

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER Kannapolis Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1810 Concord Lake Road Kannapolis, NC 28083	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews with family, staff, Nurse Practitioner, and Physician, the facility failed to provide the necessary supervision for a resident who was severely cognitively impaired, had difficulty swallowing, and was on a mechanical soft diet (foods that are naturally soft or altered [chopped, ground, mashed, or pureed] to require minimal chewing, making them safer and easier to swallow) with nectar thickened liquids (thickened consistency to slow the flow of the liquid to prevent choking and aspiration by allowing more time for the airway to close). Resident #103's family member, Family Member #1, was repeatedly observed by staff bringing the resident food items that were not consistent with his ordered diet and the facility failed to implement effective interventions to protect the resident from an avoidable accident. On 5/6/2025 Nurse #1 observed Family Member #1 bring the resident a burger, chicken nuggets, french fries, and sweet tea. Nurse #1 explained to Family Member #1 that Resident #103 was on a modified diet and should not eat the food brought in due to the risk of choking. Family Member #1 did not comply and they set the food up for the resident to eat in his room and left the facility at approximately 9:53 pm. Nurse #1 was aware Family Member #1 exited the facility, and she (Nurse #1) knowingly left the resident unsupervised with the food in front of him. Nurse #1 indicated she checked on the resident at 9:59 pm and then instructed Nurse Aide #3 to check on the resident. At approximately 10:14 pm when Nurse Aide #3 went to the resident's room to check on him, she observed Resident #103 with food in his mouth, a hamburger in his hand that was partially eaten and he was pale, unresponsive, and had a very faint pulse. Cardiopulmonary Resuscitation (CPR) was initiated and Emergency Medical Services (EMS) were called. Upon EMS arrival they continued CPR but resuscitation efforts were unsuccessful. Resident #103 was pronounced deceased at 11:20 pm. Additionally, the facility failed to provide incontinence care in a safe manner when a resident was rolled out of bed hitting the floor. The resident was on an air mattress that was raised to the highest position. The resident sustained a two-centimeter (cm) laceration to his left forehead and was transferred to the Emergency Department for treatment and returned to the facility the same shift. This was for 2 of 7 residents reviewed for supervision to prevent accidents (Resident #103 and Resident #53). Findings included: 1. Resident #103 was admitted to the facility on [DATE] diagnoses of difficulty swallowing, dementia, and stroke. Resident #103's face sheet indicated Family Member #1 was his emergency contact and Resident #103 was his own responsible party. Speech Therapy Notes for January 2025 revealed Resident #103 was treated by Speech Therapy for dysphagia (difficulty swallowing) and he was discharged from services on 1/28/2025 with a mechanical soft diet with thin liquids. Speech Therapy notes for March 2025 revealed services were initiated for Resident #103 on 3/27/2025 when he returned from the hospital on a regular diet with thin liquids. The Speech Therapist note for 3/27/2025 stated Resident #103's dietary order was changed to pureed with regular liquids due to pocketing (held food in his mouth) and choking during his initial evaluation. A Physician's Order dated 3/27/2025 indicated Resident #103 was a full code (desired resuscitative measure to be used if his breathing or heart stopped). Resident #103's quarterly Minimum Data Set assessment dated [DATE] (continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>indicated he was severely cognitively impaired, had no behaviors, required moderate assistance with eating, and he was on a mechanically altered and therapeutic diet. The assessment did not document any chewing or swallowing issues. On 4/4/2025 a Speech Therapy Discharge Summary written by the Speech Therapist stated Resident #103 was upgraded to a mechanical soft diet with regular liquids and specified regular consistency bread products and pureed fruit. A Physician's Order dated 4/4/2025 indicated Resident #103 should receive a mechanical soft diet with nectar thick liquids. The Physician's Order also indicated Resident #103 should have pureed fruit and no straws, and may have the following regular consistency foods: pancakes, muffins, biscuits, sliced bread, rolls, cake, cookies, crackers, coffee cake, pimento cheese, and peanut butter and jelly sandwiches. A progress note written by Director of Nursing (DON) #2 on 4/9/2025 at 10:53 pm indicated Resident #103's family brought water that was not nectar thick and regular consistency foods to Resident #103 and the family wanted staff to feed Resident #103 a regular diet. The note further stated it was explained to the family member (Family Member #1) that Resident #103 was seen by the Speech Therapist and it was not safe for him to eat a regular diet at this time because he was at risk of choking. A Physician's Order for a Speech Therapy evaluation and treatment dated 4/10/2025 stated Resident #103 should receive treatment for dysphagia to include diet modifications, safety and tolerance, laryngeal exercises (utilized to improve swallowing), and patient and caregiver education. The Speech Therapist's consultation notes indicated Resident #103 had a Bedside Swallow Exam on 4/10/2025 and required a mechanical soft diet with nectar thickened liquids. The swallowing exam on 4/10/2025 indicated Resident #103 had pocketing of food and coughing and choking with an increased diet texture. During a telephone interview with the Speech Therapist on 3/5/2026 at 12:00 pm she stated she evaluated Resident #103 on 4/10/2025 because nursing reported he was pocketing food and Family Member #1 had complained because she wanted him to receive a regular diet. She explained that when she attempted to upgrade the resident's diet he coughed and choked and she did not upgrade it. The Speech Therapist stated Resident #103 was on a mechanical soft diet with regular liquids and no straw in January 2025 and then his diet changed to a mechanical soft diet with nectar thick liquids, and at some point prior to May 2025 Resident #103's diet changed to mechanical soft with nectar thick liquids and no straws. The Speech Therapist stated Resident #103 could feed himself if he was given the consistency that was ordered for him. The Speech Therapist also stated Family Member #1 was noncompliant and would give Resident #103 a regular diet after she spoke with her regarding the risk of choking if Resident #103 did not follow his ordered diet. The Speech Therapist stated she was not aware of a waiver being signed for Resident #103 to eat a regular diet or any other interventions regarding Resident #103 receiving food from the family that was inconsistent with his dietary order. The Speech Therapist stated she notified Family Member #1 each time the diet order was changed. The Speech Therapist stated Resident #103 would not have understood the dangers of eating foods that were not prescribed for him. Resident #103's Physician Order for 4/24/2025 indicated Resident #103 should receive a mechanical soft diet with nectar thickened liquids consistency with no raw vegetables and pureed fruit and continue with no straw. On 4/29/2025 at 7:45 pm a Nurses' Progress Note written by Nurse #7 stated Resident #103 was discharged to the hospital due to altered mental status. A Hospital Discharge summary dated [DATE] at 1:15 pm stated Resident #103's diagnoses during his hospitalization were anemia due to gastrointestinal bleeding and there was no documentation of a diet order on the discharge summary from the hospital. On 5/6/2025 a Physician's Order stated Resident #103's diet was a mechanical soft diet with nectar thickened liquids. Resident #103's active care plan on readmission 5/6/2025 included a care plan for nutritional risk related to dementia and malnutrition that was initiated on 11/22/2024. This care plan indicated Resident #103's family brought in foods that were not conducive with his diet order despite education regarding choking hazards. The interventions, also initiated on 11/22/2024, included that the resident required supervision and assistance with meals; and for difficulty swallowing, choking, coughing, drooling, and holding food in his mouth to be reported. The (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>interventions did not specify who the signs of difficulty swallowing should be reported to. Resident #103's active care plan did not include any aggressive or combative behaviors. The only behavioral issue noted in the care plan was wandering. Unit Manager #2 was interviewed by phone on 3/5/2026 at 2:36 pm and stated she remembered having conversations with Family Member #1 on two occasions (she did not recall the dates) regarding the risk of Resident #103 choking if he ate food that was not on his prescribed diet. Unit Manager #2 explained that she had not observed Family Member #1 giving Resident #103 foods that he should not have; but Family Member #1 would come to her and complain that Resident #103 had not received a regular diet and that she had brought him regular food. Unit Manager #2 stated Family Member #1 was still insistent that Resident #103 could eat a regular diet. Unit Manager #2 stated Family Member #1 usually visited Resident #103 every other week. Unit Manager #2 stated she did not realize she had not written progress notes regarding her conversations with Resident #103's Family Member pertaining to the risk of choking if he ate foods that were not on his ordered diet. Unit Manager #2 stated Resident #103 would have been fine to eat the diet he was ordered (mechanical soft with nectar thick liquids) but he would have needed to be supervised if he was eating a regular diet since he would be at risk of choking. The Assistant Director of Nursing (ADON) was interviewed on 3/5/2026 at 11:27 am and stated the facility had several meetings with Resident #103's family member, Family Member #1, regarding the importance of following Resident #103's diet orders to prevent choking. The ADON stated she did not know why there were no progress notes regarding the meetings the facility had with Family Member #1. The ADON stated she was not aware of the facility obtaining a waiver to allow Resident #103 to eat foods that were not on his diet. The ADON stated Family Member #1 brought Resident #103 food that was not consistent with the resident's diet frequently. She further stated she had observed Family Member #1 bringing hard candy, beef stew, and cheese puffs on different occasions. The ADON stated when Family Member #1 brought in foods for Resident #103 that were not consistent with the resident's ordered diet she (the ADON) re-educated Family Member #1 on the risk of choking for Resident #103. Resident #103's medical record from 1/17/2025 through 5/6/2025 revealed no evidence of care plan meetings or other meetings (as referenced by the ADON in interview) held with Resident #103's Family Member related to education /interventions pertaining to the risk of choking if the resident ate foods that were not on his ordered diet. The only reference related to conversations with Family Member #1 during this time period (1/17/2025 through 5/6/2025) was in the 4/9/2025 note written by DON #2. A Nurse's Progress Note written by Nurse #1 on 5/7/2025 at 9:43 am stated Resident #103 refused his evening meal on 5/6/2025 and his family member (Family Member #1) brought him a burger, chicken nuggets, french fries, and a tea. Nurse #1 had tried to explain to Family Member #1 that Resident #103 was on a mechanical soft diet with nectar