STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lotus Village Center for Nursing and Rehabilitatio	179 Combs Street Sparta, NC 28675

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, North Caroliana (NC) Department of Transportation (DOT) website, and resident, staff, Physician Assistant and Medical Director interviews, the facility failed to supervise a resident, who had a diagnosis of dementia with other behavioral disturbance and known exit-seeking behaviors, from exiting the facility's locked memory care unit unsupervised and without staff knowledge for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #58). Prior to her admission to the Skilled Nursing Facility (SNF), Resident #58 eloped from the previous SNF where she had resided by climbing out a window. On 01/06/26 Resident #58 was deemed incompetent by a court and appointed a guardian. On 01/08/26, Resident #58 removed the screw from the bottom of the window frame in her room and climbed out the window wearing a sweatshirt, overalls and tennis shoes with no jacket in 50-degree Fahrenheit weather. The distance from the windowsill to the ground was 5 feet 11 inches. Resident #58 walked through the back parking lot and down the hill along a public two-lane residential road with no sidewalks. There was no posted speed limit sign; however, according to the NC DOT website, NC law sets speed limits within town or city limits at 35 miles per hour unless otherwise posted. At approximately 5:05 PM, the Activity Assistant observed Resident #58 walking along a residential road approximately 1,056 feet (0.2 miles) from the facility. Resident #58 was transported back to the facility without incident and with no injuries identified. This noncompliance had a high likelihood of causing serious injury or serious bodily harm.Findings included:A hospital Medical Doctor (MD) progress note dated 11/01/25 read in part, Resident #58 arrived at the Emergency Department (ED) on 10/31/25 from the Skilled Nursing Facility (SNF) and was being seen for a mental health evaluation. The SNF staff reported Resident #58 had been making elopement attempts and no longer wanted to be there. Resident #58 was evaluated by the hospital crisis team who recommended acute, inpatient psychiatric care and involuntary commitment.A hospital MD progress note dated 11/05/25 read in part, the MD received a report from nursing around 5:00 PM yesterday evening that [Resident #58] was having severe anxiety and reported wanting to jump out a window to hurt herself. Suicide preventions were initiated and she was given Seroquel (antipsychotic) with improvement. Discussed this incident with [Resident #58] today and she said it was a transient (temporary) time that has not returned.Resident #58 was admitted to the facility's locked memory care unit on 11/12/25 with diagnoses that included dementia-moderate with other behavioral disturbance, primary progressive multiple sclerosis (chronic autoimmune disease of the central nervous system characterized by a gradual, steady worsening of neurological function), diabetes, hypertensive heart disease without heart failure, chronic obstructive pulmonary disease (difficulty breathing), anxiety disorder, and depression. A baseline care plan dated 11/12/25 indicated Resident #58 was an elopement risk with the goal that her safety would be maintained through the review date. Interventions included for staff to reorient and redirect as needed and check placement and function of safety monitoring device every shift.Review of Resident #58's comprehensive care plans initiated on 11/12/25 revealed no care plan that addressed wandering or exit-seeking behaviors.A Safe Smoking Screen assessment dated [DATE] revealed Resident #58 currently used (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	tobacco, had no plans to stop smoking and required supervision while smoking.Review of the nursing staff progress notes for November 2025 through January 2026 revealed no entries related to exit-seeking behaviors. In addition, there was no entry related to Resident #58's elopement from the facility. A Physician's Assistant (PA) admission progress note dated 11/14/25 revealed in part, Resident #58 was admitted to the facility on [DATE] following a hospitalization. The PA noted Resident #58 was admitted to the hospital from another SNF secondary to confusion and multiple attempts to elope from the previous SNF, including an incident where she climbed out of her window. The PA noted under current medications Resident #58 had an order for Seroquel 25 milligrams (mg) every 24 hours as needed (PRN) for agitation at bedtime and no changes were made to her current medications.The admission Minimum Data Set (MDS) assessment dated [DATE] noted Resident #58 had moderate cognitive impairment. She had a height of 5 feet 7 inches, weighed 135 pounds and was independent with walking. She displayed no behaviors or wandering and received antipsychotic, antidepressant and anticonvulsant medications during the MDS assessment look-back period. A PA progress note dated 11/21/25 revealed in part, Resident #58 was seen for a follow-up visit related to her recent admission and also had a form that needed filled out for her capability to manage benefits. The PA noted Resident #58 had a diagnosis of mild cognitive disorder and he was not sure that she would be able to manage her benefits on her own at the time although she might be able to in the future.A PA progress note dated 12/08/25 revealed in part, nursing staff reported Resident #58 had been more confused and agitated that normal. She had been hovering around exits and had increased behaviors. Under the psychiatric review of symptoms, the PA noted Resident #58 had difficulty sleeping, increased confusion, agitation and exit-seeking behavior. The PA noted Resident #58's recent laboratory tests were unremarkable and he would order a urinalysis with reflux (if the initial urine test showed signs of infection or abnormality, an additional in-depth test is conducted on the same urine sample) to rule out a urinary tract infection as the possible cause of Resident #58's increased confusion and agitation.A PA progress note dated 12/10/25 revealed in part, nursing staff reported Resident #58 had increased behaviors over the past several days and as needed (PRN) Seroquel had helped with her behaviors; however, Resident #58 had been off the medication for several days with increased behaviors since then. Staff were questioning if the medication could be scheduled. An order was provided for Seroquel 25 milligrams (mg) once a day for anxiety and mood.Review of Resident #58's December 2025 Medication Administration Record (MAR) revealed a physician's order dated 12/11/25 for Seroquel 25 mg once a day for anxiety and mood. The order was initialed on the MAR daily by nursing staff as administered per physician order.Review of the State of NC Letters of Appointment Guardian of the Person document revealed Resident #58 was deemed an incompetent person and the County Department of Social Services was appointed as the Guardian of the Person by the Clerk of Superior Court effective 01/06/26.A statement written by the Activity Assistant and dated 01/08/26 revealed in part, at approximately 5:05 PM when leaving the facility, Resident #58 was observed walking down the road and had reached a point in the road between a food pantry and a thrift store. The Activity Assistant pulled her car over, asked Resident #58 what she was doing and Resident #58 asked the Activity Assistant for a ride. Resident #58 got into the car and was taken back to the facility. The Activity Assistant asked Resident #58 to go into the facility with her to figure things out, Resident #58 complied with the request and was assisted back to the memory care unit by the Activity Assistant. Nurse #3 and Nurse Aide (NA) #1 were both on the memory care unit and had just discovered Resident #58's window open with the screen pushed out.During an interview on 05/12/26 at 5:13 PM, the Activity Assistant recalled on 01/08/26 she had just gotten off work at 5:00 PM when her significant other arrived at the facility to take her home. While driving home, they almost made it to the thrift store when she noticed someone walking down the road that looked like Resident #58 and she had her significant other pull over and stop the car. She recalled it was cold outside and dusk at the time, not quite dark, and Resident #58 was wearing a sweatshirt, overalls, beret (brimless, circular soft cap), and tennis shoes with no jacket or gloves. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #58 on the unit, they both stated it was around 4:50 PM when they did rounds. Nurse #3 reported that as soon as Resident #58 was brought back to the unit, she did a head-to-toe assessment of Resident #58 with no injuries identified and Resident #58 was placed on one-to-one staff supervision. She verified she checked and all other residents on the unit were accounted for. Nurse #3 stated when she asked Resident #58 where it was she thought she was going to go, Resident #58 told her that she wanted some cigarettes and just wanted out of here. Nurse #3 stated that prior to 01/08/26, Resident #58 would pace back and forth on the unit at times but she had never attempted to elope nor had she made any attempts since. A statement written by NA #2 and dated 1/08/26 revealed in part, NA #2 and NA #1 went into Resident #58's room at approximately 4:45 PM to 4:50 PM to check on her and she was lying in the bed. NA #2 was unavailable for an interview at the time of this investigation. A Medical Director progress note dated 01/29/26 revealed in part, Resident #58 had a diagnosis of mild cognitive impairment of uncertain or unknown etiology and resided on the locked memory care unit. The Medical Director noted Resident #58 recently tried to elope but was found unharmed and brought back to the memory care unit. Following the incident, all safety measures were implemented to ensure the unit was locked and secure. Resident #58 had no further elopement attempts but was high risk and required continued care on the locked memory care unit.During an interview on 05/14/26 at 10:59 AM, the Medical Director verified that she was made aware of Resident #58's elopement on 01/08/26 and from what she recalled, Resident #58 was found outside the facility and brought back unharmed. She stated that Resident #58 obviously had a plan to go somewhere that day but then couldn't remember where it was she was wanting to go. The Medical Director explained that while Resident #58 was physically high-functioning, she had cognitive impairment and would not be safe outside unsupervised which was why she resided on the locked memory care unit. During an observation and interview on 05/13/26 at 8:48 AM, Resident #58 was lying on top of the bed with a staff member sitting in the recliner next to her providing one-to-one supervision. Resident #58 could not recall the date but did remember climbing out the window of her room stating she had just felt like going for a walk. When asked which way she went once outside, Resident #58 stated she walked down the road a bit while looking out the window and pointing to the left side (where the road led toward the funeral home next to the facility) but could not recall how far she walked. She stated the Activity Girl and her husband came by and gave her a ride back to the facility. Resident #58 expressed she didn't give them any trouble and stated, reckon I wasn't supposed to be out there. Resident #58 restated she was just going for a walk but made a bad decision and would have to deal with the consequences. When asked if she removed the screw from the window frame in order to open the window, she would not provide a direct response and