included monitoring/ documenting any changes in skin status including appearance, color, wound healing, symptoms of infection, wound size, and stage.A Braden Scale assessment was completed on 1/2/26 and indicated Resident #48 was low risk for developing a pressure ulcer.There were no weekly skin assessments documented in (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the medical record from 1/24/26 to 2/9/26. A nursing note by the Wound Nurse dated 2/9/26 read in part, Ulcer noted to posterior left knee. History of recurrent yeast rash to area and recently completed course of nystatin powders in which this area did not heal.An order dated 2/10/26 read, cleanse posterior left knee with normal saline, apply mupirocin 2% ointment (antibiotic ointment) and clean dressing daily for pressure injury. The order was discontinued on 2/18/26.An additional nursing note by the Wound Nurse dated 2/17/26 indicated the wound to Resident #48's left posterior knee was not improving and an order was obtained for a wound care referral. An order dated 2/18/26 read refer to [wound care].A weekly wound assessment dated [DATE] indicated Resident #48 had a stage 4 pressure ulcer with tendon exposed that was identified on 2/18/26 to her left rear knee. The pressure ulcer measured 2 cm in length, 1 cm in width, and 0.4 cm in depth.A Wound PA note dated 2/18/26 indicated Resident #48 was seen for a stage 4 pressure ulcer on the left posterior (back) knee that had been present for about 2 weeks. The note stated the wound was caused by the extensive contracture in the affected leg at her left knee.An order dated 2/18/26 read, cleanse back of left knee with wound cleanser. Apply xeroform gauze, calcium alginate and secure with foam dressing every day shift for pressure injury.An observation of Resident #48's pressure ulcer was completed with the Wound Nurse on 3/24/26 at 10:55 AM. Resident #48 was observed in bed; her left leg was contracted at her knee and unable to be straightened. The pressure ulcer was observed in the bend behind her left knee. The pressure ulcer was difficult to observe due to the location and degree of contracture. A white area of tendon was visualized in the wound. There were no odors or symptoms of infection present.An interview was conducted on 3/24/26 at 3:51 PM with the Wound Nurse. She said Resident #48's wound was identified on 2/9/25 and she made a nursing note about the wound. She recalled on 2/9/25 25 that the wound had a small white area with some drainage that was yellow. She stated when the wound did not improve and Resident #48 was referred to see the Wound PA. She said the wound was behind her left knee that was contracted. She reported when she was doing a treatment on 2/9/26 Resident #48 indicated she had pain behind her left knee. The Wound Nurse reported she looked deeper into the bend of her knee and could see something white and said it looked like an ulcer. The Wound Nurse reported the location of the wound made it hard for the area to be seen. The Wound Nurse reported the tendon was showing when the wound was found on 2/9/26. She reviewed the wound assessments for Resident #48 and stated it was correct that there was not a wound assessment completed until 2/18/25. She reported wounds were supposed to be assessed and measured when they were found and then weekly. She indicated the other Wound Nurse typically did the assessments and treatments for 400 hall were Resident #48 resided. She said the other Wound Nurse had left around that time and she thought that was why Resident #48's wound being documented and assessed prior to 2/18/26 had been missed. She said she was not sure if her wound was a stage 3 or 4 pressure ulcer when it was found on 2/9/26 because she had not documented it. She recalled Resident #48's tendon was exposed when she found the wound on 2/9/26 and said the wound looked the same on 2/9/26 that it did on 2/18/26 when Resident #48 was seen by the Wound PA. She stated on 2/18/26 Resident #48's pressure ulcer was a stage 4 when it was assessed by the Wound PA. She reviewed Resident #48's skin assessments and stated Resident #48 had a weekly skin assessment on 1/23/26 that did not document the pressure ulcer behind her left knee and then her next skin assessment was not until 2/10/26. She said it was unfortunate the area where the wound was located with Resident #48's contracture made the wound difficult to see.An interview was conducted with the Wound PA on 3/25/26 at 11:45 AM. He explained