thick liquids and should not eat the meal Family Member #1 brought because of the risk of choking, but Family Member #1 insisted the resident could eat a regular diet. Family Member #1 gave the resident the foods she brought (hamburger, chicken nuggets, french fries, and a tea) and left Resident #103 sitting up in bed at 9:53 pm on 5/6/2025. Nurse #1 indicated she checked on Resident #103 after Family Member #1 left and asked Nurse Aide #3 to check on Resident #103; and at 10:14 pm Nurse Aide #3 found Resident #103 was pale, unresponsive, and had a very faint pulse. Nurse #1 immediately began CPR and she instructed Nurse Aide #3 to call for EMS. EMS arrived within a few minutes and continued CPR and Resident #103 was pronounced expired at 11:20 pm. Nurse Aide #3 was interviewed by phone on 3/4/2026 at 6:36 pm and she stated she was familiar with Resident #103 but she was not usually assigned to him. She indicated she was aware Family Member #1 would bring food in for the resident that was not consistent with Resident #103's diet. Nurse Aide #3 stated if she had observed Family Member #1 giving Resident #103 food that was not consistent with his diet she would notify the nurse assigned to him. Nurse Aide #3 stated she was not assigned to Resident #103 on the evening shift (3:00 pm to 11:00 pm) of 5/6/2025 but she was told by Nurse #1, at approximately 10:00 pm on 5/6/2025, to check on the resident because Family Member #1 gave him food that was not consistent with his mechanical soft diet with nectar thick (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>liquids. Nurse Aide #3 stated Nurse #1 instructed her to check on Resident #103 because Nurse #1 was taking a break. Nurse Aide #3 revealed she checked on Resident #103 shortly after 10:00 pm and found him pale and unresponsive. Nurse Aide #3 further revealed that Resident #103 had food in his mouth and a hamburger in his hand that was partially eaten, and he was sitting up in bed. Nurse Aide #3 stated she did not see any vomit, just food in Resident #103's mouth when she checked on him. Nurse Aide #3 stated she immediately called for Nurse #1, and the nurse came and assessed him and began CPR. Nurse Aide #3 stated Resident #103 was not breathing when she called for Nurse #1. During a telephone interview on 3/5/2026 at 11:42 am with Nurse #1 she stated on 5/6/2025 Resident #103 was readmitted to the facility from the hospital before her shift began at 3:00 pm and she was assigned to Resident #103 on the 3:00 pm to 11:00 pm shift on 5/6/2025. Nurse #1 stated she cared for Resident #103 frequently before he discharged to the hospital and returned on 5/6/2025. Nurse #1 stated Resident #3 would refuse his meal trays at time, and she would assist him with eating after the refusal and he would eat when assisted. Nurse #1 stated Family Member #1 had brought in food that was not consistent with the resident's mechanical soft diet with nectar thick liquids before the incident on 5/6/2025. Nurse #1 stated she would try to remove the food or drink and would tell Family Member #1 that Resident #103 was at risk of choking if she fed him a regular diet or fluids that were not thickened. She indicated when Resident #103 received his dinner tray on 5/6/2025, which included his mechanically soft diet with nectar thick liquids, he had refused his tray. Nurse #1 stated Family Member #1 arrived at 9:43 pm and she (Nurse #1) told Family Member #1 that Resident #103 had refused his dinner tray. Family Member #1 stated that Resident #103 did not need a mechanically soft diet and nectar thick liquids and she brought him a burger, chicken nuggets, french fries, and a tea with a straw. Nurse #1 stated she explained to Family Member #1 that Resident #103 was at risk of choking if Resident #103 ate a regular consistency meal and did not follow his ordered mechanically soft diet with nectar thick liquids; but Family Member #1 set the resident up with the food she brought. Nurse #1 stated Family Member #1 left the facility at 9:53 pm and she (Nurse #1) went to the resident's room at 9:59 pm and attempted to remove the food Family Member #1 brought. She explained that Resident #103 was adamant he wanted the food and she thought he would become combative if she took the food away. Nurse #1 stated she did not add thickener to the tea or remove the meal. Nurse #1 reported she left the room after she attempted to remove the food. Nurse #1 stated at 10:00 pm while she was on her way to break she asked Nurse Aide #3 to check on Resident #103 while she (Nurse #1) took a break. Nurse #1 stated Nurse Aide #3 went to check on Resident #103 at 10:14 pm and found him pale, unresponsive, and he had a very faint pulse. Nurse #1 indicated she called a code and moved Resident #103 to a mattress and back board on the floor (because he was on an air mattress), began CPR immediately, and sent Nurse Aide #3 to call for EMS. She stated EMS arrived and took over CPR for Resident #103, and he was pronounced dead at 11:20 pm on 5/6/2025. A follow up interview was conducted by phone with Nurse #1 on 3/17/2025 at 1:46 pm and she stated that DON #2 had instructed her to re-educate Resident #103's family on the danger of the resident choking if the family brought in food that was not consistent with Resident #103's ordered diet and to refer Family Member #1 to the Speech Therapist when she insisted he should have a regular diet. She was unable to specify when this instruction from DON #2 was received. Nurse #1 reported Family Member #1 would insist each time she came in (Nurse #1 did not remember any dates) that Resident #103 should be on a regular diet. She revealed she was not given any other interventions to implement for when Family Member #1 brought in foods that were not consistent with Resident #103's diet. Nurse #1 stated she did try to take the hamburger, chicken nuggets, french fries and tea (which had a straw) from Resident #103 on the evening of 5/6/2025 but he refused and she was afraid he would become combative if she attempted to take the food because he was holding onto the food and would not allow her to take it. An EMS Report dated 5/6/2025 indicated a call was received at 10:19 pm in response to a cardiac arrest and they arrived on scene at Resident #103 at 10:26 pm. Resident #103 was on a mattress on the floor with a back board under him, receiving CPR by Fire Department (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>personnel. It was reported that the resident was last seen between 10-15 minutes prior to the call to 911. It was also reported that Resident #103 was eating when he was last seen. Fire Department personnel found food near the resident. The report indicated that EMS believed the resident went into cardiac arrest after possibly choking on food. The resident was pale, not breathing, pulseless, and still warm to touch. Fire Department personnel were suctioning the resident's airway of vomit. EMS began treating the resident with CPR and the resident continued to vomit. EMS opted to secure the airway with Endotracheal Tube (placing a flexible tubing into the windpipe to ensure a clear, protected, and controlled passage for oxygen to reach the lungs) though it was difficult and took multiple attempts for success and constant suctioning was needed to remove large amounts of vomit from the resident's airway. After 45 minutes or more into the arrest, EMS consulted the physician and resuscitation efforts were discontinued. The resident's time of death was 11:20 pm. Multiple attempts were made to contact EMS for interview, but they were unable to be reached. A review of Resident #103's death certificate dated 5/6/2026 revealed his immediate cause of death was heart attack and his secondary causes of death were chronic anemia and dementia. During a phone interview with Family Member #1 on 3/18/2026 at 10:28 am she stated that on 5/6/2025 in the evening she went to see Resident #103 after he was readmitted from the hospital. She indicated she brought takeout food for the resident (a burger, french fries, and tea). She stated when she left the facility that evening the resident had 2 more bites of his cheeseburger left and she told Nurse #1 he was finishing his meal. Family Member #1 indicated Nurse #1 stated she would check on Resident #103. She stated that on that evening, she was not informed by staff that Resident #103 could not have a regular diet. She reported she spoke with EMS after Resident #103 passed away and they indicated the resident had vomited and they suctioned a small amount of hamburger from his esophagus (tube through which food passes from the throat to the stomach) and that he had vomited before they (EMS) arrived. Family Member #1 stated she had 2 care plan meetings during Resident #103's stay at the facility, the first one was on admission and the second was just before Easter 2025 (4/20/2025) and they discussed her (Family Member #1's) issues with the resident's care but no one had talked to her about his diet or the risk of choking with her related to foods she brought in for the resident. She indicated that Resident #103 had been on a regular diet in the hospital during his admission from 4/29/2025 through 5/6/2025, so she had assumed he was still on a regular diet and no one told her he was on a mechanical soft diet with thickened liquids. She stated she had a conversation with the DON #2 the day after Resident #103 died [DATE]) and the DON told her the resident should not have had a regular diet because the Speech Therapist had evaluated him and put him on a mechanical soft diet with thickened liquids. A phone interview was conducted with Family Member #2 on 3/18/2026 at 10:06 AM. She stated that the family just did not understand why Resident #103 could eat a regular diet in the hospital and then when he returned to the facility he would be placed back on a mechanical soft diet with thickened liquids. Family Member #2 stated the facility did not have any meetings with her where they discussed the dangers of feeding Resident #103 a regular diet. She revealed that she had brought Resident #103 food several times which included cheeseburgers, french fries, chicken sandwiches, and tea. Nurse Practitioner #1 was interviewed on 3/5/2026 at 10:45 am and she stated she did not recall having a conversation with Resident #103's family regarding his diet or that he should eat a mechanical soft diet with nectar thickened liquids. Nurse Practitioner #1 stated Resident #103 should not have been left alone, and staff should have supervised him when he was given food that was not consistent with his ordered diet as it put the resident at risk of choking. The Physician was interviewed on 3/5/2026 at 12:20 pm and stated he was not made aware Resident #103 received foods that were inconsistent with his dietary orders and had not spoken with Family Member #1 regarding Resident #103's diet. The Physician stated he should have been made aware of Family Member #1 bringing in foods that could have caused Resident #103 to choke. The Physician stated the facility should have provided supervision for Resident #103 when he was given a regular diet by Family Member #1 because he was at high risk for choking. The Physician stated Resident #103 (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>file for Resident #103. Administrator #1 stated she had also requested the care plan meeting notes for Resident #103 and there were no care plan notes that indicated the facility's Interdisciplinary Team met with Family Member #1 to discuss interventions regarding her bringing him food that was not consistent with his diet. The Administrator was notified of immediate jeopardy on 3/5/2026 at 4:15 pm. The facility provided the following corrective action plan: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 5/6/25, the facility failed to remove food and/or provide supervision when a severely cognitively