just stated that the screw was in there tight but if someone wanted to, they could get the screw out.During an interview on 05/13/26 at 2:04 PM, the PA recalled he was made aware of Resident #58's elopement but was not sure if someone told him about the incident or if it was documented in the provider communication book. When asked his medical opinion regarding Resident #58 being safe outside the facility unsupervised, he stated that was hard to answer as she was rather high-functioning but she did have some cognitive impairment and might have difficulty trying to find her way back to the facility. The PA stated he felt Resident #58 would likely be safe for a short period of time, but she would not be safe outside unsupervised for a long period of time. During an interview on 05/15/26 at 12:29 PM, the DON recalled that on 01/08/26 she received a call from the Activity Assistant at 5:05 PM informing her that she had picked Resident #58 up along the side of the road near the thrift store. The DON stated the Activity Assistant reported she was driving home and saw Resident #58 walking down the road and when she asked Resident #58 where she was going, Resident #58 stated she just wanted some fresh air. She stated the Activity Assistant asked Resident #58 if she would get into the car, which she did without resistance, and the Activity Assistant brought her back to the facility. After she spoke to the Activity Assistant, the DON called Nurse #3 and asked if she was missing anyone on the unit. She had Nurse #3 go check Resident #58's room, Nurse #3 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	reported the door was closed and when she opened the door to the room, the window was open and Resident #58 was gone. The DON stated she was informed that Resident #58 had removed the screw from the window frame, opened the window and bent the screen enough to climb out the window. The DON headed back to the facility and by the time she arrived, the previous Maintenance Director had already fixed the window. When she spoke to Resident #58 about the incident, Resident #58 told the DON that she climbed out the window to get some fresh air. She stated that when Resident #58 returned to the facility, she was assessed by Nurse #3 with no injuries identified and placed on one-to-one staff supervision. The DON verified the facility was aware of Resident #58's elopement attempts from her previous SNF when she was admitted on [DATE] but she had not made any elopement attempts while at the facility prior to 01/08/26. The Maintenance Director at the time of this incident was no longer employed and unable to be interviewed at the time of this investigation.The Administrator at the time of this incident was no longer employed and unable to be interviewed at the time of this investigation.Observations of the window inside Resident #58's room were conducted on 05/12/26 at 4:50 PM and 05/14/26 at 4:52 PM. The back parking lot of the facility could be viewed from the window. There was one screw placed in the top and one screw placed in bottom of the window frame preventing the window from opening more than approximately 3 inches.An observation of the window outside of Resident #58's room was conducted with the Maintenance Director on 05/13/26 at 2:38 PM. The ground directly below and leading to the paved parking lot was grass covered. The Maintenance Director used a tape measure and the distance from the windowsill to the ground was 71 inches (5 feet 11 inches). An observation of the area where Resident #58 was found on 01/08/26 was conducted on 05/12/26 at 5:50 PM. A steep, grass-covered embankment extended along the right side of the facility from the rear to the front, leading down to the parking lot of a funeral home. The facility's rear parking lot connected to a driveway that exited onto a twoˆlane road without sidewalks. This road went around the funeral home parking lot and downhill to a stop sign. Directly across from the stop sign was a residential property with sloped terrain and trees lining the rear boundary of the property. Turning left at the stop sign, the twoˆlane road continued approximately 288 feet to a second stop sign (Google Earth was used to calculate the distance between the two stop signs). From the second stop sign, the road led straight ahead into the facility's front parking lot; to the left was an embankment; and to the right was a public two-lane road where a thrift store and food bank were located. The driving distance from the facility's rear parking lot to the area between the thrift store and food bank, where Resident #58 was found, was approximately 0.2 miles (1,056 feet). An online website named Weather Underground was used to obtain the outside weather conditions in [NAME], North Carolina on 01/08/26 which revealed at 4:55 PM: cloudy conditions, temperature of 50 degrees Fahrenheit (F) with no precipitation and South-Southeast wind speed of 8 miles per hour. The Administrator was notified of Immediate Jeopardy on 05/13/26 at 5:00 PM.The facility provided the following Corrective Action Plan of Immediate Jeopardy removal:Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 01/08/2026 at approximately 5:05 pm the Activities Assistant was driving home from the building when she saw Resident #58 walking down the side of the road in front of the facility close to a thrift store. The Activities Assistant stopped and asked Resident #58 what she was doing. Resident #58 asked the Activities Assistant for a ride. The Activities Assistant helped Resident #58 into the car and brought her back to the facility and returned her to the 400 hall. The Administrator and Director of Nursing were notified immediately. Resident #58 had removed the screw from the window and was able to open the window enough to get out. The screen was also bent and pushed outward. When Resident # 58 was asked where she was trying to go Resident #58 stated she was just going for a walk for some fresh air. Resident #58 was unable to tell us how she removed the screw. Nurse #3 assessed Resident #58 for injuries. No injuries were identified. Resident was placed on 1:1 supervision by facility staff and will remain on 1:1 supervision while residing in the facility. The Medical Director and guardian were notified of the event by the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	or via phone that a new elopement risk assessment was to be completed upon admission, quarterly, and with any significant change. The assessments are maintained in the resident's electronic medical record.Newly hired staff members will receive this education in orientation from the Director of Nursing and/or Maintenance Director on the day of orientation. In addition, newly hired nurses are educated on how to identify behaviors that trigger the need for a new elopement risk assessment to be completed.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:Effective 01/08/2026, the Maintenance Director or designee will audit all facility windows two times a week for 12 weeks to ensure that the residents' windows have a screw in place to the top of the window and the bottom so that the window does not open more than 3 inches. This will be ensured by measuring with a tape measure. Any defective item or missing screws will be corrected immediately. While the repair is being completed the window will have constant monitoring by a facility staff member.The 24-hour report will be reviewed daily by the DON/designee during the clinical meeting looking for any increased wandering and/or elopement attempts. Any areas of concern identified will be immediately assessed by the Director of Nursing/designee and interventions put into place. This will be an ongoing practice.Audits of the center's response to elopement drills will be completed 1 time a week (across all shifts/days) for 12 weeks by the Maintenance Director or designee to ensure responsiveness and demonstration of the staff to properly execute procedures outlined in the Elopement and Wandering Residents Policy.On 01/09/26 an ADHOC QAPI was initiated by the Interdisciplinary Team about the event, and the decision was made to implement the plan with monitoring. The Administrator directed the Director of Nursing and Maintenance Director on 01/09/2026 that they are responsible for forwarding the results of their audits the QAPI Committee monthly for three months. The QAPI Committee will review the audits to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. The Medical Director was made aware of the plan on 01/09/26.IJ removal and compliance date: 01/10/2026On 05/15/26, the corrective action plan was validated onsite through observations, record review, and staff interviews. The weekly monitoring logs of the elopement drills and observations of resident windows to ensure screws were in place at the top and bottom of the window frame were reviewed with no concerns identified. Observations of windows in resident's rooms revealed screws were placed tightly in the top and bottom of the window frame preventing them from opening more than 3 inches. Elopement binders were observed at each nurses' station and reception area that contained a picture of each resident identified as high-risk along with along with a printout of their profile page that listed pertinent identification such as age, date of birth and emergency contact numbers, a document for each resident indicating whether or not they wore an elopement device, and staff search assignments in the event of a missing person. The Social Worker confirmed she was made aware of her responsibility for maintaining the elopement binders. Interviews conducted with staff on various shifts and departments revealed they received education on the facility's elopement policy and procedure and participated in elopement drills. Staff were able to verbalize where the elopement binders were located and what information they contained, what to do when a resident demonstrated exit-seeking behaviors, and what to do in the event of a missing resident. Nurses were able to verbalize the process for completing and documenting elopement risk assessments. The IJ removal and compliance date of 01/10/26 was validated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. Building B. Wing	05/15/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews, the facility failed to develop individualized, person-centered care plans that included areas of focus for smoking, exit-seeking behaviors, use of an elopement alarm device, and activities of daily living (ADL) for 3 of 28 sampled residents (Residents #58, #69 and #3). Findings included: 1. Resident #58 was admitted to the facility on [DATE] with diagnoses that included personal history of nicotine dependence, dementia with other behavioral disturbance, anxiety disorder, and depression. A Safe Smoking Screen assessment dated [DATE] revealed Resident #58 currently used tobacco, had no plans to stop smoking and required supervision while smoking. A Physician's Assistant (PA) admission progress note dated 11/14/25 revealed in part, Resident #58 was admitted to the facility on [DATE] following a hospitalization. The PA noted Resident #58 was admitted to the hospital from another skilled nursing facility (SNF) secondary to confusion and multiple attempts to elope from the previous SNF, including an incident where she climbed out of her window. Review of Resident #58's medical record revealed an active physician order dated 11/16/25 for an elopement alarm device to the right wrist due to poor safety awareness. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #58 was not coded for tobacco use or utilizing a wander/elopement alarm. A Medical Director progress note dated 01/29/26 revealed in part, Resident #58 had a diagnosis of mild cognitive impairment of uncertain or unknown etiology and resided on the locked memory care unit. The Medical Director noted Resident #58 recently tried to elope but was found unharmed and brought back to the memory care unit. Following the incident, all safety measures were implemented to ensure the unit was locked and secure. Resident #58 had no further elopement attempts but was high risk and required continued care on the locked memory care unit. The quarterly MDS assessment dated [DATE] revealed Resident #58 used a wander/elopement alarm daily. Current tobacco use was not coded on the MDS assessment. Review of Resident #58's comprehensive care plans last revised on 02/26/26 revealed no care plan that addressed smoking, exit-seeking behaviors or use of an elopement alarm device. During an observation on 05/11/26 at 11:08 AM, Resident #58 was observed sitting outside with a staff member and another resident smoking a cigarette with no concerns noted. During an interview on 05/14/26 at 3:12 PM, the MDS Coordinator reported she currently developed all the comprehensive care plans for residents at the facility. She confirmed Resident #58 used tobacco, utilized an elopement alarm device and displayed exit-seeking behaviors as evidenced by her elopement from the facility on 01/08/26. The MDS Coordinator reviewed Resident #58's care plans (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and stated she should have included plans that addressed smoking, use of an elopement alarm device and exit-seeking behaviors as they were all areas that she would normally care plan and it was an oversight. During an interview on 05/15/26 at 2:22 PM, the Administrator expressed she would expect care plans to be comprehensive and accurately reflect the residents' needs. 2. Resident #69 was admitted to the facility on [DATE] with diagnoses that included non-Alzheimer's dementia, depression, chronic obstructive pulmonary disease (COPD), muscle weakness, and history of falling. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #69 had severe cognitive impairment. He displayed no behavioral symptoms or rejection of care and wandered 4 to 6 days. He was occasionally incontinent of urine and always incontinent of bowel. He required substantial/maximum assistance with toileting hygiene, shower/bathing, putting on/taking off footwear and required partial/moderate assistance with lower body dressing and personal hygiene. He was independent with ambulation without the use of an assistive device and had one fall with minor injury during the MDS assessment look-back period. Review of Resident #69's comprehensive care plans last revised on 03/23/26 revealed no care plan that addressed his ADL needs. During an interview on 05/14/26 at 3:12 PM, the MDS Coordinator reported she currently developed all the comprehensive care plans for residents at the facility. She reviewed Resident #69's care plans and confirmed there was no care plan that addressed his ADL needs. The MDS Coordinator stated looking back, she should have developed a care plan that addressed the ADL areas where he needed more assistance so staff would know what level of care to provide. During an interview on 05/15/26 at 2:22 PM, the Administrator explained an ADL care plan ties into the Kardex (reference tool that contains a brief overview of a resident's daily care needs and safety precautions) which tells the nurse aides what level of care the resident required. She stated it was her expectation that ADL care plans were developed for every resident in the facility 3.Resident #3 was admitted on [DATE] with diagnoses that included dementia. A physician orders dated 2/7/25 included a wander alarm (a wearable electronic device that trigger door locks or alarms when a resident approaches an exit, allowing for freedom of movement within safe, monitored boundaries) to be placed on Resident #3's left lower leg and to monitor the wander alarm placement on the left lower leg every shift. A review of Resident #3's care plan last updated on 3/18/26 did not include a care plan for wandering or elopement risk. A review of Resident #3's quarterly Minimum Data Set (MDS) dated [DATE] coded him cognitively intact. He was not coded for having a wander/elopement alarm and had no wandering behaviors. On 5/14/26 at 3:13 PM the MDS Coordinator stated she was responsible for revising and reviewing Resident #3's care plan. She stated Resident #3 had an order for a wander alarm with a history of wandering and exit seeking and she had overlooked the order and did not care plan the resident for (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wandering or elopement risk. The Administrator stated on 5/15/26 at 2:30 PM Resident #3's care plan should be accurate and reflect the needs of the Resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations, record reviews and staff interviews, the facility failed to date medications when opened and remove expired and unlabeled medications from 4 of 4 medication carts reviewed for medication storage (Medication Carts 100/200/300/400).The findings included:Review of the facility's medication formulary dated 2025-2026 indicated to:- discard albuterol sulfate nebulization solution in 7 days after opening foil pouch,- discard fluticasone-vilanterol 42 days after opening foil tray,- discard budesonide inhalation solution 14 days after opening foil pouch.a. On 05/13/26 at 11:30 AM an observation was conducted of the 100-hall medication cart along with Nurse #2. The observation yielded one box of albuterol sulfate nebulization solution dated 04/15/26 that was available for use. The box contained one open and undated foil pouch of albuterol sulfate solution. The observation also yielded one open and undated fluticasone-vilanterol inhalation foil tray that was available for use. The dispensed date was 03/18/26.An interview was conducted with Nurse #2 on 05/13/26 at 11:30 AM. The Nurse explained that it was the third shift nurses' responsibility to clean the medication carts which meant to clean the carts and remove the expired medications and send them back to the pharmacy. She stated the nurse who opened the package should date the medication so that the nurses would know when to discard the medication.b. On 05/13/26 at 12:09 AM an observation was conducted of the 200-hall medication cart along with Nurse #2. The observation yielded one box of albuterol sulfate nebulizing solution that was available for use. The box contained an open and undated foil pouch of the albuterol sulfate solution.An interview was conducted with Nurse #2 on 05/13/26 at 12:09 AM. The Nurse explained that it was the third shift nurses' responsibility to clean the medication carts which meant to clean the carts and remove the expired medications and send them back to the pharmacy. She stated the nurse who opened the package should have dated the medication so the nurses would know when to discard the medication.c. At 10:17 AM on 05/13/26 an observation was conducted of the 300-hall medication cart along with Medication Aide (MA) #1. The observation yielded one open and unlabeled tube of oral gel pain medication.An interview was conducted with the Medication Aide on 05/13/26 at 10:17 AM. The MA explained that she normally worked on the 300-hall medication cart when she worked and she did not know who the open tube of oral gel belonged to nor did she know how long it had been on the medication cart.d. On 05/13/26 at 9:34 AM an observation was conducted of the 400-hall medication cart along with Nurse #1. The observation yielded a box of budesonide inhalation suspension dated 02/17/26 that was available for use. The box contained one open foil pouch of budesonide vials that was not dated when opened. The observation also yielded one open and undated fluticasone-vilanterol inhalation foil tray that was available for use. The dispensed date was 02/11/26.On 05/13/2026 at 9:34 AM during an interview with Nurse #1, the Nurse explained that all the nurses were responsible for keeping the medication carts clean and orderly which included removing expired medications from the carts and returning them to the pharmacy. The Nurse stated that she did not realize that the expired medications were on the medication cart. She stated the nurse who opened the package should date the package so that the nurses would know when to discard the medication.On 05/14/26 at 2:25 PM an interview was conducted with the Director of Nursing (DON) who explained that it was the third shift nurses' responsibility to check and clean the medication carts and the first shift nurses' along with herself were to check the medication carts behind them. The DON could not recall the last time she checked the medication carts. She stated the nurse who opens the package should date the package so that the nurses would know when to discard the medication.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and Psychiatric Nurse Practitioner (NP) interviews, the facility failed to obtain consent and inform the resident or Responsible Party in advance of the risks and benefits of psychotropic medications prior to initiation for 2 of 5 residents reviewed for unnecessary medications (Resident #9 and Resident #58).The findings included: 1. Resident #9 was admitted to the facility on [DATE] with diagnoses that included vascular dementia and anxiety. Review of Resident #9's admission physician orders dated 01/13/26 revealed buspirone (antianxiety medication) 15 milligrams (mg) one tablet by mouth twice a day. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9's cognition was moderately impaired. He displayed no behavioral symptoms and received antianxiety medications during the MDS assessment look-back period. Review of Resident #9's physician orders dated 02/08/26 indicated to increase buspirone to 15 mg one tablet by mouth three times a day. Review of the February 2026 Medication Administration Record for Resident #9 revealed buspirone was administered at 15 mg twice a day until 02/09/26 when it was increased to 15 mg three times a day through the remainder of the month of February 2026. Review of Resident #9's electronic medical record revealed no documentation that Resident #9 or the Responsible Party was informed in advance of the risks and benefits of of increasing buspirone 15 mg to three times a day on 02/09/26. On 05/14/26 at 2:30 PM an interview was conducted with the Director of Nursing (DON), who explained that Resident #9 was being followed by Psychiatry and the Psychiatry provider was responsible for obtaining informed consents from the resident or the responsible party before a psychoactive medication was initiated or increased. The DON stated Social Services was responsible for auditing the informed consents and she did not know when the last audit was completed. On 05/14/26 at 2:30 PM an interview was conducted with Social Services who explained that she had only been in her role for a few months and had never been informed that she was responsible for auditing the informed consents for the psychoactive medications. An interview was conducted with the Psychiatric NP on 05/15/26 at 8:30 AM. The Psychiatric NP explained that she did not obtain informed consents for the residents' psychoactive medications and that she had never been informed that it was her responsibility to obtain informed consents. On 05/15/26 at 2:22 PM an interview was conducted with the Administrator who had only been at the facility for seven weeks. She explained that the facility was not obtaining informed consent for the psychoactive medications, but she would have expected it to be done. 2. Resident 58 was admitted to the facility on [DATE] with diagnoses that included dementia with other behavioral disturbance, anxiety disorder, and depression. (continued on next page)