that essentially Resident #48's tendon was creating pressure from the inside because of how tight it was. He reported her wound was a stage 4 pressure ulcer because the tendon was exposed. He said the tendon looked good and healthy with no signs of infection or necrosis (dead tissue). He further explained there was no pressure component from the outside that caused the pressure ulcer. He said the pressure was internal from the tendon itself being so tight. He did not think there was an intervention that could have prevented the wound from occurring or that would be enough to help it heal. He thought it was (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inevitable that the wound would develop because of how tight Resident #48's tendon and the contracture were.An interview was conducted with the Physician on 3/26/26 at 1:25 PM. The Physician stated Resident #48 had always had the contracture to her left leg at the degree it was currently. She did not think there was any intervention that could have been put into place by the facility that would have prevented her from developing the pressure ulcer. The Physician stated that logically doing skin assessments routinely would help identify wounds earlier before they were a stage 3 or 4 pressure ulcer. The Physician said wounds should be assessed, documented, and measured when they were identifiedAn interview was conducted with the DON on 3/26/26 at 4:33 PM. She reported Resident #48's contractures had been present and unchanged since she was admitted to the facility. She said they had tried therapy, but she was unable to tolerate therapy or any type of positioning device for her left knee contracture. She recalled a wedge had been tried for her left knee contracture but said it put more pressure on the tendon and had caused discomfort. She said pillows were the most comfortable for positioning for Resident #48 and her leg contracture. The DON said she expected for a full wound assessment including measurements and documentation of the wound to be completed when Resident #48's wound was found. She said that Resident #48 should have had weekly skin assessments completed and documented by a nurse.An interview was conducted with the Wound Nurse on 3/24/26 at 11:14 AM. The Wound Nurse stated that prior to January 2026 NAs completed resident skin checks during baths/showers. She explained NAs were supposed to complete a shower sheet when they gave a resident a bath/ shower, mark on the sheet if there were any skin issues seen and then give the shower sheet to the floor nurse to review. The Wound Nurse indicated the shower sheets were also reviewed by the UM's. She said the floor nurses or UM's let her know if there was a new wound she needed to look at. The Wound Nurse stated that starting in January 2026 resident skin assessments were supposed to be completed weekly by a nurse and that the Wound Nurses were responsible for completing the weekly skin assessment. She reported that there had been two Wound Nurses, she stated she typically did the 100/200 side of the building, and the other Wound Nurse did the 300/400 side. She said the other Wound Nurse left about a month ago and she was currently the only Wound Nurse. She said there had been a schedule for routine skin assessment until about a month ago and that the schedule had gone away when the other Wound Nurse left. She said there currently was not a routine schedule for weekly skin assessments just that they were supposed to be completed weekly. The Wound Nurse said that the UM's and floor nurses were currently responsible for doing the weekly skin assessments. The Wound Nurse stated Braden Scale assessments were supposed to be completed for all residents on admission, quarterly, and as needed for changes in mobility or when new wounds occurred. She reported that the UM's were responsible for completing the Braden Scale assessments for residents. She said skin assessments were important to help identify skin issues early. She stated Braden Scale assessments were important to help identify residents who were at risk for skin breakdown and so preventative measures could be implemented. She thought wounds may have been found before they were a stage 3 or 4 pressure ulcer if routine skin assessments had been completed nurses because nurses were better able to assess than NAs.An interview was conducted with the Director of Nursing (DON) on 3/26/26 at 4:33 PM. The DON stated she expected for a full assessment to be completed, documented, and treatment orders to be placed when a new wound was identified. She stated assessing the wound included looking at the wound, measuring it, staging the wound if applicable, and documenting it in the wound assessment or a progress note. The DON stated she was not aware Braden Scale assessments were not being completed. She reported Braden Scale assessments should be completed on admission, quarterly, and with any change in mobility or when a new wound was identified. The DON said she was no