impaired resident (Resident #103) readmitted to the facility with a history of dementia, stroke, and difficulty swallowing, was on a mechanical soft diet with nectar thickened liquids was provided a hamburger, chicken nuggets, French fries, and a sweet tea by his daughter. Resident #103's nurse made the resident's daughter aware during her visit, Resident #103 refused his dinner and spit out his medications. The daughter asked the nurse, is it that mashed food, he won't eat that referring to dinner. At 9:53pm prior to leaving, the family member communicated to the nurse she brought food for the resident and set the food up on his bedside table. The nurse informed the daughter Resident #103 couldn't have that food. When the nurse attempted to remove the food, Resident #103 refused for it to be taken away. After the nurses' failed attempt to remove the food, the nurse exited the room failing to provide supervision while Resident #103 consumed the food. At 9:59pm, the nurse checked on the resident and he did not appear to be choking or having difficulty swallowing the food. The nurse asked the NA to provide frequent checks on Resident #103. At 10:14pm, the NA made the nurse aware Resident #103 was exhibiting a change in his condition. Upon assessment, Resident #103 was found to be pale, unresponsive with a faint pulse. The Nurse assessed and there was no food present in Resident #103's mouth. Resident #103 was a full code and CPR was initiated. Emergency Medical Services (EMS) was called at 10:20pm, arriving at 10:23pm and took over the chest compressions and artificial ventilation efforts (CPR). Resuscitation efforts were unsuccessful, and Resident #103 was pronounced deceased at 11:20pm. The resident's daughter returned to the facility and was present during the code and pronouncement. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with modified diets to include mechanical soft, puree, and thickened liquids have the potential to be affected by the deficient practice. On 5/7/25 The Director of Nursing and the Assistant Director of Nursing conducted an audit of all current residents with modified diets to include mechanical soft, puree, and thickened liquids. Ten residents were identified to be on a pureed diet, twenty-two residents were identified to be on a mechanical soft diet, and five residents were on thickened liquids. The Director of Nursing and the Assistant Director of Nursing continued their audit of mechanically altered diets and thickened liquids to ensure tray tickets matched diet orders. No discrepancies were noted. On 5/7/25, the Director of Nursing and Assistant Director of Nursing interviewed staff to identify residents on mechanically altered diets and/or thickened liquids to ascertain residents consuming foods and/or liquids inconsistent with physician diet orders. No concerns were identified. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 5/7/25 The Director of Nursing and/or Assistant Director of Nursing began educating all nursing staff on the immediate removal of food/drink inconsistent with physician diet orders and notification to licensed nurses. Licensed nurses will educate residents and/or family on risks versus benefits at that time. On 5/7/25, the Director of Nursing educated the Director of Rehab (DOR) who communicates with their team after clinical meetings. During daily clinical meetings, new admits and/or physician orders of therapeutic diets are communicated and Social Worker, along with the IDT, is responsible for scheduling care plan meetings to review informed care decisions. During daily clinical meetings and review of progress notes, change of conditions and Situation Background Assessment Recommendation (SBAR), care plan meetings will be scheduled through the Social Worker with residents and/or family as needed to obtain informed care decision consents, as well as a referral to speech therapy. An interfacility communication form will be completed and provided to (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>the Director or Rehab (DOR) for speech referrals and the Certified Dietary Manager for physician diet [TRUNCATED]</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to discard expired multi-use medications on 1 of 2 medication carts reviewed (Medication Cart [DATE]) and failed to date multi-use medications upon opening, as required by manufacturer recommendations, on both medication carts reviewed (Medication Cart [DATE] and Medication Cart [DATE]). These failures have the potential to result in the administration of expired or improperly labeled medications. Findings included: 1) An inspection was conducted on [DATE] at 11:10 AM of Medication cart [DATE] in the presence of Med Aide #1. The observation revealed no opened date on the following multi-dose medications: -Two multi-dose bottles of neo-polymyxin B eye drop with no opened date (according to the manufacturer's directions, this medication must be discarded 28 days after opening). -One multi-dose bottle of tobramycin 0.03 % eye drops with no opened date (according to the manufacturer's directions, this medication must be discarded 28 days after opening). -One multi-dose bottle of latanoprost ophthalmic solution 0.005 % eye drops with no opened date (according to the manufacturer's directions, this medication must be discarded 42 days after opening). - Three insulin glargine dial-a-dose pens (according to the manufacturer's directions, this medication must be discarded 28 days after opening). -Two insulin lispro insulin dial-a-dose pens (according to the manufacturer's directions, this medication must be discarded 28 days after opening). -One insulin aspart dial-a-dose pen (according to the manufacturer's directions, this medication must be discarded 28 days after opening). -One insulin degludec dial-a-dose pen (according to the manufacturer's directions, this medication must be discarded 56 days after opening). An interview was conducted on [DATE] at 11:20 AM with Medication Aide (MA) #1. She confirmed all multi-use medications should be dated upon opening, and she discarded the undated items discovered during the inspection. MA #1 explained she did not handle the insulin as that would be the nurse's responsibility. She stated if any insulin had to be administered today Nurse #2 would be administering them. She explained she normally checked the dates on the eye drops but she had not checked them on the day of the interview. She went on to say she did not realize the bottles of eye drops were not labeled with an open date. An interview was conducted on [DATE] at 11:23 AM with the Assistant Director of Nursing (ADON). She explained medication aides and nurses were to always write the open date and the expiration date on multi dose insulin vials/pens and the opened date on eye drops. She stated she was unaware the staff were not marking the open dates and expiration dates on the medications. The ADON discarded the insulin that was not dated on Medication cart [DATE]. 2a) An inspection was conducted on [DATE] at 11:42 AM of Medication cart [DATE] in the presence of Med Aide #2. The observation revealed a multi-dose bottle of timolol eye drops with no open date (according to the manufacturer's directions, this medication must be discarded 28 days after opening). Med Aide #2 confirmed the medication should be dated upon opening and she discarded the bottle of eye drops. 2b) An inspection was conducted on [DATE] at 11:42 AM of Medication cart [DATE] in the presence of Med Aide #2. The observation revealed the following expired multi-dose medications: -One insulin glargine dial-a-dose pen opened [DATE] (according to the manufacturer's directions, this medication must be discarded 28 days after opening). -Two insulin lispro dial-a-dose pen, one with an open date of [DATE] and one with an open date of [DATE] (according to the manufacturer's directions, this medication must be discarded 28 days after opening). -Two bottles of neo-polymyxin eye drops opened on [DATE] and on [DATE] (according to the manufacturer's directions, this medication must be discarded 28 days after opening). -Tobram eye drops opened on [DATE] (according to the manufacturer's directions, this medication must be discarded 28 days after opening). -Four bottles of latanoprost eye drops opened [DATE], [DATE], [DATE], and the fourth bottle opened on [DATE] (continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>(according to the manufacturer's directions, this medication must be discarded 42 days after opening).On [DATE] at 11:40 AM an interview was conducted with Medication Aide (MA) #2. She stated she didn't realize the eye drops were expired and/or did not have an open date on them. She went on to explain it was hard to take the time to figure out if the medication was expired because she felt she was always running out of time and that it was an oversight. A follow-up interview was conducted on [DATE] at 11:51 AM with the Assistant Director of Nursing (ADON). The ADON explained medication aides and nurses were to always write the open date and the expiration date on multi dose insulin vials/pens and the opened date on eye drops. She stated she was unaware the staff were not doing labeling medications with the open date. The ADON discarded the insulins that were expired on Medication cart [DATE].A follow-up interview was conducted on [DATE] at 12:10 PM with Medication Aide (MA) #2. One of the Latanoprost eye drops had an open date for [DATE] written on the bottom of the bottle and [DATE] on the lid of the medication bottle. When asked why there were two dates on the bottle MA #2 stated she did not see the date written on the bottom of the bottle and she had written [DATE] on the lid. She further explained she did not recall who came to her this morning ([DATE]) but they told her, Everything in the medication cart should have a date on it. The MA explained she went through and wrote [DATE] on the medications which did not have a date on them.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with residents and staff, the facility did not maintain a resident bed in safe working condition for 1 of 1 resident room reviewed for a safe and homelike environment on 1 of 4 halls (Resident #58).An initial observation of Resident #58's room on 03/01/2026 at 1:58PM, revealed Resident #58 was in a semi-private room and positioned in the bed near the door. Observation revealed the head of the bed was elevated in an upright position and the bed was positioned above its lowest setting. At the time of observation, the bed was unplugged. Electrical wiring was observed hanging beneath the bed. Multiple internal wires (white, blue, red, and yellow) were visible along with a gold-colored exposed wire. The exposed wiring appeared damaged and was not properly secured to the bed frame. A review of the facility maintenance work order logbook dated 09/15/2025 through 03/01/2026 revealed no documentation of a work order submitted regarding Resident #58's bed.The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #58 was cognitively intact and dependent on staff assistance for transferring in and out of bed.On 03/01/2026 at 2:38 PM, Resident #58 who resided in room [ROOM NUMBER], was interviewed and stated her bed had not been functioning properly and reported the bed had not been working for several months. Resident #58 stated she reported her bed concerns to the Maintenance Director because she was unable to independently adjust or move the bed because the bed remote was not working. Resident #58 reported maintenance staff had come to look at the bed several times; however, she was unable to recall the specific dates. Resident #58 stated maintenance staff did not return after those visits, and the bed had not been repaired. Resident #58 further stated the bed remained partially elevated in a sitting position and caused back soreness and discomfort. Resident #58 reported