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	345261	A. Building B. Wing	05/15/2026

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #58 had moderate impairment in cognition. She displayed no behavioral symptoms and received antipsychotic and antidepressant medication during the MDS assessment look-back period. Review of the April 2026 Medication Administration Record (MAR) for Resident #58 revealed the following physician orders: 03/13/26: bupropion (antidepressant medication) 150 milligrams (mg) in the morning for depression and anxiety. 03/23/26 (discontinued on 04/28/26): buspirone (antianxiety medication) 10 mg two times a day for anxiety. 03/24/26: quetiapine fumarate (antipsychotic medication) 25 mg one time a day for dementia with agitation. Continued review of the April 2026 MAR revealed the medications were initialed daily by nursing staff as administered per physician orders. Review of Resident #58's electronic medical record revealed no documentation that Resident #58 or her Responsible Party were informed in advance of the risks and benefits of initiating bupropion, buspirone or quetiapine fumarate and consented to the treatment. During an interview on 05/14/26 at 2:25 PM, the Director of Nursing (DON) explained that Resident #58 was being followed by Psychiatry, and the Psychiatry provider was responsible for obtaining informed consent from the resident or the responsible party before a psychoactive medication was initiated or increased. The DON stated Social Services was responsible for auditing the informed consents and she did not know when the last audit was completed. During an interview on 05/14/26 at 2:30 PM, the Social Services staff member explained that she had only been in her role for a few months and had never been informed that she was responsible for auditing informed consents for psychoactive medications. During a phone interview on 05/15/26 at 8:30 AM, the Psychiatric Nurse Practitioner explained that she did not obtain informed consent for residents' psychoactive medications and had never been informed that it was her responsibility to obtain informed consents. During an interview on 05/15/26 at 2:22 PM, the Administrator reported she had only been at the facility for seven weeks. The Administrator explained that the facility was not obtaining informed consents for psychoactive medications, but she would have expected it to be done.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure code status information was accurate throughout the medical record and in locations designated by the facility for 1 of 1 resident reviewed for advance directives (Resident #63).Findings included:Resident #63 was admitted to the facility on [DATE].Review of the Code Status binder kept at the nurses' station on 05/11/26 at 3:45 PM revealed Resident #63 had a DNR form signed by the physician effective 03/27/25 with no expiration date. An advance directive care plan, revised 03/11/26, indicated Resident #63 was a full code. Interventions included: advanced directive would be honored as instructed and review the advance directive status periodically and as needed.Review of Resident #63's electronic medical record revealed an active physician's order dated 03/11/26 for full code.The admission Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #63 with severe cognitive impairment.Review of the profile page in Resident #63's electronic medical record revealed a code status of Do Not Resuscitate (DNR).Review of Resident #69's medical record revealed a Social Services progress note dated 05/12/26 revealed a second copy of the admissions agreement and a Medical Orders for Scope of Treatment (MOST, signed medical document that translates a patient's end-of-life care preferences into actionable physician orders) was sent to Resident #69's representative by certified mail on 05/07/26.During an interview on 05/12/26 at 12:30 PM, Nurse #1 explained nurses were recently informed they were now responsible for verifying a resident's code status with the resident or their representative and getting the appropriate advanced directive forms filled out. Nurse #1 stated there were two places to look for a resident's code status, the physician order in the electronic medical record and the code status binder at the nurses' station. Nurse #1 confirmed the physician order for Resident #63 indicated he was a full code but the advanced directive in the code status binder was for a DNR. Nurse #1 stated in the event of an emergency, she was instructed to go by the resident's advanced directive filed in the code status binder. During an interview on 05/12/26 at 12:50 PM, the Director of Nursing (DON) revealed the facility utilized the MOST form and nurses were responsible for completing the form with the resident or their representative upon admission or within 48 hours. The DON explained staff could view the physician order for code status in the resident's electronic medical record or check the code status binder kept at the nurses' station. She stated the physician order and code status binder should match. The DON explained that in the event of an emergency, staff should follow the resident's advanced directive filed in the code status binder.During an interview on 05/15/26 at 2:22 PM, the Administrator stated all residents should have a completed MOST form on file. The Administrator stated the physician order and MOST form filed in the code status binder should match.