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 3 medication errors out of 26 opportunities, resulting in a medication error rate of 11.45% for 3 of 4 residents observed during the medication administration (Resident #1, Resident #81 and Resident #119).The findings included:1. Resident #1 was admitted to the facility on [DATE] with diagnoses that included constipation.Review of Resident #1's physician order dated 01/06/26 for polyethylene glycol powder (laxative) give 17 grams by mouth one time a day for constipation.On 03/24/26 at 10:00 AM an observation was made of Nurse #1 during a medication administration. The Nurse prepared the 17 grams of polyethylene glycol powder by mixing it in a cup of water then took the medication to Resident #1's bedside and set the cup on the over bed table. Nurse #1 proceeded to give the Resident the medications from the medication cup then picked up a flavored liquid used to swallow the medications. The Nurse left the room without giving Resident #1 the polyethylene glycol medication.At 10:30 AM on 03/24/26 Nurse #1 was asked about Resident #1's polyethylene glycol medication that she mixed up for the Resident and Nurse #1 stated, Oh, I left it on his table, didn't I? Nurse #1 then went back into the Resident's room where the liquid mixture remained on the table. The Nurse stated she forgot to give the medication to the Resident because she was nervous.An interview was conducted with the Director of Nursing on 03/27/26 at 12:34 PM, who explained that her expectation was that the nurses provide the medications as they were ordered and Nurse #1 should have given Resident #1 his laxative.2. Resident #81 was admitted to the facility on [DATE] with diagnoses that included constipation.Review of Resident #81's physician orders revealed an order dated 12/14/23 for polyethylene glycol (laxative) one packet by mouth every other day for constipation. Dissolve in 4-6 oz of fluid.An observation of a medication administration was made of Nurse #2 on 03/24/26 at 9:20 AM. The Nurse prepared Resident #81's medications which included dissolving the polyethylene glycol in water. The Nurse took the medication to the Resident and administered the medications that she had crushed and gave one drink of the polyethylene glycol mixture then sat the liquid on the Resident's over bed table and left the room.At 10:33 AM on 03/24/26 Nurse #2 was asked about Resident #81's polyethylene glycol and the Nurse stated, Oh, I should not have left the drink in the Resident's room because it had medication in it, I should have made sure he drank all of his medication.An interview was conducted with the Director of Nursing on 03/27/26 at 12:34 PM, who explained that her expectation was that the nurses provide the medications as they were ordered and Nurse #2 should have given Resident #2 all the medication while she was in the room and not left it.3. Resident #119 was admitted to the facility on [DATE] with diagnoses that included gastroesophageal reflux disease.Review of Resident #119's physician orders dated 03/19/26 for calcium carbonate (antacid) 600 milligrams (mg) one tablet by mouth in the morning for supplement.A medication administration observation was conducted on 03/24/26 at 8:45 AM with Nurse #3. The Nurse prepared and administered the Resident's medications which included calcium carbonate 1000 mg.An interview was conducted with Nurse #3 on 03/24/26 at 1:32 PM. The Nurse was asked to show the calcium carbonate bottle that she dispensed Resident #119's calcium carbonate from and the bottle read 1000 mg per tablet. Nurse #3 stated she did not think calcium carbonate tablets came in 600 mg tablets and stated she would let the provider know about the dosage.An interview was conducted with the Director of Nursing on 03/27/26 at 12:34 PM, who explained that her expectation was that the nurses adhere to the five rights of medication administration and if Nurse #3 had done that then the medication error would not have happened.