the position was uncomfortable and made it difficult for her to remain asleep.On 03/02/2026 at 9:53 AM, an interview was conducted with Nurse Aide (NA) #1. NA #1 stated she typically provided care for Resident #58. NA #1 observed the resident's bed was in a high position and stated when care was not being provided the bed should be lowered to the near-lowest height. NA #1 stated Resident #58's bed appeared to be in the highest position. NA #1 also observed a frayed electrical cord and noted the bed was not plugged in. NA #1 reported the bed remote was missing the down button, preventing the bed from being lowered. NA #1 stated maintenance concerns were typically documented by staff in the maintenance logbook and reported she would notify the Maintenance Director. NA #1 stated she had not previously noticed the bed would not lower and reported Resident #58 had not voiced any concerns regarding the bed. NA #1 further stated Resident #58 preferred to remain in bed.On 03/02/2026 at 12:33 PM, an interview was conducted with a Housekeeper. The Housekeeper reported she typically cleaned Resident #58's room and she had not previously noticed concerns with Resident #58's bed. During the interview, the Housekeeper observed the bed remote appeared broken and the bed could not be lowered.On 03/02/2026 at 12:38 PM, an interview and observation were conducted with the Maintenance Director. The Maintenance Director stated he was not aware of any concerns regarding Resident #58's bed prior to 03/02/2026. The Maintenance Director inspected Resident #58's bed and observed exposed wiring beneath the bed. He stated the wiring appeared to have been pulled from the control box connected to the motor. The Maintenance Director further observed the bed was plugged in. The Maintenance Director examined the bed remote and observed one of the buttons was damaged and the internal wiring was exposed. He stated if someone attempted to press the button there was a potential risk of electrical shock. The Maintenance Director confirmed the bed could not be lowered and stated he would replace the bed himself. The Maintenance Director stated the facility had a system in place for reporting maintenance concerns. He reported staff were to document maintenance issues using the paper log located at the nurses' station. The Maintenance Director stated staff were expected to record repair concerns in the (continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>log for maintenance to review and address. On 03/04/2026 at 10:00 AM, an interview with the Administrator was conducted. The Administrator stated her expectation would be for staff to identify and report maintenance concerns promptly and ensure resident equipment was maintained in safe working conditions.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews with resident and staff, the facility failed to ensure a resident who was dependent on staff assistance for incontinence care (Resident #18) and for changing soiled clothing (Resident #87) received assistance when needed for 2 of 11 residents reviewed for activities of daily living (Residents #18 and #87). The findings included: 1. Resident #18 was admitted to the facility on [DATE] with diagnoses that included dementia. The resident's active care plan, last updated on 10/03/25, identified incontinence as a focus area. Interventions included cleansing the perineal area with each incontinence episode, monitoring and documenting intake and output per facility policy, and monitoring/documenting for signs and symptoms of urinary tract infection. Resident #18's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated his cognition was severely impaired and he did not refuse any care. Resident #18 was independent with bed mobility, he required supervision or touching assistance to walk 50 feet with two turns, and he required partial/moderate assistance with transfers. Resident #18 required substantial/maximal assistance to shower/bathe self, and personal hygiene, and he was dependent on staff for toileting hygiene. He was always incontinent with bowel and bladder. On 03/02/26, a continuous observation was conducted from 1:03 PM to 1:25 PM. During this period, Resident #18 was observed lying in bed on his left side with his eyes closed. He was wearing black, thin pants, and his brief was visibly exposed above the waistline. The bed sheet beneath him displayed a straw colored wet area extending approximately 10 inches around his lower body, with an additional yellowish brown dried border extending about 3 inches beyond the wet area. No nursing assistants were present or available on the hall at any point during the observation period. An interview was conducted on 03/02/26 at 2:01 PM with Nursing Assistant (NA) #6. She confirmed she was the direct care NA for Resident #18 and that she was accompanied by an orientee. NA #6 reported that she provided incontinence care to Resident #18 between 8:15 AM and 8:30 AM. She stated that she returned to check on him at 11:30 AM and noted that his brief was wet and required changing, at which time the resident refused care. She reported notifying Nurse #2 of the refusal. NA #6 stated that she did not return to Resident #18's room after the 11:30 AM check. She further stated she went to lunch at 1:30 PM and did not change the resident prior to leaving for lunch. When asked why, she replied, because I had to get food, I was starving. NA #6 also reported that she completes incontinence rounds every two hours and as needed. At the time of the interview she had not been back to Resident #18's room. An observation and interview were conducted on 03/02/26 at 2:14 PM with Nursing Assistant (NA) #7. He confirmed that he had been orienting with NA #6 throughout the day. NA #7 stated they provided incontinence care to Resident #18 at approximately 8:30 AM. He reported they entered the resident's room again prior to lunch, though he was unable to recall the exact time. According to NA #7, Resident #18 stated he was tired and requested that they return later to complete the change. NA #7 further stated that neither he nor NA #6 returned to Resident #18's room after that visit prior to lunch. He also reported that he was not aware of NA #6 notifying Nurse #2 that Resident #18 had refused incontinence care at any point during the day. During an observation and interview conducted on 03/02/26 at 1:30 PM, the Director of Nursing (DON) confirmed that Resident #18's clothing, brief, and bed linens were wet and that the resident required changing. She stated that her expectation was for staff to provide incontinent care before a resident's clothing or bedding becomes wet or soiled. The DON further indicated she was unaware that Resident #18 had not received the necessary incontinence care. An observation and interview were conducted on 03/02/26 at 1:40 PM with Nursing Assistant (NA) #5. NA #5 removed and confirmed that Resident #18's clothing, brief, and linens were wet with urine. Resident #87's skin was intact with no redness noted. She stated that although she was not assigned as Resident #18's direct care NA for the day, the Director of Nursing requested her assistance in changing the resident. An interview was conducted on 03/02/26 at approximately 4:05 PM with Nurse #2. She confirmed she (continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>was the direct care nurse for Resident #18 on this date. Nurse #2 stated that Nursing Assistant #6 did not notify her at any time on 03/02/26 that Resident #18 had refused incontinent care.2. Resident #87 was admitted to the facility on [DATE] with diagnoses that included intermittent explosive disorder (a mental health condition characterized by recurrent, impulsive, and intense outbursts of aggression or violence that are grossly disproportionate to the situation) and vascular dementia. Resident #87's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated his cognition was severely impaired and he exhibited no behaviors. He usually understood others and he had highly impaired hearing. Resident #87 required set-up/clean-up with eating and required supervision or touching with oral hygiene. He required partial/moderate assistance with personal hygiene and substantial/maximum assistance with dressing. Resident #87's active care plan, last revised on 02/28/26, included the focus area of an activity of daily living (ADL) self-care deficit. The interventions included for staff to assist with dressing and undressing and to assist him to choose simple comfortable clothing that enhances his ability to dress self. An observation was conducted on 03/01/26 at 11:43 AM of Resident #87 lying in bed wearing a plain blue long-sleeved shirt. The shirt contained dried food particles and dried white and tan-colored spill marks. Resident #87 was eating his lunch at the time of the observation and stated, I'm okay. An observation was conducted on 03/01/26 at 2:52 PM of Resident #87 lying on his bed wearing a long-sleeved shirt. The shirt had dried food particles and dried spill marks present. An observation was conducted on 03/02/26 at 10:00 AM of Resident #87 lying on his bed wearing the same soiled long-sleeved shirt observed the previous day. The shirt continued to have dried food particles and dried spill marks. When asked if he knew how long he had been wearing the shirt, Resident #87 stated, It's been 3 days; it needs to be changed. He was unsure whether he had asked anyone to change the soiled shirt. An observation and interview were conducted on 03/02/26 at 10:25 AM with Medication Aide (MA) #1. She accompanied this surveyor to Resident #87's room and confirmed that the resident's shirt was soiled with crumbs, dried and hardened food spots, and dried white-colored beverage spills. She further verified that this was the same soiled shirt Resident #87 had been wearing on 03/01/26. MA #1 stated she would notify the Nursing Assistant (NA) assigned to Resident #87 that his clothing needed to be changed. She also confirmed she was the direct care MA for Resident #87 on both 03/01/26 and 03/02/26. MA #1 reported that she assumed the assigned NA would have changed the resident's shirt during morning care or after lunch on 03/01/26. An interview was conducted on 03/02/26 at 1:50 PM with Nursing Assistant (NA) #5. NA #5 confirmed that she was the direct care NA for Resident #87 on this date. She stated she had not provided morning care to Resident #87 at the time Medication Aide (MA) #1 notified her, around 10:30 AM, that the resident's shirt was soiled and had been worn since the previous day. NA #5 reported that she then entered the room at that time and provided morning care to Resident #87. Unsuccessful attempts were made to interview the direct care Nursing Assistant assigned to Resident #87 on 03/01/26 for the 7:00 AM to 7:00 PM and the 7:00 PM to 7:00 AM shifts. An interview was conducted on 03/04/26 at 2:03 PM with the Director of Nursing (DON). The Director of Nursing stated that residents were expected to remain neat, clean, and dressed in clean garments, with their activities of daily living (ADL) needs met. She explained that staff were expected to change residents' clothing after meals if soiling occurs. She also reported she was not aware that Resident #87's ADL had not been met.