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	345261	A. Building B. Wing	05/15/2026

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to complete admission Minimum Data Set (MDS) assessments no later than 14 calendar days after the residents' admission (Residents #2 and #63) and failed to complete Care Area Assessments (CAA) comprehensively that addressed the underlying causes and contributing factors of the triggered care area (Residents #58 and #9) for 4 of 28 sampled residents. Findings included: 1. Resident #2 was admitted to the facility on [DATE]. Review of Resident #2's electronic medical record revealed an admission MDS assessment dated [DATE] that was marked as completed on 01/16/26. During an interview on 05/14/26 at 3:12 PM the MDS Coordinator verified Resident #2's admission MDS assessment was not completed within the regulatory timeframe. The MDS Coordinator explained she was out of work at the time and got behind on completing assessments. During an interview on 05/15/26 at 2:22 PM the Administrator explained admission MDS assessments should be completed within 14 days of the resident's admission. She stated it was her expectation for MDS assessments to be completed and submitted within the regulatory timeframes. 2. Resident #63 was admitted to the facility on [DATE]. Review of Resident #63's electronic medical record revealed an admission MDS assessment with an Assessment Reference Date (ARD, referring to the last day of the observation period) of 03/20/26 that was marked as completed on 03/26/26. During an interview on 05/14/26 at 3:12 PM, the MDS Coordinator verified Resident #63's admission MDS assessment dated [DATE] was not completed within the regulatory timeframe. The MDS Coordinator explained she set the ARD wrong which was why the MDS assessment was completed late. During an interview on 05/15/26 at 2:22 PM, the Administrator explained admission MDS assessments should be completed within 14 days of the resident's admission. She stated it was her expectation for MDS assessments to be completed and submitted within the regulatory timeframes. 3. Resident #58 was admitted to the facility on [DATE] with diagnoses that included dementia-moderate with other behavioral disturbance, anxiety disorder, and depression. Review of the Care Area Assessment (CAA) summary from Resident #58's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the CAA for Psychotropic Drug Use triggered for Resident #58. There was no documentation in the assessment that provided any information in the analysis of findings that described the nature of Resident #58's problem, possible causes, contributing factors, and risk factors for the triggered care area. The information in the CAA noted Resident #58 is at risk for adverse drug reaction to the use of psychotropic medication and (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antidepressant and Psychotropic Drug Use would be addressed in the care plan. Review of the CAA summary from Resident #58's admission MDS assessment dated [DATE] revealed the CAA for Cognitive Loss/Dementia triggered for Resident #58. There was no documentation in the assessment that provided any information in the analysis of findings that described the nature of Resident #58's problem, possible causes, contributing factors, and risk factors for the triggered care area. The information in the CAA noted Resident #58 has a cognitive decline per the BIMS (Brief Interview for Mental Status, a standardized screening tool used to evaluate cognition on a scale of 0 to 15) of 11 and Cognitive Loss/Dementia would be addressed in the care plan. During an interview on 05/14/26 at 3:12 PM, the MDS Coordinator reported she currently completed all the care areas assessments of the MDS except the Activities assessment. The MDS Coordinator stated the CAAs triggered by information from the MDS to help develop the care plan. She explained that the analysis of findings puts together the story of how the triggered areas (CAAs) effects the day-to-day activities and/or functioning of the residents. The MDS Coordinator acknowledged that Resident #58's CAAs for Psychotropic Drug Use and Cognitive Loss/Dementia did not address the underlying cause or contributing factors and stated she should have written a complete CAAs for the triggered care areas. During an interview on 05/15/26 at 2:22 PM, the Administrator stated it was her expectation for the CAAs to be completed and contain a comprehensive analysis of findings for the triggered care areas. 4. Resident #9 was admitted to the facility on [DATE] with diagnoses that included vascular dementia and anxiety. Review of the Care Area Assessment (CAA) Summary from Resident #9's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the CAA for Psychotropic Drug use triggered for Resident #9. There was no documentation in the assessment that provided any information in the analysis of findings that described the nature of Resident #9's problem, possible causes, contributing factors and risk factors for the triggered care area. The information in the CAA noted Resident #9 is at risk for adverse drug reaction to the use of psychotropic med for anxiety. Proceed to CP (care plan). An interview was conducted with the MDS Coordinator on 05/14/26 at 3:15 PM. She stated she currently completed all the care areas assessments of the MDS except the Activities assessment. The MDS Coordinator stated the CAAs triggered by information from the MDS to help develop the care plan. She continued to explain that the analysis of findings puts together the story of how the triggered areas (CAAs) effects the day-to-day activities and or functioning of the residents. The MDS Coordinator acknowledged that Resident #9's CAA for Psychotropic Drug Use was lacking in that there was no underlying cause or contributing factors and stated she should have written a complete CAA for the Psychotropic Drug Use. An interview was conducted with the Administrator on 05/15/26 at 2:22 PM. The Administrator stated it was her expectation for the CAAs to be completed and contain a comprehensive analysis of findings for the triggered care areas.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. Building B. Wing	05/15/2026

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 14 days of the Assessment Reference Date (ARD, referring to the last day of the observation period) for 1 of 28 sampled residents reviewed (Residents #2). Findings included:Resident #2 was admitted to the facility on [DATE].Review of Resident #2's electronic medical record revealed a quarterly MDS assessment with an ARD of 04/03/26 that was marked as completed on 04/20/26.During an interview on 05/14/26 at 3:12 PM, the MDS Coordinator verified Resident #2's quarterly MDS assessment dated [DATE] was not completed within the regulatory time frame. The MDS Coordinator was unsure why Resident #2's MDS assessment was completed late and stated it was an oversight.During an interview on 05/15/26 at 2:22 PM, the Administrator explained quarterly assessments should be completed within 14 days of the ARD. She stated it was her expectation for MDS assessments to be completed and submitted within the regulatory timeframes.

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	345261	A. Building B. Wing	05/15/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of Preadmission Screening and Resident Review (PASRR) (Resident #6), alarms (Resident #58 and Resident #3) and current tobacco use (Resident #58) for 3 of 28 residents reviewed for accuracy of assessments.The findings included: 1. Resident #6 electronic medical record (EMR) included a Level II PASRR Determination Notification letter issued 09/12/2025 with no expiration date. Resident #6 was admitted to the facility on [DATE] with a cumulative diagnosis which included anxiety disorder, depression and bipolar disorder. Resident #6's admission MDS assessment dated [DATE] indicated Resident #6 was not currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. An interview was conducted on 05/14/26 at 3:15 PM with the MDS Coordinator who completed Resident #6's admission MDS assessment. When asked about Resident #6's admission MDS assessment and Level II PASRR status the MDS Coordinator stated she had overlooked the Level II PASRR Determination Notification letter when completing the assessment. An interview was conducted on 05/15/26 at 2:30 PM with the Administrator who stated she expected all MDS assessments to be completed accurately. 2. Resident #58 was admitted to the facility 11/12/25 with diagnoses that included personal history of nicotine dependence and dementia with other behavioral disturbance. A Safe Smoking Screen assessment dated [DATE] revealed Resident #58 currently used tobacco, had no plans to stop smoking and required supervision while smoking. The Treatment Administration Record (TAR) for Resident #58 revealed a physician's order dated 11/16/25 for an elopement alarm device to the right wrist due to poor safety awareness. The order was initialed by nursing staff as completed for each 12-hour shift on 11/16/25, 11/17/25, and 11/18/25. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #58 was not coded for current tobacco use or use of a wander/elopement alarm. During an interview on 05/14/26 at 3:12 PM, the MDS Coordinator revealed her process for completing MDS assessments was to assess the resident, review the resident's medical record, write everything down, and then enter the information on the MDS assessment. The MDS Coordinator confirmed Resident #58 used tobacco and explained she usually looked at a resident's TAR when completing the MDS assessment but had overlooked nursing staff initialing the wander/elopement alarm device as being used by Resident #58 during the MDS assessment look-back period. During an interview on 05/15/26 at 2:22 PM, the Administrator stated she expected all MDS assessments to be completed accurately. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #3 was admitted on [DATE] with diagnoses that included dementia. A physician order dated 2/7/25 included a wander alarm (a wearable electronic device that trigger door locks or alarms when a resident approaches an exit, allowing for freedom of movement within safe, monitored boundaries) to be placed on Resident #3's left lower leg and to monitor the wander alarm placement on the left lower leg every shift. A review of Resident #3's Medical Administration Record (MAR) for March 2026 noted the wander alarm was being checked every shift as ordered. A review of Resident #3's quarterly Minimum Data Set (MDS) dated [DATE] noted he was cognitively intact and he was not coded as having a wander/elopement alarm. On 5/14/26 at 3:13 PM the MDS Coordinator stated she had completed Resident # 3's MDS dated [DATE]. She confirmed Resident # 3 had an active order for a wander alarm when the MDS was completed. The MDS Coordinator stated she had overlooked the order and did not code the MDS correctly. The Administrator stated on 5/15/26 at 2:30 PM MDS assessments should be accurate and Resident #3's wander alarm should have been coded.

