STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345317	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clayton Rehabilitation and Healthcare Center	204 Dairy Road Clayton, NC 27520

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews the facility failed to ensure staff were knowledgeable that they should protect the privacy of a resident's medical information by not texting over a nonsecure personal phone to the Nurse Practitioner a resident's name and medical information. This was for 1 of 1 sampled resident reviewed for privacy of health care information (Resident #1).The findings included:Record review revealed Resident # 1 was admitted to the facility on [DATE] after being hospitalized from [DATE] to 9/10/25. Resident # 1 also had a gastrostomy tube placed while hospitalized . Review of nursing notes revealed an entry documented by the Interim DON (Director of Nursing) on 9/10/25 at 6:30 PM noting at 6:30 PM Resident # 1 had arrived by stretcher to the facility. Interview with the interim DON on 10/16/25 at 10:40 AM revealed she was the Unit Manager at the time Resident # 1 was admitted on [DATE]. According to the interim DON, there was a MA (medication aide) assigned to the hall to which Resident # 1 was admitted , and Nurse # 5 was working on the hall who covered the Medication Aide's hall for things the Medication Aide could not do. Nurse # 5 was then responsible for Resident # 1's care after he was admitted on [DATE] at 6:30 PM.Interview with Nurse # 5 on 10/15/25 at 4:40 PM revealed he had been working on the hall adjacent to the hall where Resident # 1 was admitted and he had never been told he was responsible for the resident. Around 8:30 PM on 9/10/25 MA # 2 came to get him because Resident # 1 was bleeding from his gastrostomy tube site. He was able to apply a bandage to Resident # 1's gastrostomy site and get it to stop bleeding. He could find no medical history or orders in the electronic record and tried to call the former DON without success. Somewhere between 11:00 and 11:50 PM, he was still present in the facility when the night shift nurse came to get him because the resident's gastrostomy tube site was bleeding again and the nurse was a newer nurse and wanted his help. He again helped stop the bleeding. He was concerned about the resident, and he wanted to make sure the NP (Nurse Practitioner) knew to check the resident first thing in the morning given that there were no orders and he had bleeding to his gastrostomy tube site. He therefore sent a text to the NP. Nurse # 5 was interviewed regarding whether the facility used a secure and private messaging communication application to communicate with the NP and replied he had not been told about a way to communicate in a secure manner. He showed the surveyor a text he had sent to the NP on the night of 9/10/25 on his personal phone which had the resident's name (Resident #1) and information about the resident bleeding from his gastrostomy site. According to Nurse # 5 he had done this out of concern and because no one had trained him otherwise that he could not text medical information with resident's names and personal health information on a personal phone to the NP.The interim DON was interviewed on 10/16/25 at 10:40 AM and reported they did not have any type of secure health care messaging app that would be compliant with HIPPA (the Health Information and Health Insurance Portability and Accountability Act). Nurses were to call and verbally speak to the NP if there was a need to do so.

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, Nurse Practitioner, and Pharmacist, the facility failed to ensure a nurse knew he was responsible for a newly admitted resident in order that the nurse reconcile what medications had been given to the resident at the hospital, then validate with the facility provider what medications were needed on day of admission to the facility, and administer those medications (Resident # 1). Additionally, the facility failed to ensure nurses were knowledgeable about a newly admitted resident's medical history and could access the medical history when they were assigned to that resident (Resident # 1) and that a resident (Resident # 19) did not miss a dose of a medication ordered four times per day. This was for 2 or 10 residents reviewed for professional standards of practice (Resident #1 and Resident #19). The findings included: 1. Record review revealed Resident # 1 was admitted to the facility on [DATE] after being hospitalized from [DATE] to 9/10/25 with pneumonia, septic shock, diabetic ketoacidosis, and encephalopathy. Resident # 1 also had diagnoses which included history of stroke, congestive heart failure, diabetes, peripheral artery disease, chronic obstructive pulmonary