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and resident and staff interviews, the facility failed to store a plastic syringe used for enteral water flushes (water flushes are essential to maintain gastrostomy/feeding tube patency, prevent clogging and support hydration), dry and with the plunger separated from the syringe and free from moisture for 1 of 2 residents reviewed for enteral feeding management (Resident #27). This practice had the potential for bacterial growth and contamination. Findings included: Resident #27 was admitted to the facility on [DATE] with diagnoses of muscle weakness, malnutrition, adult failure to thrive, gastrostomy status (indicates the presence of a gastrostomy tube/feeding tube, which is surgically placed to provide direct access to the stomach for nutrition and hydration when oral intake is insufficient or unsafe), and dysphagia. Review of admission Minimum Data Set (MDS) dated [DATE] revealed Resident #12 was cognitively intact and was coded for tube feeding. The MDS confirmed Resident #12's average fluid intake per day by IV fluids or tube feeding was 501 cc/day or more per day. Review of Resident #27's order dated 01/07/26 revealed the resident was ordered to receive water flush of 60 milliliters (ml) four times a day. During observation and interview with Resident #27 on 03/02/26 at 10:10 AM the syringe used for enteral water flushes was observed with the plunger in the syringe which was wet with clear condensation. The syringe was stored in a plastic bag on the bedside table dated 02/26/26. Resident #27 stated that around 9:00 AM that day Nurse #4 gave his ordered water flush and put the syringe back together and laid it on his bedside table. Resident #27 indicated nursing staff rarely left syringe apart to allow it to air dry. Review of Resident #12's Medication Administration Record (MAR) dated 03/02/26 revealed Nurse #4 had signed off Resident #12's morning flush at 9:00 AM. An interview with Nurse #4 on 03/02/26 at 10:15 AM revealed she was not aware the syringe required to be dried before placing the syringe back in the storage bag. Nurse #4 indicated she was aware the plastic syringe and plunger should be washed if residue was left in the syringe but was not aware the plunger should be separated to air dry to prevent any bacterial growth in the syringe. Nurse #4 confirmed she had given Resident #27's his water flush through his feeding tube earlier this shift on 03/02/26. An interview and observation on 03/03/26 at 9:40 AM revealed the Director of Nursing (DON) in Resident #27's room. The DON observed Resident #27's syringe at bedside which was wet with the plunger inside the syringe. The DON revealed the plastic syringe, and plunger should be washed and the plunger should be left out of the syringe to allow it to air dry to prevent any bacterial growth. The DON discarded the syringe and further revealed nurses had been educated on this protocol and all new hires had been educated during orientation. The DON revealed the facility's policy was that plastic syringes were to be discarded every 24 hours and for the plunger to be taken out of the plastic syringe after use to air dry. An interview with the Administrator on 03/04/26 at 9:30 AM stated Nurse #4 should have washed the plastic syringe and allowed them to dry completely to prevent any bacterial growth.</p>		

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NAME OF PROVIDER OR SUPPLIER Kannapolis Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1810 Concord Lake Road Kannapolis, NC 28083	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff and Medical Director interviews, the facility did not administer intravenous (IV) fluids (give fluids through a vein) according to physician orders for 1 of 2 residents reviewed for intravenous therapy (Resident #6).The findings included:Resident #6 was admitted to the facility on [DATE] with a diagnosis of chronic pain.The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #6 was cognitively intact.Resident #6 had a verbal order from the Medical Director that was received and transcribed by Unit Manager #2 on 2/27/26 at 8:52 AM and stated 0.9% sodium chloride intravenous solution was to be administered at 80 milliliters/hour (mL/hr.) for a total of 2 liters for dehydration. Review of Resident #6's medication administration record (MAR) for February 2026 included an order dated 2/27/26 for the administration of sodium chloride intravenous fluids to be infused at 80 mL/hr. for a total of 2 liters. The MAR included a confirmation space for each 8-hour shift (day, evening and night shift). A checkmark indicated administered, 2 indicated refused, and 9 indicated other/see nurses' notes. Review of the MAR for 2/27/26 revealed the evening and night shifts and were coded as administered. Review of the MAR for 2/28/26 revealed the day and evening shifts and were coded as administered. The 2/28/26 night shift was coded as other/see nurses notes. The MAR note created on 2/28/26 at 11:21 PM by Nurse #3 stated Resident #6 refused IV fluids for the night shift.Review of Resident #6's MAR for March 2026 included an order dated 2/27/26 for the administration of sodium chloride intravenous fluids to be infused at 80 mL/hr. for a total of 2 liters. The 3/1/26 MAR had Nurse #2's initials and a checkmark symbol for day and evening shifts indicating the IV fluids were administered. The 3/1/26 MAR had an entry by Nurse #3 at 7:44 AM that IV fluid D5NS infusing due to no sodium chloride 0.9% available. The 3/1/26 MAR entry for night shift was coded by Nurse #3 on 3/1/26 at 8:07 AM with a 9 and it stated IV D5 0.9 NS infusing at 80mL/hr.On 03/01/2026 at 3:42 PM, an observational interview of Resident #6 seated in her manual wheelchair revealed she had a saline lock (a small, flexible tube placed in the hand or arm vein that acted like a port for medicine and fluids) in her forearm. A one-liter bag of 5% dextrose (sugar) and 0.9% sodium chloride (D5NS) was connected by thin transparent tubing to the saline lock in Resident #6's forearm. The bag was labeled 3/1 and had no initials. Resident #6 had received approximately one half of the one-liter bag of IV fluids. Resident #6 reported that she was getting IV fluids because she was dehydrated and needed some more fluids. Resident #6 stated she didn't like to drink so the fluids were helping her. Resident #6 was unable to identify the type of fluids infusing and reported that she had been receiving IV fluids all day.During an interview on 3/2/26 at 10:44 AM, Nurse #2 stated she received report during the 3/1/26 morning shift at approximately 7:00 AM that Resident #6's IV fluids had completed infusing during the night and that a new bag had been hung just before shift change. Nurse #2 stated she did not complete the visual inspection of the IV fluid bag or tubing during her initial medication pass on 3/1/26 or at any time during the 3/1/26 day shift and therefore could not confirm which fluids had been given. She acknowledged she was required to visually confirm the fluid type, amount of fluid infused, and that the IV fluid's flow rate matched the provider's order but did not do it because she became distracted when passing medications for the units not go to check it afterward. She stated that the 0.9% sodium chloride fluid was usually available through the automated medication dispensing system. Nurse #2 stated she was aware that as a medication nurse, she was required to follow provider orders as written. She said she would begin the notification process with the provider regarding the IV fluid error. Attempts to conduct a telephone interview with Nurse #3 on 3/2/26 and on 3/3/26 to interview her regarding her two MAR entries on 3/1/26 that stated D5NS was infusing were unsuccessful. During an interview on 03/02/2026 at 2:15 PM, the Medical Director reported he was not yet informed that D5NS had been hanging for Resident #6 instead of the ordered sodium chloride IV solution. Medical Director stated he had no concerns (continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>about adverse outcomes from Resident #6 being administered the D5NS fluid. The Medical Director reported he was aware there had been a prior shortage of the IV fluid 0.9% sodium chloride and could not speculate as to why they did not administer the 0.9% sodium chloride fluids. The Medical Director stated he expected staff to notify the provider of any issues with medication administration. Medical Director stated he expected staff to notify the on-call provider when he or another facility provider was not on site. He added that IV fluids were given for dehydration and, because Resident #6 was not diabetic, he believed the liter of D5NS was not harmful. In an interview on 3/2/26 at 2:55 PM, the Director of Nursing (DON) stated she was not aware that Nurse #2 and Nurse #3 had administered the wrong IV fluids to Resident #6. She reported that staff were expected to administer IV fluids according to the provider's orders. The DON stated that Nurse #2 acknowledged she did not check the fluids and later realized she had infused the wrong solution. The DON said that Nurse #2 should have notified the provider that the 0.9% sodium chloride solution was not available for Resident #6 and monitored the resident for any adverse. The DON explained that staff used an automated medication distribution system that dispenses the ordered fluids for each resident and that staff were required to use pharmacy supplied fluids. The DON stated the pharmacy sent IV fluids with labels for the individual resident that included resident identifiers, name of what was in the bag of fluids, flow rate, and expirations date. She added that some stock fluids were also available in the automated medication dispensing system if needed. During a follow-up interview on 3/4/26 at 12:30 PM, the DON indicated she was not aware the nursing staff documented D5NS was used because the 0.9% sodium chloride solution was not available for Resident #6. She stated staff should have notified the pharmacy, which would have provided clarification on why the sodium chloride was unavailable.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and Nurse Practitioner (NP), resident, and staff interviews, the facility failed to obtain a physician's order for the use of continuous oxygen for 1 of 6 residents reviewed for respiratory care (Resident #16). The findings included: Resident #16 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD) and chronic respiratory failure on 3 liters of oxygen via nasal cannula. A quarterly Minimum Data Set assessment dated [DATE] indicated Resident #16 was cognitively intact and was coded with the use of oxygen. Resident #16's active care plan, last reviewed 12/31/25 included a focus area for COPD, at risk for respiratory distress. The interventions included oxygen via nasal cannula as ordered. An NP progress note dated 1/17/26 read that Resident #16 utilized 3 liters of oxygen continuously. A review of Resident #16's nursing progress notes from 9/11/25 to 2/28/26 revealed he was using oxygen continuously. A review of Resident #16's December 2025, January 2026, February 2026 and March 2026 Physician orders did not include an order for oxygen. In an observation, conducted in conjunction with an interview, on 3/1/26 at 11:30 AM, Resident #16 was lying in bed watching television. The meter on the oxygen concentrator showed oxygen was flowing at 2 liters via nasal cannula to the resident. Resident #16 stated he used oxygen continuously. Resident #16 did not present with any shortness of breath or distress during the interview and observation and was able to carry on a conversation. Resident #16 was observed lying in bed watching television on 3/2/26 at 12:32 PM. The meter on the oxygen concentrator showed oxygen was flowing at 2 liters via nasal cannula to the resident. Resident #16 was not short of breath during the observation. On 3/3/26 at 9:16 AM, Resident #16 was observed with the meter on the oxygen concentrator showing the oxygen was flowing at 2 liters via nasal cannula to the resident. Resident #16 was not short of breath during the observation. On 3/3/26 at 12:00 PM, an interview occurred with Medication Aide (MA) #1 who had been assigned to care for Resident #16 frequently. She confirmed Resident #16 utilized oxygen continuously and stated that she recalled he had used 2 liters of oxygen in the past and thought that's what he still used. The MA verified there was no order in the resident's medical record for the continuous use of oxygen but could not explain why one wasn't present. In an interview on 3/3/26 at 2:48 PM, the Assistant Director of Nursing (ADON) stated Resident #16 required continuous oxygen for his COPD. The ADON verified there was no order for the continuous use of oxygen in the resident's medical record and stated there should have been an order written for it. She felt it had been dropped off the order list at some time but was unable to definitively say when. The ADON stated she would contact the provider and ensure Resident #16 had an order for the prescribed amount of oxygen. A phone interview occurred with NP #2 on 3/3/26 at 4:50 PM. The NP explained that when she last assessed Resident #16 on 1/17/26, she had made no changes to his plan of care, which included the use of oxygen at 3 liters continuously. She stated she would expect the facility to have an order for Resident #16's use of oxygen at 3 liters via nasal cannula continuously.