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	345261	A. Building B. Wing	05/15/2026

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and resident interviews, the facility failed to revise a resident's care plan to indicate the development of a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers (Resident #70).The findings included:Resident #70 was admitted to the facility on [DATE] with diagnoses that included stage III pressure ulcer to coccyx.Review of Resident #70's wound note dated 02/27/26 revealed he had a stage III pressure wound to his coccyx.Review of Resident #70's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact. Resident #70 was coded for having one or more unhealed pressure ulcers/injuries and coded as having 2 stage II pressure ulcers with one that was present upon admission. Resident #70 was also coded as using a pressure reducing device for bed and was receiving pressure ulcer care.Review of Resident #70's care plan last updated on 04/10/26 revealed no care plan or interventions for pressure ulcers.During an interview with the MDS Coordinator on 05/14/26 at 3:27 PM, she reported she was familiar with Resident #70. She also reported she was responsible for updating resident care plans quarterly or when care or significant changes occurred. The MDS Coordinator verified that when she completed his quarterly MDS assessment on 03/31/26 she coded Resident #70 as having pressure ulcers/wounds and she either missed or forgot to update Resident #70's care plan at that time to reflect the development of those pressure wounds. An interview with the Director of Nursing on 05/14/26 at 4:06 PM revealed she expected pressure ulcer/wounds to be care planned. She verified that Resident #70's care plan did not currently have a pressure ulcer/wound care plan and stated it should have been updated to reflect the pressure ulcer/wounds when Resident #70's quarterly MDS assessment was completed and indicated he had pressure ulcer/wounds.An interview with the Administrator on 05/15/26 at 8:32 AM revealed Resident #70's pressure ulcer/wounds should be noted on his care plan. She reported she felt the main reason for the completion of MDS assessments was to ensure a resident's care plan was accurate and complete.

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	345261	A. Building B. Wing	05/15/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews, the facility failed to ensure a resident's toenails were trimmed and podiatry services were arranged for 1 of 1 resident reviewed for foot care (Resident #69).Findings included:Resident #69 was admitted to the facility on [DATE] with diagnoses that included non-Alzheimer's dementia, depression, chronic obstructive pulmonary disease (COPD), muscle weakness, and history of falling.The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #69 had severe cognitive impairment. He displayed no behavioral symptoms or rejection of care and wandered 4 to 6 days. He required substantial/maximum assistance with toileting hygiene, shower/bathing, putting on/taking off footwear and required partial/moderate assistance with lower body dressing and personal hygiene. He was independent with ambulation without the use of an assistive device and had one fall with minor injury during the MDS assessment look-back period.Review of Resident #69's comprehensive care plans last revised on 03/23/26 revealed no care plan that addressed his activities of daily living (ADL) needs.Resident #69's medical record from admission through 05/11/26 revealed no consultation reports or notations in Resident #69's medical record that he had been seen by a podiatrist. During an interview on 05/14/26 at 10:25 AM, Nurse #3 reported she was first notified of the condition of Resident #69's toenails on 05/11/26. She stated she informed the Physician Assistant who evaluated Resident #69 and provided an order for a podiatry referral. Nurse #3 stated Resident #69 usually wore socks, and she hadn't noticed the condition of his toenails previously. She explained she had not noticed Resident #69 have any issues with ambulation as he often walked rapidly down the hall and he had not complained of any pain or discomfort. Nurse #3 stated that she would have thought staff would have mentioned the condition of his toenails sooner so that a podiatry referral could have been obtained for him to see the Podiatrist. Review of Resident #69's physician orders revealed an order dated 05/11/26 that read, refer to podiatry for a toenail trim.An observation of Resident #69 was conducted on 05/11/26 at 10:47 AM. Resident #69 was lying in bed, sleeping soundly, and covered with a bed sheet with his bare feet exposed. The great (big toes) toenails on both feet were thick and jagged. The toenails of the second through fifth toes on both feet were long and extended past the toenail bed. The toenails curved flat around the tip of the toes, wrapped partially around the back of the toe pad and curved inward along the mid to lower part of the toe pad.During an interview on 05/12/26 at 12:30 PM, Nurse #1 revealed she routinely provided care to Resident #69 and confirmed his toenails were thick and curved. She explained the Nurse Aides (NAs) didn't trim a resident's toenails if they were thick like Resident #69's and in those cases, an order was obtained from the provider for the resident to be seen by the Podiatrist. Nurse #1 stated she had previously put in a request with the provider for a podiatry referral (could not recall when) and was not sure why he had not been seen. Nurse #1 reviewed Resident #69's medical record and stated an order for a podiatry referral was put in yesterday (05/11/26). During an interview on 05/12/26 at 2:37 PM, NA #1 revealed she routinely provided care to Resident #69 and confirmed the toenails on both of Resident #69's feet were long and curved over the tip of the toe and around the back of the toe pads. She explained that when a resident was diabetic or had thick toenails like Resident #69, NAs did not trim the toenails. NA #1 stated the condition of Resident #69's toenails had been like that for awhile and she had informed the nurse (could not recall who) that he needed to see the Podiatrist for a trim. NA #1 expressed the condition of Resident #69's toenails did not appear to cause him discomfort or limit his walking but it was difficult for them to keep socks on his feet.During an interview on 05/14/26 at 9:36 AM, the Social Services staff member reported that she had been in her position a little over a month and had not been informed that Resident #69 needed to see the Podiatrist until she was notified of the podiatry referral on 05/11/26. The Social Services staff member explained when she received a podiatry referral, she contacted the podiatry group the facility utilized and filled out the necessary (continued on next page)

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	345261	A. Building B. Wing	05/15/2026