disease, neuropathy, anxiety, hypertension and gastrostomy tube placement. Review of nursing notes revealed an entry documented by the Interim DON (Director of Nursing) on 9/10/25 at 6:30 PM noting at 6:30 PM Resident # 1 had arrived by stretcher to the facility, he was alert and oriented, and that he had dried blood around his gastrostomy site. Review of Resident # 1's admission nursing assessment revealed it was signed as completed by the interim DON on 9/11/25. Interview with the interim DON on 10/16/25 at 10:40 AM revealed she was the Unit Manager at the time Resident # 1 was admitted on [DATE]. The other Unit Manager and the former DON had helped put orders in the electronic record for the resident and Nurse # 5 had been told that Resident # 1 had arrived and he was responsible for the resident. Nurse # 5 had been working on the 3:00 PM to 11:00 PM shift when the resident was admitted . According to the interim DON, there was a MA (medication aide) assigned on the hall to which Resident # 1 was admitted , and Nurse # 5 was working on the hall who covered the Medication Aide's hall for things the Medication Aide could not do. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Nurse # 5 on 10/15/25 at 4:40 PM revealed he had been working on the hall adjacent to the hall where Resident # 1 was admitted . There was a Medication Aide (MA #2) working on Resident # 1's hall on the evening of 9/10/25. He had not been told anything about the resident being admitted and he never saw a resident being rolled by on a stretcher to the Medication Aide's hall. He had been busy with residents on his own hall and had been in rooms. The current Interim DON (former Unit Manager) had not spoken to him and no one else had told him that he was responsible for Resident # 1. Around 8:30 PM on 9/10/25 MA # 2 came to get him because Resident # 1 was bleeding from his gastrostomy tube site. That was the first time that he was aware the resident was there and his responsibility. He looked in the electronic record and could not find orders or the resident's discharge summary to know what medical problems the resident had. He was able to apply a bandage to Resident # 1's gastrostomy site and get it to stop bleeding. MA # 2 told him the resident was not supposed to have anything by mouth, and she thought his medications had been ordered. Since he could find nothing in the record, he told MA # 2 that he would see what medications were delivered from the pharmacy. He then went back to his assigned hall. Nurse #5 stated somewhere between 11:00 and 11:50 PM, he was still present in the facility when the night shift nurse came to get him because the resident's gastrostomy tube was bleeding again and the nurse was a newer nurse and wanted his help. He again helped stop the bleeding. Nurse #5 confirmed he never gave Resident # 1 any medications on 9/10/25 and he did not know if the MA # 2 had checked his blood sugar. He was not even aware the resident was a diabetic. He had no discussions that evening with the Nurse Practitioner about medications or care. Nurse #5 indicated he did try to get in touch with the former DON but could not reach her. Review of facility 9/10/25 admission orders and hospital records noting when medications were last given before transfer to the facility revealed the following information: Resident # 1 was ordered Atorvastatin 40 mg (milligrams) via PEG (percutaneous gastrostomy tube) at bedtime for a diagnosis of hyperlipidemia. The order showed on Resident # 1's September 2025 MAR (Medication Administration Record) as entered into the electronic record on 9/10/25 at 4:07 PM. This medication was scheduled on the MAR to be administered at 10 PM. Resident # 1's hospital MAR for the date of 9/10/25 showed Resident # 1 had not received this medication at the hospital before transfer to the facility. There was no documentation that the resident received Atorvastatin on 9/10/25. Review of a list of the facility's back up supply of medications revealed Atorvastatin was in the back up supply of medications. Review of Resident # 1's medications delivered to the facility revealed Resident # 1's personal supply of Atorvastatin was delivered to the facility on 9/10/25 at 8:10 PM. Resident # 1 had an order for Alprazolam 1 mg (milligram) via PEG two times a day for 14 days for a diagnosis of anxiety. The order showed on Resident # 1's September 2025 MAR as entered into the electronic record on 9/10/25 at 4:07 PM. The MAR included that the scheduled evening dose was due at 5:00 PM. A review of the hospital discharge summary and the hospital MAR indicated this was a new scheduled medication for the resident. Review of a list of the facility's back up supply of medications revealed this medication was available in back up supply for the resident. Review of Resident # 1's medications delivered to the facility revealed Resident # 1's personal supply of Alprazolam was delivered to the facility on 9/10/25 at 8:10 PM. There was no indication that the Resident received any Alprazolam on the evening of 9/10/25. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident # 1 had an order for Gabapentin 300 mg via PEG two times per day for neuropathy. The order showed on Resident # 1's September 2025 MAR as entered into the electronic record on 9/10/25 at 4:29 PM. The evening dose was scheduled to be administered at 9:00 PM. There was no documentation that the resident received Gabapentin on 9/10/25. Review of a list of the facility's back up supply of medications revealed this medication was available in back up supply for the resident. Review of Resident # 1's medications delivered to the facility revealed Resident # 1's personal supply of Gabapentin was delivered to the facility on 9/10/25 at 8:10 PM. Resident # 1 had an order for Carvedilol 6.25 mg via PEG two times per day for a diagnosis of hypertension. This order showed on Resident # 1's September MAR as entered into the electronic record on 9/10/25 at 3:35 PM. The evening dose of Carvedilol was scheduled at 5:00 PM on the facility MAR. Review of the hospital MAR revealed the Carvedilol had been scheduled for 9:00 AM and 9:00 PM while the resident was hospitalized and the resident had not had his second dose of Carvedilol on 9/10/25 before transport from the hospital to the facility. Review of a list of the facility's back up supply of medications revealed this medication was available in a dosage of 3.125 mg in back up supply. Review of Resident # 1's medications delivered to the facility on 9/10/25 revealed Resident # 1's personal supply of Carvedilol was delivered on 9/10/25 at 8:10 PM. (A review of vital signs revealed on night shift which began at 11:00 PM on 9/10/25 the resident's blood pressure was 129/68). Resident # 1 had an order for FSBS (Finger Stick Blood Sugars) to be done before meals and at bedtime. Review of the September MAR revealed no documented FSBS. Nurse # 6 had cared for Resident # 1 starting at 11:00 PM on 9/10/25 through 7:00 AM on 9/11/25. Nurse # 6 was interviewed on 10/16/25 at 2:54 PM and reported the following information. She could not see Resident #1's orders or the hospital discharge summary either when she looked on her shift. It seemed to her as if orders might not have been confirmed in the electronic system. Nurse #6 explained it did show up on the MAR for her to flush the resident's gastrostomy tube and she had done that. She did not give medications or done other measures. Nurse #6 stated the resident had no complaints of pain and slept through the night shift. Nurse # 6 did not report the resident was anxious from not receiving any Alprazolam. Review of NP # 1's 9/11/25 note revealed Resident # 1 was alert and communicative when she saw the resident that day. NP # 1 further documented the following information. Nursing staff had informed her that the resident's blood sugar was high on the glucometer. The resident was ordered to receive 18 Units of Humalog insulin and upon recheck it was still high. Another 18 Units of Humalog insulin was ordered and administered. At 2:30 PM on 9/11/25 the resident's blood sugar registered 309. The NP was interviewed on 10/17/25 at 4:50 PM and reported the following information. Not having a FSBS the night before did not lead to the problems with Resident # 1's blood sugar control on 9/11/25. Resident # 1 was well known to one of the facility physicians and had a long history of having wide fluctuations in his blood sugar. She was in the facility on 9/11/25 and had checked on him frequently on 9/11/25 and he was okay. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was held with the Administrator (who was newly hired during the week of Resident # 1's admission), the Regional Clinical Director, and the Regional Director of Operations on 10/24/25 at 2:30 PM. The Regional Clinical Director was interviewed regarding the professional expectations when a newly admitted resident arrived at the facility. According to the Regional Clinical Director, the list of medications with times the resident had received medications at the hospital had come with Resident # 1 when he was admitted to the facility. Therefore, the staff could have referenced the hospital MAR. If a medication was ordered to be administered twice per day, the primary nurse should review this information and have a discussion with the NP to validate which medications needed to be started on the evening of admission and then administer them. 2. Resident #19 was admitted to the facility on [DATE] with a diagnosis of Parkinson's disease. A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #19 