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and physician, resident and staff interviews, the facility failed to administer insulin in accordance with the physician's orders for 13 out of 30 days in June 2025 for 1 of 3 residents reviewed for significant medication error (Resident #33). The findings included: Resident #33 was originally admitted to the facility on [DATE] with diagnoses that included diabetes type 2. An annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #33 was cognitively intact and received seven days of insulin injections during the seven-day look back period. Resident #33's care plan, last reviewed on 6/10/25 included a focus area for diabetes. The interventions included providing diabetic medication as ordered by the physician. A review of Resident #33's physician orders included the following: An order dated 5/27/25 for Humalog insulin. Inject 12 units subcutaneously (SQ) three times a day. An order dated 6/3/25 for Humalog Kwikpen. Inject per sliding scale before meals and at bedtime. The sliding scale was as follows: If fasting blood sugar is 0-250= 0 units. Notify physician if less than 70. 251-300= 6 units301-350= 8 units351-400= 10 units401-450= 12 unitsGreater than 450 give 15 units and recheck in 2 hours. Notify physician for continued result greater than 450. An order dated 6/17/25 for Lantus Solostar insulin. Inject 38 units SQ daily. A review of the June 2025 Medication Administration Record (MAR) revealed the following insulin was not signed off as given or refused by Resident #33: Humalog insulin. Inject 12 units SQ three times a day. Missing documentation for 6/2/25 at 5:00 PM, 6/6/25 at 11:00 AM, 6/8/25 at 5:00 PM, 6/13/25 at 5:00 PM, 6/16/25 at 5:00 PM, 6/17/25 at 5:00 PM, 6/19/25 at 11:00 AM, 6/20/25 at 5:00 PM, 6/25/25 at 11:00 AM, 6/26/25 at 5:00 PM, 6/28/25 at 6:00 AM and 11:00 AM, and 6/29/25 at 11:00 AM and 5:00 PM. Lantus Solostar insulin. Inject 38 units SQ daily at 9:00 AM. Missing documentation for 6/19/25, 6/25/25, 6/28/25 and 6/29/25. Humalog Kwikpen. Inject per sliding scale before meals and at bedtime. Missing documentation for 6/6/25 at 11:00 AM, 6/8/25 at 4:00 PM, 6/13/25 at 4:00 PM, 6/14/25 at 9:00 PM, 6/16/25 at 4:00 PM, 6/19/25 at 11:00 AM, 6/20/25 at 4:00 PM and 9:00 PM, 6/25/25 at 11:00 AM, 6/26/25 at 4:00 PM, 6/28/25 at 6:00 AM and 11:00 AM and 6/29/25 at 11:00 AM. A quarterly MDS assessment dated [DATE] indicated Resident #33 was cognitively intact and received six days of insulin injections during the seven-day look back period. Resident #33's active care plan, last reviewed 1/21/26, included a focus area for diabetes. The interventions included providing diabetic medications as ordered by the physician. An interview with Resident #33 was conducted on 3/1/26 at 11:57 AM. She recalled asking nursing staff about receiving her insulin injections in June 2025 but could not remember the specific dates or frequency. She stated that having to ask about her insulin occurred frequently and that she was always told that someone would give her the insulin injection. On 3/3/26 at 10:13 AM, an interview occurred with Medication Aide (MA) #1 who was assigned to care for Resident #33 on 6/6/25 for the 7:00 AM to 3:00 PM shift, 6/13/25 for the 3:00 PM to 11:00 PM shift, 6/19/25 for the 7:00 AM to 3:00 PM shift, 6/20/25 for the 3:00 PM to 11:00 PM shift, 6/25/25 for the 7:00 AM to 3:00 PM shift, 6/28/25 for the 7:00 AM to 3:00 PM shift and 6/29/25 for the 7:00 AM to 3:00 PM shift. She explained that an MA was not allowed to administer insulin and that one of the nurses would have done this for any resident requiring insulin, to include Resident #33. She indicated that she would have to ask a nurse to provide the insulin when it was due to be given. MA #1 indicated that the nurse would be either the floor nurse, the Assistant Director of Nursing (ADON) or the MDS nurse and that there was not a nurse assigned to administer insulin. MA #1 reviewed the June 2025 MAR and verified that the referenced dates were blank and did not indicate if the insulin was provided or refused by Resident #33. She was unable to recall which nurse would have administered the insulin as ordered to Resident #33. A phone interview occurred with MA #12 on 3/5/26 at 2:50 PM. He was assigned to care for Resident #33 on 6/8/25 for the 3:00 PM to 11:00 PM shift. MA #12 stated that as an MA he could not administer insulin injections and would have to ask a nurse to provide the insulin when it was due to be given. He was unable to recall (continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>which nurse would have administered Resident #33's insulin on the evening of 6/8/25. A phone interview was conducted with MA #9 on 3/4/26 at 11:54 AM, who explained that as an MA she could not administer insulin injections and would have to ask a nurse to provide the insulin when it was due to be given. She indicated that a nurse would administer Resident #33's insulin. The MAR was reviewed with MA #9 for missing insulin documentation on 6/14/25 at 9:00 PM. She was unable to recall which nurse would have administered Resident #33 with her insulin. On 3/4/26 at 11:58 AM, a phone interview occurred with MA #10, who explained that as an MA she was unable to administer insulin injections and would have to locate a nurse to provide the insulin when it was due to be administered. She indicated that either the floor nurse, unit manager or ADON would have provided insulin injections to Resident #33. MA #10 was assigned to Resident #33 on 6/2/25, 6/16/25, 6/17/25 and 6/29/25 for the 3:00 PM to 11:00 PM shift. She was unable to recall which nurse administered insulin injections to Resident #33 during the referenced dates. The ADON was interviewed on 3/3/26 at 4:18 PM and explained that when an MA was working on the medication cart, a nurse would come and administer insulin as needed for the residents. She indicated it would be whoever was available and there was no designated nurse responsible for insulin injections on any given shift. The ADON reviewed Resident #33's June 2025 MAR and verified the referenced dates were blank and did not indicate if the insulin was provided or refused by Resident #33. She was unable to state who would have administered the insulin injections. An interview was conducted with MDS Nurse #2 on 3/4/26 at 9:58 AM. She stated that she had been the Unit Manager for the area that Resident #33 resided in June 2025. She explained that an MA would not have been able to administer insulin injections and that it would have been either the floor nurse, ADON, unit manager or MDS nurse, but there was not a designated staff member to provide insulin injections. MDS Nurse #2 reviewed Resident #33's June 2025 MAR and verified there were multiple blank areas for Resident #33's insulin injections that did not indicate if the insulin was provided or refused by Resident #33. MDS #2 stated she couldn't recall if she had administered insulin to Resident #33 on the referenced dates in June 2025. A phone interview was completed with Nurse #5 on 3/4/26 at 11:47 AM. She stated that MAs were not allowed to administer insulin and that either she would assist with insulin injections when she worked at the facility, as well as the ADON, unit manager, or any nurse that was available. She was assigned as the floor nurse in the area that Resident #33 resided on 6/19/25, 6/25/25, 6/28/25 and 6/29/25 for the 7:00 AM to 3:00 PM shift. The dates were reviewed with Nurse #5, but she could not recall if she administered insulin to Resident #33 or another nurse. The Physician was interviewed on 3/4/26 at 12:42 PM and stated that he would expect nursing staff to document when insulin was provided as ordered. He reviewed Resident #33's medical record and indicated there was no ill effects if she had not received insulin on the referenced dates and that her accuchecks remained at her baseline. The Director of Nursing was interviewed on 3/4/26 at 1:28 PM. She indicated she had begun employment at the facility early part of February 2026. She stated that MAs were expected to request a nurse to provide the insulin when it was due. She indicated that it would be expected for nursing staff to document when insulin was provided or refused by any resident.</p>		

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<p>F 0628</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews with Responsible Party (RP), residents, and staff, the facility failed to provide the resident and RP with a written notice of transfer including the reason for the hospital transfer for 4 of 4 residents reviewed for hospitalization (Residents #33, #53, #69 and #31). The findings included:</p> <p>1) Resident #33 was admitted to the facility on [DATE].</p> <p>Review of the medical record revealed a family member was listed as Resident #33's RP.</p> <p>Resident #33 was transferred to the hospital on 5/20/25 for shortness of breath, 9/9/25 for shortness of breath, 11/16/25 for nausea and vomiting, 11/27/25 for abdominal pain and 12/26/25 for abdominal pain. Resident #33 was readmitted to the facility after each hospitalization. There was no documentation that a written notice of transfer was provided to the RP and resident, for each of the dates the resident was transferred to the hospital, including the reason for the transfers.</p> <p>A quarterly Minimum Data Set assessment dated [DATE] indicated Resident #33 was cognitively intact.</p> <p>A phone interview was completed with Resident #33's RP on 3/2/26 at 5:05 PM. She stated she was always informed by phone when Resident #33 was transferred to the hospital but had not received anything in writing from the facility.</p> <p>On 3/3/26 at 2:34 PM, an interview was conducted with Unit Manager #1, who stated when a resident was transferred to the hospital, a copy of the face sheet, medication list, any Do Not Resuscitate information, other pertinent information and the Bed Hold policy was sent with them. The RP was notified by phone of the change and reason for the hospital transfer. The Unit Manager did not know who was responsible for the written notice of transfer when a resident was transferred to the hospital.</p> <p>Social Worker #1 was interviewed on 3/3/26 at 2:40 PM and explained that she had worked at the facility for approximately three weeks but was not working at the facility from May 2025 to December 2025. Social Worker #1 was unable to explain why a written notice of transfer including the reason for the hospital transfer was not sent to the RP when Resident #33 was transferred to the hospital. Social Worker #1 stated she was unaware of a written notice of transfer including the reason for the hospital transfer was required when a resident was transferred to the hospital.