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	forms to get the resident enrolled for services and on the list to be seen at the next facility podiatry clinic. She stated she was currently working on getting Resident #69 enrolled with the podiatry group services so that he could be seen at the podiatry clinic scheduled on 05/26/26.An observation was conducted of Resident #69's toenails with the Director of Nursing (DON) on 05/14/26 at 11:10 AM. Resident #69 was lying in bed wearing gripper socks on both feet. The DON donned gloves and removed the gripper socks from both of Resident #69's feet. The DON acknowledged the great toenails on both of Resident #69's feet were thick and jagged and the toenails of the second through fifth toes of both feet were long, extended past the toenail bed and curved flat around the tip of the toes, wrapped partially around the back of the toe pad and curved inward along the mid to lower part of the toe pad.During an interview on 05/14/26 at 11:15 AM, the DON reported she was unaware of the condition of Resident #69's toenails prior to the observation. She expressed the condition of Resident #69's toenails appeared to have been in that condition for an extended time and needed trimmed. She stated the NAs trimmed a resident's toenails as part of routine care but if the resident had thick toenails or was diabetic, the resident was referred to the Podiatrist. She stated a podiatry referral for Resident #69 was obtained by the provider on 05/11/26. The DON stated staff should have noticed the condition of Resident #69's toenails when providing care and brought it to the provider's attention so that a podiatry referral could have been made sooner. During an interview on 05/15/26 at 2:22 PM, the Administrator stated she did not observe Resident #69's feet but was informed of the condition of his toenails by the DON yesterday (05/14/26). The Administrator explained that they had a Podiatrist who came to the facility to provide podiatry services for residents. She stated staff should have identified and notified the provider of the condition of Resident #69's toenails to obtain a podiatry referral. The Administrator stated she would have expected staff to have identified the condition of Resident #69's toenails upon his admission, during daily care or during weekly skin audits.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, the Physician Assistant, and the Medical Director, the facility failed to implement an order for a urinalysis with reflex to culture (a two-step urine testing method) for 1 of 2 residents reviewed with symptoms of a urinary tract infection (Resident #27).The findings included:Resident #27 was admitted to the facility on [DATE] with cumulative diagnosis of multiple sclerosis (a chronic, progressive neurological disorder), neurogenic bladder, interstitial cystitis (a condition causing persistent pelvic pressure and bladder pain), anxiety disorder and depression.The admission Minimum Data Set (MDS) assessment dated [DATE] and the quarterly MDS assessment dated [DATE] revealed Resident #27 was cognitively intact, able to be understood and understand others and had an indwelling catheter.The care plan dated 11/05/25 indicated Resident #27 as having an indwelling catheter with nursing interventions to monitor, record and report to physician any signs and symptoms of a urinary tract infection including: pain, burning, blood tinged urine, deepening of urine color, foul smelling urine, cloudiness, no output, increased heart rate, increased temperature, altered mental status, change in behaviors, change in eating habits.A Psychiatry Nurse Practitioner (NP) note dated 04/28/26 documented concern for a possible urinary tract infection contributing to the resident's mental status changes and indicated the need to rule out infection.A physician order dated 04/28/26, created by the Director of Nursing (DON) and signed by the Psychiatry NP, directed staff to collect a urine sample on 04/29/26 and send it to the lab for a urinalysis with culture and sensitivity due to Resident #27's confusion.An interview was conducted on 05/15/26 at 9:32 AM with the nurse assigned to Resident #27 on 04/29/26. Nurse #4 stated that the assigned nurse was responsible for collecting urine samples when orders were in place. Nurse #4 did not recall collecting a urine sample on 04/29/26.An interview was conducted on 05/15/26 at 10:21 AM with the DON, who stated that on 04/28/26 she entered the physician order for a urinalysis with reflex to culture, with collection beginning at 7:00 AM on 4/29/26 and ending at 6:59 AM on 04/30/26, into Resident #27's electronic health record and did not know why it was not completed. The DON stated the nurse assigned to Resident #27 was responsible for collecting urine samples. The DON revealed the order dropped off the medication administration record (MAR) after the collection time passed and was forgotten. The DON stated she expected staff to complete the order and expressed concern that an undetected urinary tract infection could result in sepsis.An interview was conducted on 05/13/26 at 2:30PM with the Physician Assistant (PA). The PA stated that he had ordered a urinalysis on 05/12/25 at the request of Resident #27 and was unaware of the previously missed urinalysis. After being informed that the urinalysis ordered on 04/28/26 had not been completed, the PA noted that an untreated urinary tract infection could progress to sepsis within that timeframe.Initial lab results from a urinalysis collected on 5/13/26 showed a possible urinary tract infection.A physician progress note dated 05/14/26 indicated that the urinalysis obtained the previous day showed negative nitrates and positive leukocyte esterase, the patient's vital signs were stable, and the team would await culture results before starting treatment.An interview was conducted on 05/14/26 at 11:00 AM with the Medical Director, who stated staff were expected to follow all physician orders.An interview was conducted on 05/15/26 at 2:30 PM with the Administrator, who stated all physician orders must be addressed and that the facility needed a tracking process to ensure orders were completed.

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	345261	A. Building B. Wing	05/15/2026

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews with the resident, staff, Physician Assistant and Medical Director, the facility failed to provide pain management for a resident who reported acute, severe pain rated at a 8 out of 10 (0 meaning no pain and 10 meaning the worst pain experienced) during wound care treatment of a Stage 3 pressure ulcer. This deficient practice affected 1 of 3 residents reviewed for effective pain management (Resident #2).The findings included: Resident #2 was admitted to the facility on [DATE] with diagnoses including obstructive uropathy, cerebrovascular accident, diabetes mellitus, depression, moisture-associated skin damage (MASD) and other specified arthritis at multiple sites.A review of the admission Minimum Data Set (MDS) assessment dated [DATE] and the quarterly MDS assessment dated [DATE] revealed that Resident #2 was cognitively intact, did not display any behaviors, was able to make her needs known, received scheduled as needed (PRN) pain medication, had pain frequently and reported that pain frequently interfered with sleep, physical therapy and day-to-day activities. The quarterly MDS assessment also coded Resident #2 for having a stage 3 pressure ulcer.Resident #2 had an active medication order with a start date of 04/20/26, for hydrocodone/acetaminophen 10 milligrams/325 milligrams (MG) (opiod pain medication combined with acetaminophen used to relieve moderate to severe pain) one (1) tablet by mouth every 6 hours, as needed for break through pain.A continuous observation of wound care treatment and resident interview were conducted on 05/12/26 at 3:05 PM until 3:20PM. During the treatment, Nurse # 2 cleansed Resident #2's wound with gauze soaked in wound cleansing solution. Resident #2 gasped with a complaint of stinging pain. The wound was approximately 3 centimeters by 3 centimeters; it appeared dark pink with a moist textured open area surrounded by a larger area of scar tissue. Nurse #2 did not respond to the complaint of pain and continued with the treatment, applying calcium alginate (highly absorbent wound dressing) and silver sulfadiazine (topical antibiotic), followed by covering with a border dressing. Resident #2 again complained of pain stating, That hurts me. Nurse #2 did not reply and continued with care, providing a clean brief, cleaned up her supplies, and exited the room. At 3:20 PM Resident #2 stated her pain was 8 out of 10 and used her call light to request PRN pain medication.During an observation on 05/12/26 at 4:00 PM, Nurse #2 provided Resident #2 with one hydrocodone/acetaminophen 10/325 MG tablet.An interview was conducted on 05/12/26 at 4:20 PM with Nurse #2, who stated that she was often the assigned nurse for Resident #2 and completes the wound care treatment every day she works, except Fridays, when the wound care doctor was present. Nurse #2 stated that Resident #2 complained of pain when she performed the wound care treatment, which was why she always administered PRN pain medication after completing the treatment.An interview was conducted on 05/15/26 at 10:21 AM with Director of Nursing (DON), who stated when a resident reports pain during care the nurse must stop what they are doing, assess the pain, provide PRN pain medicine if available, notify physician if PRN pain medication is not available, and reassess the pain before continuing care.An interview was conducted on 05/13/26 at 2:30 PM with the Physician Assistant (PA), who stated that PRN pain medication could be administered before wound care treatment begins, but ordering it that way can be problematic for a nurse's workflow. The PA also stated that he would expect a nurse to pause wound care and administer PRN pain medication if a resident expressed pain.An interview was conducted on 05/14/26 at 11:00 AM with the Medical Director, who stated that if Resident #2 expressed pain during care she expected the nurse to stop the care, assess the pain and provide PRN pain medication if available.An interview was conducted on 05/15/26 at 2:30 PM with the Administrator, who stated if a resident complains of pain during care, she expects nurses to stop and assess the pain, notify MD, check for PRN orders, and provide available medication.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff interviews, the facility failed to maintain a complete and accurate medical record by not documenting a resident's elopement from the facility and not documenting a nurse assessment to check for injuries upon the resident's return for 1 of 3 residents reviewed for complete and accurate medical records (Resident #58). Findings included:Resident #58 was admitted to the facility's locked memory care unit on 11/12/25.A statement written as part of the facility's investigation by the Activity Assistant and dated 01/08/26 revealed in part, at approximately 5:05 PM when leaving the facility, Resident #58 was observed walking down the road and had reached a point in the road between a food pantry and a thrift store. The Activity Assistant pulled her car over, asked Resident #58 what she was doing and Resident #58 asked the Activity Assistant for a ride. Resident #58 got into the car and was taken back to the facility. The Activity Assistant asked Resident #58 to go into the facility with her to figure things out, Resident #58 complied with the request and was assisted back to the memory care unit by the Activity Assistant. A statement written as part of the facility's investigation by Nurse #3 and dated 01/08/26 revealed Resident #58 was observed in bed at 4:30 PM when Nurse #3 was conducting a medication pass. Nurse #3 noted a skin assessment was completed and Resident #58 had no open areas or injuries.Review of Resident #58's electronic medical record revealed the only nurse assessment documented on 01/08/26 was at 10:00 PM following a fall Resident #58 had while in the shower.Review of the January 2026 nursing staff progress notes for Resident #58 revealed no entry related to her elopement from the facility on 01/08/26. During an interview on 05/14/26 at 10:25 PM, Nurse #3 reported she was Resident #58's assigned nurse on 01/08/26 during the hours of 6:30 AM to 6:30 PM. Nurse #3 stated she received a call from the Director of Nursing (DON) at approximately 5:10 PM informing her that the Activity Assistant had found Resident #58 walking down the road and was bringing her back to the facility. Nurse #3 stated immediately upon Resident #53's return to the facility, she completed a head-to-toe assessment of Resident #58 with no injuries identified. She explained for any incident, per facility protocol, nurses were to document an assessment, and a progress note in the resident's electronic medical record. Nurse #3 reviewed Resident #58's electronic record and confirmed there was no assessment or progress note documented by her on 01/08/26. Nurse #3 stated she always made sure to document and thought she had for Resident #58. She could not explain what happened and stated her best guess was that it was an oversight.During an interview on 05/15/26 at 12:29 PM, the DON stated that on 01/08/26 upon Resident #58's return to the facility after her elopement, she instructed Nurse #3 to complete a head-to-toe assessment on Resident #58. She stated Nurse #3 assessed Resident #58 and no injuries were identified. The DON reviewed Resident #58's electronic medical record and verified there was no nurse assessment or progress note documented by Nurse #3 on 01/08/26. The DON stated she would have expected Nurse #3 to have documented the nurse assessment and a progress note related to Resident #58's elopement from the facility.During an interview on 05/15/26 at 2:22 PM, the Administrator stated there should have been a nurse assessment and a progress note documented in the electronic medical record related to Resident #58's elopement from the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lotus Village Center for Nursing and Rehabilitatio	179 Combs Street Sparta, NC 28675