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and staff interviews, the facility failed to maintain a clean and orderly interior as evidenced by hall floors being dirty with multiple areas of stains, dirt, debris, and dried fluid/water spots. This was observed on 2 of 6 hallways reviewed for environment (front common area hallway and rear common area hallway).Findings included:A. An observation made on 03/23/26 at 9:40 AM of the facility's front common hallway floor which was located between two resident wings revealed multiple areas that contained stains, dirt, debris, and multiple dried fluid/water spots too numerous to count. The floor appeared to have dirt and debris pushed into the corners of the walls. There was also observed dirt and debris pushed into corners, in a small alcove, underneath a water fountain. Observations were also made of residents, visitors, and staff utilizing this hallway as a pass through to resident rooms.An additional observation of the facility's front common hallway floor was completed on 03/27/26 at 8:15 AM revealed the floor to remain in the same condition as earlier in the week with multiple spots of dirt and debris and dried water/fluid spots that had collected dirt. Observations of residents, staff, and visitors utilizing this hallway continued.B. An observation made on 03/23/26 at 9:49 AM of the facility's rear common hallway floor which was located between the two resident wings revealed multiple areas that contained stains, dirt, debris, and multiple dried water/fluid spots too numerous to count. The floor also appeared to have dirt and debris pushed into corners and along the wall. Staff and residents were also observed to use this hallway as a passthrough to and from the activities room and other resident rooms.Additional observations of the facility's rear common hallway floor were completed on 03/27/26 at 8:23 AM and revealed the floor to remain in the same condition as earlier in the week with multiple spots of dirt, debris, and water/fluid spots.An interview with the Housekeeping Director on 03/27/26 at 8:45 AM revealed she had staff working at the facility 7 days a week. She stated they were responsible for cleaning the common areas first and when that was completed, her staff would move to cleaning the residents' rooms. She reported common area cleaning included sweeping and mopping floors, dusting, and wiping down high touch areas. The Housekeeping Director indicated that Maintenance Staff Member #1 was typically responsible for buffing the floors but was assisting this week with mopping the common area hallways.A walk-through of the front and rear common hallway floors with the Housekeeping Director was started on 03/27/26 9:18 AM in conjunction with an interview. The Housekeeping Director reported the floors were a constant issue due to spills from residents and salt and debris from the winter.During the walkthrough with the Housekeeping Director, an observation was made of a staff member (Maintenance Staff Member #1) mopping parts of both the common area hallway floors on 03/27/26 from 9:20 AM through 9:25 AM. Maintenance Staff Member #1 was observed making his way down the hall with the wet mop, going over the dirty fluid/water spots. After the staff member mopped the area, the water/fluid spots remained. The spots were tested for fastness (how easily the spot could be removed) with the bottom of a shoe. It was observed that the water/fluid spots were easily removed by rubbing the sole of a shoe over them. An observation was made of dirt and debris in an alcove under a water fountain that was pushed against the wall. The Housekeeping Director indicated that water/fluid spots should not remain on the floors if easily removed with the bottom of a shoe. The Housekeeping Director reported that Maintenance Staff Member #1 had been responsible for mopping and cleaning of the front and rear common area hallways that week.An interview with the Maintenance Staff Member #1 on 03/27/26 at 9:22 AM revealed he worked in the maintenance department and normally would only buff the floors. He stated he had been responsible for mopping the floors that week as a favor for the Housekeeping Director. He indicated he had no knowledge of any complaints or concerns about the cleanliness of the floors. Maintenance Staff Member #1 also indicated he felt the floors were getting cleaned how he mopped and did not identify the reason the water/fluid spots remained in areas he had already mopped.During a follow-up interview with the (continued on next page)

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Housekeeping Director on 03/27/26 at 9:26 AM she indicated that while the floors had been mopped by the Maintenance Staff Member #1, they still appeared dirty in areas.A walkthrough of the facility with observations of the front and rear common hallway floors with the Director of Nursing on 03/27/26 at 9:35 AM conducted in conjunction with an interview, revealed she felt that the areas where the Maintenance Staff Member #1 had reportedly already mopped were not clean and indicated it did not appear as though there had been any effort into removing water/fluid spots or getting dirt and debris removed. The Director of Nursing reported she felt the floors throughout the facility were in an unacceptable condition with the amount of dirt, debris, and water/fluid spots. The Director of Nursing also reported she had voiced her concerns to the Administrator previously but did not know if it had been addressed.During an interview and walkthrough of the facility's front and rear common hallway floors with the Administrator on 03/27/26 at 10:09 AM, the Administrator revealed she was not happy with the condition of the floors throughout the entire facility. She verified that it was the responsibility of the Maintenance Staff Member #1 to keep the floors clean. She explained the floors throughout the facility had been stripped and waxed approximately 2 weeks prior but due to the salt from the winter, it broke down the wax quickly, and the floors needed to be rebuffed. She reported the floors in the facility definitely needed to be cleaner and reported it appeared to her as though more effort needed to be exercised into ensuring that dirt, debris, and fluid/water spots were removed when the floors were mopped.