</p> <p>An interview occurred via phone on 3/4/26 at 11:04 AM, with the former Social Worker #2 who stated that she worked at the facility for about seven months and her last day there was 2/5/26. She stated she was not working at the facility in May 2025. Social Worker #2 stated that she was unaware a written notice of transfer including the reason for the hospital transfer was required when a resident was transferred to the hospital and had not been informed to provide this document for Resident #33's transfers to the hospital on 9/9/25, 11/16/25, 11/27/25 or 12/26/25.</p> <p>The Administrator was interviewed on 3/3/26 at 2:53 PM and stated she had been employed at the facility since 11/21/25. She stated she was not aware a written notification was required to the (continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>resident and/or RP when a resident was transferred to the hospital.</p> <p>2) Resident #53 was admitted to the facility on [DATE].</p> <p>Review of the medical record revealed a family member was listed as Resident #53's RP.</p> <p>Resident #53 was transferred to the hospital on 7/30/25 following a fall, 1/4/26 for altered mental status and 2/18/26 for altered mental status. Resident #53 was readmitted to the facility after each hospitalization. There was no documentation that a written notice of transfer was provided to the resident and RP, for each of the dates the resident was transferred to the hospital, including the reason for the transfers.</p> <p>A quarterly Minimum Data Set assessment dated [DATE] indicated Resident #53 had moderately impaired cognitive skills for daily decision making.</p> <p>Attempts to interview Resident #53's RP were unsuccessful.</p> <p>On 3/3/26 at 2:34 PM, an interview was conducted with Unit Manager #1, who stated when a resident was transferred to the hospital, a copy of the face sheet, medication list, any Do Not Resuscitate information, other pertinent information and the Bed Hold policy was sent with them. The RP was notified by phone of the change and reason for the hospital transfer. The Unit Manager did not know who was responsible for the written notice of transfer when a resident was transferred to the hospital.</p> <p>Social Worker #1 was interviewed on 3/3/26 at 2:40 PM and explained that she had worked at the facility for approximately three weeks but was not working at the facility from July 2025 to January 2026. Social Worker #1 was unable to explain why a written notice of transfer including the reason for the hospital transfer was not sent to the RP when Resident #53 was transferred to the hospital, prior to her employment. Social Worker #1 stated she was unaware of a written notice of transfer including the reason for the hospital transfer was required when a resident was transferred to the hospital, therefore one was not provided to Resident #53's RP on 2/18/26.</p> <p>An interview occurred via phone on 3/4/26 at 11:04 AM, with the former Social Worker #2 who stated that she worked at the facility for about seven months and her last day there was 2/5/26. Social Worker #2 stated that she was unaware of a written notice of transfer including the reason for the hospital transfer was required when a resident was transferred to the hospital and had not been informed to provide this document for Resident #53's transfers to the hospital on 7/30/25, or 1/4/26.</p> <p>The Administrator was interviewed on 3/3/26 at 2:53 PM and stated she had been employed at the facility since 11/21/25. She stated she was not aware a written notification was required to the resident and/or RP when a resident was transferred to the hospital.</p> <p>3) Resident #69 was admitted to the facility on [DATE].</p> <p>Review of the medical record revealed a family member was listed as Resident #69's RP.</p> <p>Resident #69 was transferred to the hospital on [DATE] for shortness of breath. Resident #69 was readmitted to the facility after the hospitalization. There was no documentation that a written notice of transfer was provided to the RP and resident, including the reason for the transfer.</p> <p>(continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0628</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>A quarterly Minimum Data Set assessment dated [DATE] indicated Resident #69 had moderately impaired cognition.</p> <p>A phone interview was completed with Resident #69's RP on 3/1/26 at 5:52 PM. She stated she had been informed by phone when Resident #69 was transferred to the hospital but had not received anything in writing from the facility.</p> <p>On 3/3/26 at 2:34 PM, an interview was conducted with Unit Manager #1, who stated when a resident was transferred to the hospital, a copy of the face sheet, medication list, any Do Not Resuscitate information, other pertinent information and the Bed Hold policy was sent with them. The RP was notified by phone of the change and reason for the hospital transfer. The Unit Manager did not know who was responsible for the written notice of transfer when a resident was transferred to the hospital.</p> <p>Social Worker #1 was interviewed on 3/3/26 at 2:40 PM and explained that she had worked at the facility for approximately three weeks but was not working at the facility in December 2025. Social Worker #1 was unable to explain why a written notice of transfer including the reason for the hospital transfer was not sent to the RP when Resident #69 was transferred to the hospital. Social Worker #1 stated she was unaware of a written notice of transfer including the reason for the hospital transfer was required when a resident was transferred to the hospital.</p> <p>An interview occurred via phone on 3/4/26 at 11:04 AM, with the former Social Worker #2 who stated that she worked at the facility for about seven months and her last day there was 2/5/26. Social Worker #2 stated that she was unaware of a written notice of transfer including the reason for the hospital transfer was required when a resident was transferred to the hospital and had not been informed to provide this document for Resident #69's transfer to the hospital on [DATE].</p> <p>The Administrator was interviewed on 3/3/26 at 2:53 PM and stated she had been employed at the facility since 11/21/25. She stated she was not aware a written notification was required to the resident and/or RP when a resident was transferred to the hospital.</p> <p>4. Resident #31 was admitted to the facility on [DATE].</p> <p>Review of the medical record revealed Resident #31 was listed as her own Responsible Party (RP).</p> <p>Resident #31 was transferred to the hospital on [DATE] with complaints of shortness of breath and low oxygen saturation. Following the hospitalization, Resident #31 was readmitted to the facility.</p> <p>Review of the medical record revealed no documentation that a written notice of transfer, including the reason for the transfer, was provided to Resident #31 and/or her emergency contact.</p> <p>An annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #31's cognition was intact.</p> <p>Resident #31 was hospitalized and was not available for an interview during the survey time.</p> <p>Attempts to interview Resident #31's emergency contact were unsuccessful.</p> <p>On 03/03/26 at 2:34 PM, an interview was conducted with Unit Manager #1 who explained when a (continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>resident was transferred to the hospital, a copy of the face sheet, medication list, any Do Not Resuscitate information, the Bed Hold policy and other pertinent information and was sent with them. The RP was notified by phone of the change and reason for the hospital transfer. Unit Manager #1 did not know who was responsible for the written notice of transfer when a resident was transferred to the hospital.</p> <p>An interview occurred via phone on 03/04/26 at 11:04 AM, with former Social Worker #2 who stated that she worked at the facility for about seven months and her last day there was 02/05/26. Social Worker #2 stated that she was unaware a written notice of transfer including the reason for the hospital transfer was required when a resident was transferred to the hospital and had not been informed to provide this document for Resident #31's transfer to the hospital on [DATE].</p> <p>The Administrator was interviewed on 03/03/26 at 2:53 PM and stated she had been employed at the facility since 11/21/25. She stated she was not aware that a written notification was required to be given to the resident and/or RP when a resident was transferred to the hospital.</p>

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>Based on record review, observations, and staff interviews, the facility failed to post the daily nurse staffing sheet daily for 1 out of 5 days observed (3/1/26). The facility also failed to post accurate daily staffing information as compared to the daily staffing schedules for licensed and unlicensed nursing staff for 22 out of 28 days reviewed (2/1/26, 2/2/26, 2/3/26, 2/4/26, 2/5/26, 2/6/26, 2/7/26, 2/9/26, 2/10/26, 2/11/26, 2/12/26, 2/13/26, 2/14/26, 2/15/26, 2/18/26, 2/19/26, 2/20/26, 2/24/26, 2/25/26, 2/26/26, 2/27/26, and 2/28/26). The findings included: 1) The posted daily nursing staffing sheet was observed outside the Director of Nursing's (DON) office door on 3/1/26 at 10:40 AM and was dated 2/17/26. The DON was interviewed on 3/2/26 at 1:10 PM and stated that she had been at the facility since 2/5/26 and was managing the schedule and daily posted nursing staffing sheets. The DON reported that she had failed to update the daily posted nurse staffing sheets, which was why the sheet dated 2/17/26 remained posted. 2) A review of the facility's daily posting for nursing staff for the past 28 days (2/1/26 to 2/28/26) as compared to the daily staffing schedule included an inaccurate total of nursing staff worked, which included the following: a. The nursing schedule for 2/1/26 indicated that 5 Nurse Aides (NAs) worked from 7:00 AM to 3:00 PM and 9 NAs worked from 3:00 PM to 11:00 PM. The daily posted nurse staffing sheet for 2/1/26 documented that 6 NAs worked from 7:00 AM to 3:00 PM and 7 NAs worked from 3:00 PM to 11:00 PM. b. The nursing schedule for 2/2/26 indicated that 11 NAs worked 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/2/26 documented that 9 NAs worked 7:00 AM to 3:00 PM. c. The nursing schedule for 2/3/26 indicated that 12 NAs worked 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/3/26 documented that 10 NAs worked from 7:00 AM to 3:00 PM. d. The nursing schedule for 2/4/26 indicated that 10 NAs worked 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/4/26 documented that 9 NAs worked 7:00 AM to 3:00 PM. e. The nursing schedule for 2/5/26 indicated that 12 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/5/26 documented that 10 NAs worked 7:00 AM to 3:00 PM. f. The nursing schedule for 2/6/26 indicated that 9 NAs worked 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/6/26 documented that 8 NAs worked 7:00 AM to 3:00 PM. g. The nursing schedule for 2/7/26 indicated that 8 NAs worked 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/7/26 documented that 6 NAs worked 7:00 AM to 3:00 PM. h. The nursing schedule for 2/9/26 indicated that 10 NAs worked from 7:00 AM to 3:00 PM and 3 Licensed Practical Nurses (LPNs) worked 3:00 PM to 11:00 PM. The daily posted nurse staffing sheet for 2/9/26 documented that 9 NAs worked 7:00 AM to 3:00 PM and 4 LPNs worked 3:00 PM to 11:00 PM. i. The nursing schedule for 2/10/26 indicated that 11 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/10/26 documented that 9 NAs worked 7:00 AM to 3:00 PM. j. The nursing schedule for 2/11/26 indicated that 9 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/11/26 documented that 8 NAs worked 7:00 AM to 3:00 PM. k. The nursing schedule for 2/12/26 indicated that 9 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/12/26 documented that 7 NAs worked 7:00 AM to 3:00 PM. l. The nursing schedule for 2/13/26 indicated that 11 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/13/26 documented that 