was cognitively intact. A review of the care plan dated 8/16/25 revealed Resident #19 was care planned for Parkinson's disease with interventions including medications as ordered by the physician. A review of the physician's order revealed an order dated 8/01/25 for carbidopa-levodopa (a Parkinson's disease medication) 25-100 Milligrams (mg) to administer 2 tablets by mouth every 4 hours (around the clock). A review of Medication Administration Record (MAR) for the month of October revealed carbidopa-levodopa was signed off as having been administered to Resident #19 for all scheduled doses on 10/11/25. A record review of Medication Administration Audit Report for the day of 10/11/25, revealed Resident #19 was documented as having received her carbidopa-levodopa at the following times 12:00am dose was administered at 12:55am, 4:00am dose was administered at 5:44am, 8:00am dose was administered at 11:14am, 12:00pm dose was administered at 11:22am, 4:00pm dose was administered at 6:23pm, and the resident was not documented as having been administered the 8:00pm dose. An interview conducted with Resident #19 on 10/17/25 at 11:10am revealed on 10/11/25 she missed one (1) dose of carbidopa-levodopa. She experienced aggressive tremor and some confusion. An interview conducted with the Director of Nursing (DON) on 10/17/25 at 2:30pm revealed she was unaware Resident #19 missed a dose of her carbidopa-levodopa medication. A phone interview conducted on 10/17/25 at 2:40pm with Nurse Aide (NA) #11 revealed she worked 7:00pm to 11:00pm on 10/11/25 and she recalled Resident #19 telling NA #11, she missed a dose of her carbidopa-levodopa medication. NA #11 stated she did not tell the hall nurse because the nurse was right next to her room with the medication cart and she assumed that she was going into Resident #19's room soon. A phone interview conducted on 10/17/25 at 3:00pm with Nurse #19 revealed she recalled giving Resident #19 carbidopa-levodopa medication; however, the medication was administered late due to her being new to the hall and Resident # 19's room was at the end of the hall. The nurse further explained she had the medication on the cart however, she gave the medication late. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator on 10/17/25 revealed he was unaware Resident #19 missed a dose of medication. A phone interview conducted on 10/20/25 at 3:38pm with Pharmacy Director revealed that if a resident missed a dose of carbidopa-levodopa medication it would not have immediate effect on the resident if a dose was missed, because the dosage of carbidopa-levodopa is not enough to affect a person if they missed one dose. An interview conducted on 10/20/25 at 4:15pm with the Nurse Practitioner revealed there would not be any harm to Resident #19's health if a dose of carbidopa-levodopa medication was missed.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with staff, Physician, Paramedics, and Fire Department First Responders, the facility failed to ensure basic lifesaving support was provided effectively when residents lost signs of life on weekends. The facility failed to ensure emergency equipment was in a place which would not delay resuscitation efforts for Resident # 21. One facility nurse (Nurse # 1) reported a delay in finding an AMBU bag (Artificial Manual Breathing Unit) to ventilate Resident # 21 and another facility nurse (Nurse # 2) along with emergency medical responders reported an AMBU bag was never used by facility staff to ventilate Resident # 21. (An AMBU bag is used to ventilate a resident who has stopped breathing so that with each chest compression oxygenated blood will circulate while resuscitation efforts are being conducted). Additionally, chest compressions were performed by facility staff without a hard surface beneath Resident # 21. In addition, when Resident #24 was found without signs of life, chest compressions were performed by staff without Resident # 24 being on a rigid surface until EMS arrived and took over care of the resident. Interview with a representative from the American Heart Association who identified herself as the reference person for instructors of BLS (Basic Life Support) reported the material content of BLS instructs that individuals should ideally be on a hard surface to help create adequate blood flow to the heart with compressions. According to the American Heart Association representative, performing compressions on a soft surface further presses an individual down into the soft surface. Both Residents # 21 and # 24 expired when EMS was unable to successfully resuscitate them. This was for 2 of 2 sampled residents who had chosen to have resuscitation efforts provided and experienced a cardiac arrest while under the care of