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to document that a Resident or Responsible Party (RP) were provided education regarding the benefits and potential side effects of the influenza and pneumococcal immunization or if the Resident received the influenza and pneumococcal immunization or did not receive the vaccines due to a medical contradiction or refusal. In addition, there was no documentation that the Resident was offered the influenza and pneumococcal immunization. This occurred for 1 of 5 residents reviewed for immunizations (Resident #58).The findings included:A review of the facility's policy entitled Influenza Vaccination last revised 01/01/26 read in part that Influenza vaccinations will be routinely offered from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine. Following assessment for potential medical contraindications, influenza vaccinations may be administered in accordance with physician-approved standing orders.A review of the facility's policy entitled Pneumococcal Vaccine last revised 01/01/26 read in part that each resident will be assessed for pneumococcal immunization upon admission. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized in accordance with physician-approved standing orders. Resident #58 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease.Review of Resident #58's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident's cognition was moderately impaired and did not receive the influenza vaccination because it was not offered. The MDS also indicated that Resident #58's pneumococcal vaccination was not up to date, and the vaccination was not offered.Review of Resident #58's electronic health record revealed no signed consent indicating the vaccines had been offered, no record of administration, or refusal documentation for the influenza and pneumococcal vaccines. Further review of the medical record also revealed no documentation of the benefits or potential side effects of the influenza and pneumococcal vaccines.An interview was conducted with the Interim Director of Nursing (DON) on 05/15/26 at 11:24 AM. The DON reviewed Resident #58's medical record and did not find any information regarding the influenza and pneumococcal vaccinations being offered, declined or that information about potential side effects was provided to the Resident or the Responsible Party. The DON explained that she could not find a history of Resident #58's vaccinations and that someone should have followed up on the immunizations after the Resident's admission to the facility. The DON stated the Regional Quality Assurance Nurse was responsible for the Infection Control Program which included immunizations.On 05/15/2026 at 11:34 AM during a telephone interview with the Regional Quality Assurance Nurse the Nurse explained that she was the Infection Control Preventionist which included immunizations. She continued to explain that the nurses were doing a good job keeping up with obtaining consent or declinations and giving the immunizations on admission, but when she looked at the immunization records during the survey, she could not find the information for Resident #58, and she did not know why. The Nurse reported the expectation was that the nurses obtain the information on admission as part of the admission procedure. She stated the Director of Nursing should have followed up with the residents who were already in house and made sure the immunizations were offered along with the benefits and potential side effects and the documentation was completed. The Regional Quality Assurance Nurse indicated that the DON knew that it was expected of her to ensure that the immunizations were done and the Regional Quality Assurance Nurse would be the final check to ensure the process was completed. The Regional Quality Assurance Nurse added, it had been a while since she had made a final check to ensure the process was completed.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to assess residents for eligibility and ensure residents were offered the COVID-19 vaccination for 3 of 5 residents reviewed for immunizations (Resident #2, Resident #6 and Resident #9).The findings included:A review of the facility's policy entitled COVID-19 Vaccination last revised 01/01/2026 read in part that COVID-19 vaccinations will be offered to resident as per Centers for Disease Prevention and Control (CDC) guidelines unless it is medically contraindicated, the individual has already been immunized or refuses to receive the vaccine. Following assessment for potential medical contraindications, COVID-19 vaccinations for residents may be administered in accordance with physician approved standing orders.a. Resident #2 was admitted to the facility on [DATE].Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #2 was cognitively intact and was coded Yes, for COVID-19 immunization being up to date.Review of Resident #2's electronic medical record revealed the last COVID-19 immunization given to the Resident was 11/16/23 before her admission to the facility. There was no documentation in the medical record that indicated the COVID-19 vaccine had been offered to Resident #2 or education had been provided to Resident #2 regarding the benefits and potential side effects of the COVID-19 vaccine.b. Resident #6 was admitted to the facility on [DATE].Review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #6 was cognitively intact and was coded No, for Covid-19 immunization being up to date.Review of Resident #6's medical record revealed no history of a Covid-19 vaccination. There was no documentation in the medical record that indicated the COVID-19 vaccine had been offered to Resident #6 or education had been provided to Resident #6 regarding the benefits and potential side effects of the COVID-19 vaccine.c. Resident #9 was admitted to the facility on [DATE].Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #9's cognition was severely impaired and was coded Yes, COVID-19 vaccine was up to date.Review of Resident #9's medical record revealed the last COVID-19 vaccine given to Resident #9 was 02/01/22 before admission to the facility. There was no documentation in the medical record that indicated the COVID-19 vaccine had been offered to Resident #9 or education had been provided to Resident #9 regarding the benefits and potential side effects of the COVID-19 vaccine.An interview was conducted with the interim Director of Nursing (DON) on 05/15/26 at 11:24 AM. The interim DON explained that the latest version of the COVID-19 vaccination should be offered on admission and annually. She reported that education on risk versus benefits should be offered to the resident or responsible party and they should be signing that they received this education and should be documented in the resident's medical record. The interim DON indicated the system failure was that no one continued to follow up on the immunization process to ensure that the vaccines were offered and given at the time of admission and annually afterwards.On 05/15/2026 at 11:34 AM during a telephone interview with the Regional Quality Assurance Nurse the Nurse explained that she was the Infection Control Preventionist which included COVID-19 immunizations. She continued to explain that the nurses were doing a good job keeping up with obtaining consent or declinations and giving the COVID-19 vaccine on admission, but when she looked at the immunization records during the survey, she could not find the information for Resident #2, Resident #6 and Resident #9, and she did not know why. The Nurse reported the expectation was that the nurses obtain the information on admission as part of the admission procedure. She stated the DON should have followed up with the residents who were already in house and made sure the COVID-19 vaccines were offered along with the benefits and potential side effects and the documentation was completed. The Regional Quality Assurance Nurse indicated that the DON knew that it was expected of her to ensure that the immunizations were done and the Regional Quality (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assurance Nurse would be the final check to ensure the process was completed. The Quality Assurance Nurse added, it had been a while since she had made a final check to ensure the process was completed.