7 NAs worked 7:00 AM to 3:00 PM. m. The nursing schedule for 2/14/26 indicated that 9 NAs worked from 7:00 AM to 3:00 PM and 8 NAs worked 3:00 PM to 11:00 PM. The daily posted nurse staffing sheet for 2/14/26 documented that 8 NAs worked 7:00 AM to 3:00 PM and 6 NAs worked from 3:00 PM to 11:00 PM. n. The nursing schedule for 2/15/26 indicated that 8 NAs worked from 7:00 AM to 3:00 PM and 9 NAs worked 3:00 PM to 11:00 PM. The daily posted nurse staffing sheet for 2/15/26 documented that 7 NAs worked 7:00 AM to 3:00 PM and 8 NAs worked from 3:00 PM to 11:00 PM. o. The nursing schedule for 2/18/26 indicated that 11 NAs worked from 7:00 AM to 3:00 PM and 2 Registered Nurses (RNs) worked from 3:00 PM to 11:00 PM. The daily posted nurse staffing sheet for 2/18/26 documented that 9 NAs worked from 7:00 AM to 3:00 PM and 1 RN worked (continued on next page)</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>from 3:00 PM to 11:00 PM. p. The nursing schedule for 2/19/26 indicated that 10 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/19/26 documented that 9 NAs worked from 7:00 AM to 3:00 PM. q. The nursing schedule for 2/20/26 indicated that 4 LPNs and 9 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/20/26 documented that 3 LPNs and 8 NAs worked 7:00 AM to 3:00 PM. r. The nursing schedule for 2/24/26 indicated that 11 NAs worked from 7:00 AM to 3:00 PM, 2 LPNs worked 3:00 PM to 11:00 PM and 7 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 2/24/26 documented that 9 NAs worked 7:00 AM to 3:00 PM, 1 LPN worked 3:00 PM to 11:00 PM and 6 NAs worked 11:00 PM to 7:00 AM. s. The nursing schedule for 2/25/26 indicated that 11 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/25/26 documented that 9 NAs worked 7:00 AM to 3:00 PM. t. The nursing schedule for 2/26/26 indicated that 10 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/26/26 documented that 9 NAs worked 7:00 AM to 3:00 PM. u. The nursing schedule for 2/27/26 indicated that 14 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/27/26 documented that 12 NAs worked 7:00 AM to 3:00 PM. v. The nursing schedule for 2/28/26 indicated that 3 LPNs and 10 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/28/26 documented that 2 LPNs and 9 NAs worked 7:00 AM to 3:00 PM. On 3/4/26 at 9:35 AM, an interview occurred with the Director of Nursing who stated that she was managing the staffing schedule and daily postings. She was able to review the staffing schedules and daily postings and verified the number of staff working from 2/1/26 to 2/28/26 did not match. She stated that she had failed to count the Medication Aides (MAs) and Restorative Nurse Aides in the total number of NAs working, as well as had not updated the daily posted nurse staffing sheet when a staff member came in to cover a need. The Administrator was interviewed on 3/4/26 at 1:28 PM and stated that the daily staff schedule posting and the staffing schedule should match the number of staff worked on any given shift.</p>		

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<p>F 0585</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and Resident Representative (RR), resident and staff interviews, the facility failed to indicate if grievances had been resolved, how the results were communicated to the complainant, when the results of the grievances had been provided to the complainant and also failed to provide a written grievance response summary for 3 of 3 residents reviewed for grievances (Residents #52, #69 and #39). The findings included:</p> <p>A review of the facility grievance policy, dated 11/14/25, included, in part, In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum:</p> <p>The date the grievance was received.</p> <p>The steps taken to investigate the grievance.</p> <p>A summary of the pertinent findings or conclusions regarding the residents' concern(s).</p> <p>A statement as to whether the grievance was confirmed or not confirmed.</p> <p>Any corrective action taken or to be taken by the facility as a result of the grievance.</p> <p>The date the written decision was issued.</p> <p>1) Resident #52 was admitted to the facility on [DATE].</p> <p>An annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #52 was cognitively intact.</p> <p>A review of the facility's grievance logs from April 2025 to February 28, 2026, revealed a grievance report had been initiated on 1/21/26 by Resident #52, regarding a desire to have the change left over from a shopping trip deposited back into his resident funds. Review of the grievance form revealed it did not indicate if the grievance had been resolved, how the results of the investigation were communicated to the complainant, when the results were communicated to the complainant and no indication that a written summary was provided.</p> <p>An interview occurred with Resident #52 on 3/4/26 at 9:50 AM who had filed the grievance form on 1/21/26. He stated he couldn't recall if anyone discussed the resolution with him and stated that he had never received nor been offered a written resolution of the grievance from the facility</p> <p>The Business Office Manager was interviewed on 3/4/26 at 10:10 AM and stated that Resident #52's funds were deposited back into his account. She stated that she had spoken with Resident #52 to let him know the money had been deposited but didn't provide anything for him in writing.</p> <p>A phone interview was conducted with Social Worker #2 on 3/4/26 at 11:04 AM. She reported that she had been employed at the facility for approximately seven months and that her last day was 2/5/26. (continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>She stated she maintained the grievance logs and provided resolutions by phone or in person when they had not already been addressed by other management staff. She added that she had not been issuing written grievance resolutions because she was unaware this was required. Social Worker #2 could not recall if she had spoken with Resident #52 or if someone else did.</p> <p>The Administrator was interviewed on 3/3/26 at 3:10 PM and stated that she felt the grievance for Resident #52 had been resolved. She added that she was not aware a written resolution to grievances was required and that the facility had only been discussing the resolution with the RR or resident via phone or in person.</p> <p>She acknowledged that the facility needed to complete the portion of the grievance form to indicate when the grievance was resolved, if the complainant was satisfied, and how the investigation results were communicated. The Administrator stated it was her expectation for the facility to adhere to the regulatory guidelines regarding written grievance response summaries.</p> <p>2) Resident #69 was admitted to the facility on [DATE].</p> <p>A review of the facility's grievance logs from April 2025 to February 28, 2026, revealed the following grievance reports were initiated by Resident #69's RR:</p> <p>A grievance report initiated on 7/10/25 regarding missing clothes. This grievance form had a check mark that the grievance was resolved. There was no indication of how the results of the investigation were communicated to the RR, when the results of the investigation were communicated to the RR and no indication a written summary was provided.</p> <p>A grievance report initiated on 9/10/25 regarding concerns of notification. This grievance form did not indicate if the grievance was resolved, how the results of the investigation were communicated to the RR, when the results of the investigation were communicated to the RR and no indication a written summary was provided.</p> <p>A grievance report initiated on 10/23/25 regarding showers, room cleanliness and receiving statements. There was an attachment of a nursing progress note from the former Director of Nursing dated 10/24/25 where she met with Resident #69's RR regarding her concerns. The grievance form did not indicate if the grievance had been resolved, how the results of the investigation were communicated to the RR and no indication that a written summary was provided.</p> <p>A quarterly MDS assessment dated [DATE], indicated Resident #69 had moderately impaired cognition.</p> <p>A phone interview occurred with Resident #69's RR on 3/3/26 at 5:01 PM. She explained that when she had a concern, the facility would normally talk to her on the phone or when she visited her husband. She stated she had never received anything in writing regarding the resolution of her grievance concerns and was not always satisfied with the resolutions.</p> <p>A phone interview was conducted with Social Worker #2 on 3/4/26 at 11:04 AM. She reported that she had been employed at the facility for approximately seven months and that her last day was 2/5/26. Social Worker #2 stated that each time Resident #69's RR had a concern it was addressed by the nursing department either via phone or face to face. She stated she maintained the grievance logs and provided resolutions by phone or in person when they had not already been addressed by other (continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>management staff. She added that she had not been issuing written grievance resolutions because she was unaware this was required.</p> <p>The Administrator was interviewed on 3/3/26 at 3:10 PM and stated that she was not aware a written resolution to grievances was required and that the facility had only been discussing the resolution with the RR or resident via phone or in person. She acknowledged that the facility needed to complete the portion of the grievance form to indicate when the grievance was resolved, if the complainant was satisfied, and how the investigation results were communicated. The Administrator stated it was her expectation for the facility to adhere to the regulatory guidelines regarding written grievance response summaries.</p> <p>3. Resident #39 was admitted to the facility on [DATE].</p> <p>A review of the facility grievance policy, dated 11/14/25, included, in part, In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated her cognition was intact.</p> <p>A review of the facility's grievance logs from April 2025 to February 28, 2026, revealed a grievance report had been initiated on 1/19/26 by Resident #39, regarding her not receiving incontinence care on 01/18/26. The grievance form did not indicate if the grievance was resolved, how the results of the investigation were communicated to the complainant or when the results were communicated to Resident #39.</p> <p>An interview occurred with Resident #39 on 03/02/26 at 11:57 AM. The resident explained when she had a concern, the facility would normally talk to her about the results. She stated she had never received anything in writing regarding the resolution of her grievance concerns.</p> <p>A phone interview was conducted with Social Worker #2 on 03/04/26 at 11:04 AM. She reported she had been employed at the facility for approximately seven months and that her last day of employment with the facility was 02/05/26. Social Worker #2 stated when Resident #39 or her emergency contact had a concern it was addressed by the nursing department either via phone or face to face. She stated she maintained the grievance logs and provided resolutions by phone or in person when they had not already been addressed by other management staff. She added that she had not been issuing written grievance resolutions because she was unaware this was required.</p> <p>An interview was conducted on 03/03/26 at 3:10 PM with the Administrator. She stated she was not aware a written resolution to grievances was required and that the facility had only been discussing the resolution with the resident or Resident Representative (RR), via phone or in person. The Administrator stated it was her expectation for the facility to adhere to the regulatory guidelines regarding written grievance response summaries.</p>		