facility staff (Resident #21 and Resident #24).Immediate jeopardy began on [DATE] when staff failed to provide effective Cardiopulmonary Resuscitation (CPR) for Resident # 21. Immediate Jeopardy was removed on [DATE] when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity D to ensure education is completed and monitoring systems put in place are effective.The findings included: Documentation in the facility policy for CPR, dated as revised on 2/2025, revealed the facility's procedure for administering CPR incorporates the steps covered in the American Heart Association guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. The policy also directed that if a resident's DNR status was unclear, CPR would be initiated until it is determined that there is a DNR or a physician's order not to administer CPR. Review of facility personnel records revealed Nurse # 1, Nurse # 2, Nurse #3, Nurse #4, and NA #1 had current CPR training certificates based on the American Heart Association guidelines. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Documentation in the 2025 American Heart Association Guidelines for Cardiopulmonary and Emergency Cardiovascular Care revealed the following information under the heading of Metrics for High Quality CPR. In adult cardiac arrest, it is preferred to perform CPR on a firm surface and with the person in the supine position, when feasible and does not delay chest compressions. A firm surface improves the likelihood of adequate chest compression depth. Studies have supported that optimal chest compressions are best delivered with the person on a firm surface such as the floor. The initiation guidelines for CPR were separated into categories which included instructions for lay individuals and those for health care professionals. The directions for health care professionals included directions if there was one health care responder versus two. When there were more than two health care responders the directions were for both compressions and ventilations to be performed. The directions read, During adult cardiac arrest, a lone health care professional should commence with chest compressions rather than with ventilations. It is reasonable for health care professionals to perform chest compressions and ventilation for all adult patients in cardiac arrest from either a cardiac arrest or noncardiac arrest. Further information was provided regarding the importance of the ventilations as follows: Numerous studies have shown improved outcomes when ventilations are provided in addition to chest compressions for adults in cardiac arrest. Delivery of chest compressions without assisted ventilation for prolonged periods could be less effective than conventional CPR (compressions plus ventilation) because arterial oxygen content decreases as CPR duration increases. 1. Resident # 21 was admitted to the facility on [DATE]. The resident had multiple diagnoses which included heart failure with an ejection fraction of 35% to 40 % (the amount of blood pumped from the main heart chamber with each heartbeat which is normally 50% to 70%), chronic atrial fibrillation, diabetes, chronic obstructive pulmonary disease, and history of respiratory failure with hypoxia. A review of Resident # 21's closed electronic record revealed a banner of information at the top of the electronic record that the resident's advance directive was that he was a full code. Resident # 21's care plan, initiated on [DATE], did not include any advance directives that the resident had chosen not to be resuscitated in the event of death. There were no advance directives in the care plan. Review of Resident # 21's admission Minimum Data Set assessment, dated [DATE], revealed the resident was cognitively intact. On [DATE] at 11:38 PM Nurse # 2 documented the following information. Resident # 21 was found in his room around 9:40 PM unresponsive, resident's pulse was also faint. I began assessing resident, resident pulse stopped and breathing; EMS called and CPR started until EMS arrived around 9:45 PM. CPR performed until 10:09 PM. Time of death ruled 10:09 PM. (The date of [DATE] corresponded to a weekend day). Review of EMS records revealed the following information. The 911 call was received on [DATE] at 9:37 PM. EMS was dispatched at 9:40 PM. EMS was on the scene at 9:46 PM and at patient at 9:49 PM. According to the EMS report it was EMS and the FD (Fire Department) first responders who initiated CPR. Resuscitation efforts were not successful, and time of death was recorded on the EMS report as 10:08 PM on [DATE]. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:00 PM the Staff Development Nurse was interviewed regarding steps taught to employees regarding initiating CPR to a resident when staff are newly hired. The Staff Development Nurse reported the following information. New staff are taught where the crash carts are located and regarding equipment and how to check for a resident's code status. The person who finds an unresponsive person is to yell out first for someone to page overhead to get more help. The charge nurse is then to run the code and direct staff members to perform CPR. A resident's code status is found both in the electronic record and on a paper chart. NA (Nurse Aide) # 2 cared for Resident # 21 on the 3:00 to 11:00 PM shift on [DATE]. NA # 2 was interviewed on [DATE] at 1:15 PM and reported she recalled the events of [DATE] as follows: The resident had been okay in the early afternoon and was talking. Then later in the shift she noticed that the resident was breathing kind of funny. It was like someone who was scared when they breathed, and he was breathing fast. She thought this was sometime around 9:00 PM. She had alerted a nurse. There were three nurses who went to check on the resident. She knew they called EMS, and they worked on his chest. She did not recall the nurse's names. Nurse # 2 was interviewed via phone on [DATE] at 8:56 AM and reported she recalled the events of [DATE] as the following: She had taken the resident's vital signs earlier on the 3:00 PM to 11:00 PM shift and they were all within normal limits. Resident # 21 had been receiving oxygen, and his oxygen saturation was 95%. He had eaten his dinner that evening. She had been keeping her eye on him because he had looked pale that evening. She had been assigned to two halls that night. She had been working on her other assigned hall when Nurse Aide # 2 came to get her and asked for help because the resident was in distress. She yelled for help after Nurse Aide # 2 alerted her because she had already had a concern the resident looked pale. Nurse # 1, who had heard her yell, also came with her to the room. She (Nurse # 2) did not see the resident breathing, and she could not feel a radial pulse. Nurse # 1, who was with her, felt as if she saw a pulsation in the resident's neck. Everything happened fast. She immediately ran to call 911 and passed the phone to a Nurse Aide as she went to look for the resident's code status. She first looked in the electronic medical record, and it was not there. The area where this information was supposed to be was blank when she looked. She recalled there were paper charts and went to look at those. She found Resident # 21 was a full code. They started CPR. Nurse # 3 also came to help. She thought Nurse # 3 was aware of the situation because Nurse # 3 had heard her yell. Nurse # 3 left the room to go find an AMBU bag. She and Nurse # 1 performed chest compressions and Nurse # 1 also tried to find an oxygen mask in order to give oxygen through a mask since they could not find an AMBU bag. She did not recall if they were successful in finding an oxygen mask before EMS (Emergency Medical Services) arrived. She was not sure but did not think Nurse # 3 was doing anything except looking for an AMBU bag before EMS arrived. A Code Blue had never been called overhead to get further help. Nurse #2 indicated she had not been employed at the facility for very long and did not know how to use the intercom in order to announce a Code Blue. Nurse # 3 was interviewed via phone on [DATE] at 1:21 PM and reported she recalled the events of [DATE] as the following: She was coming back from break when she heard there was a Code Blue, and she was not sure how she heard there was a Code Blue. She rushed to the room and brought a crash cart. Another Nurse Aide also brought a crash cart. Nurse # 1 and Nurse # 2 performed chest compressions, and one used an AMBU bag. She had not participated in chest compressions or ventilations. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse # 1 was interviewed on [DATE] at 2:31 PM initially and reported she recalled the events of [DATE] as the following: She had been at the desk with Nurse # 2 when a Nurse Aide came and reported Resident # 21 looked worse. She knew Nurse # 2 had been concerned about the resident. Since she knew Nurse # 2 had been concerned, she jumped up when she heard the Nurse Aide report he looked worse. Upon entering the room the resident was breathing, she (Nurse # 1) could feel a faint radial pulse, and she could see a visible pulsation in his neck where he had a prior injury making it easier to see the pulse. They tried to get a blood pressure on the resident and could not get one. They had not been in the room very long when the resident stopped breathing. It had been about 2 minutes after they entered. They did two or three rounds of chest compressions, and they also ventilated the resident. She did the first set of compressions and then Nurse # 2 took over. Nurse # 3 had provided ventilation. Nurse # 1 was interviewed a second time on [DATE] at 4:30 PM regarding Nurse # 3's comments that she (Nurse # 3) had not provided ventilation and regarding Nurse # 2's comments that they could not find an AMBU bag in order to ventilate the resident. Nurse # 1 reported the following information. She (Nurse # 1) had sent Nurse # 3 to get an AMBU bag on the closest crash cart when the resident coded. There should have been an AMBU bag on the crash cart, but Nurse # 3 could not find an AMBU bag on that cart. There was a second crash cart located in the facility on another hall. This crash cart was furthest from Resident # 21's room. She (Nurse # 1) sent Nurse # 3 to the second crash cart to get an AMBU bag after Nurse # 3 could not find one on the first crash cart. None of the Nurse Aides had responded. She did not think that Nurse # 2 knew how to use the intercom to call a Code Blue and some of the other staff members did not either. Nurse # 1 was also interviewed regarding whether a backboard had been utilized and reported they had not used one. She did not recall if a backboard had been on the crash cart. Nurse # 1 was also interviewed regarding if there had been a delay in finding the resident's code status and reported she heard Nurse # 2 say, I am not seeing this when Nurse # 1 initially looked at the electronic medical record that had been near the resident's doorway on the medication cart. Nurse # 1 reported she did see how things could have gone better but that they had finally found an AMBU bag and Nurse # 3 had ventilated the resident. The First Responder, who identified himself as the Paramedic Supervisor of the EMS crew that responded on [DATE], was interviewed via phone on [DATE] at 4:26 PM and reported he recalled the events of [DATE] as the following: He had entered with the Fire Department (FD) First Responders, and they were first on the scene. When entering the staff were about to start CPR but had not started. The resident had no pulse and was not breathing. There were no crash carts that he saw. He and the FD First Responders started CPR. The First Responder, who identified himself as the Lead Paramedic, was interviewed via phone on [DATE] at 4:43 PM via phone and reported he recalled the events of [DATE] as the following: When he arrived, the FD First Responders and the Paramedic Supervisor had entered before them. He did not recall seeing any crash carts. The Paramedic Supervisor and the FD First Responders had started CPR. There had been no AMBU bag being used on the resident before they had arrived. There had been no backboard under the resident. Fire Department First Responder # 1 was interviewed via phone on [DATE] at 11:55 AM and reported he recalled the events of [DATE] as the following: When the FD First Responders entered the staff were doing compressions, but he did not believe they were doing ventilations. He did not want to say for sure. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Fire Department First Responder # 2 was interviewed via phone on [DATE] at 2:07 PM and reported the following information. When the Fire Department Responders arrived, the staff were doing compressions without a backboard, and they were not providing ventilation. There had been no AMBU bag in the room. According to the Fire Department First Responder # 2 the FD did not have a policy about doing CPR. The compressions were taken over by them with the resident in the bed without the backboard and FD First Responder # 2 felt like they were getting good compressions. An observation of Crash Cart A on [DATE] at 9:41 AM revealed this was the crash cart that had been located closest to Resident # 21's room. It was stationed just past the nursing station for the 100, 200, and 300 halls. There was a binder on the crash cart with directions that the 11:00 PM to 7:00 AM shift nurse should check the crash cart daily to ensure the lock had not been broken on the cart and if the lock was broken then the contents were to be checked, replaced if needed, and the lock replaced. The signature sheet had no checks/initials from [DATE] through [DATE]. There was a backboard and an AMBU bag on top of the cart. A representative from the American Heart Association was interviewed on [DATE] at 2:52 PM regarding the course material taught for basic life support. The representative identified herself as the person who is called by instructors when they have material and content questions. This representative reported the following information. Ideally individuals are to be moved to a hard surface which is typically the floor to do CPR. If that is not reasonable, then another hard surface can be used such as a table. The material content included the information that doing compressions on an individual on a soft surface would further push them into the soft surface whereas compressions on a hard surface help create adequate blood flow to the heart with compressions. The Interim Director of Nursing, who had been serving as Director of Nursing on [DATE], was interviewed on [DATE] at 10:30 AM and reported the following information. She was aware that Resident # 21 had coded on [DATE] but she had not been made aware there had been any problems. It was her understanding that the resident's respirations were shallow and then he lost a pulse. She knew Nurse # 2 had been in the room when this had happened and the staff had started CPR. It was her expectation that if a resident coded then a Code Blue would be announced over the intercom. There were directions by the phone regarding how to page overhead if needed. Nurses should use a backboard for compressions and there was supposed to be an AMBU bag on every crash cart which should be used for ventilation. Interview with the Administrator on [DATE] at 3:51 PM revealed he had not been made aware of any problems with providing resuscitation efforts for Resident # 21. The Corporate Regional Clinical Director was interviewed on [DATE] at 2:20 PM and reported she had been informed the resident had coded and asked if everything had gone okay. No one had reported any problems with providing resuscitation efforts for the resident and she had not been aware of any problems. On [DATE] at 4:40 PM the Physician, who was filling in for the Medical Director while the Medical Director was on leave, reported the following information. He could not say what had transpired in a Code at the facility since he was not present. In general, even if everything is done correctly with a code, a resident can still die regardless of correct resuscitation efforts. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Resident #24 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease, type 2 diabetes mellitus, dysphagia, stroke, coronary artery disease, and hyperlipidemia. Resident #24 had an advance directive with a physician's order for full code, dated as initiated on [DATE]. Documentation on a Medicare 5-Day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 had short- and long-term memory problems, did not speak, and was rarely/never understood or understood others. Resident #24 was coded on the same assessment as having a feeding tube for her nutrition and hydration. Documentation in an SBAR (Situation, Background, Assessment, Recommendation) summary note written by Nurse #3 on [DATE] at 11:13 AM revealed the following information. Resident #24 was seen by Nurse #3 on nursing rounds and for medication administration. When Nurse #3 returned, Resident #24 was unresponsive. Upon entering the room, Nurse #3 noted Resident #24 was without a pulse, and her chest was not rising or falling. Nurse #3 was unable to obtain vital signs on Resident #24. A Code Blue and 911 were called, and CPR (cardiopulmonary resuscitation) was initiated. A phone interview was conducted with Nurse #3 on [DATE] at 9:43 AM, and the following information was provided. Nurse #3 started between 7:30 AM and 8:00 AM on [DATE] taking blood sugars levels and administering insulin to the diabetic residents on her assignment. Resident #24 was one of the last residents for whom she took a blood sugar reading and administered insulin on that day. Nurse #3 then took vital signs and administered medications to the residents on her assignment, starting at the top of the hallway again. When Nurse #3 arrived at the room of Resident #24, Nurse #3 crushed up all the medications to be administered via the feeding tube and went into the room to obtain vital signs. Resident #24 had a good blood pressure reading, but the pulse oximeter on her finger was fluctuating. While the pulse oximeter reading was going up and down, Nurse #3 administered the crushed medications to Resident #24 via her tube feeding. Nurse #3 noted the pulse oximetry reading settled on 88%. (A normal pulse oximetry reading is typically 95% to 100%. This indicated that blood is carrying enough oxygen to the organs and tissues.) Nurse #3 ran to get an oxygen concentrator and tubing. Upon returning to the room of Resident #24, Nurse #3 saw that Resident #24 was not breathing, lowered the head of the bed, turned off the tube feeding, and began CPR by doing chest compressions. Nurse #3 did not know at what time she returned or how long it took her to obtain the oxygen concentrator. Nurse #3 confirmed that she did not leave Resident #24 to perform an overhead page for Code Blue. Nurse #3 saw Nurse Aide (NA) #8 in the hallway and stated to NA #8 to call 911 and Code Blue. Nurse #3 continued chest compressions until another nurse (Nurse #4) and a Nurse Aide (NA) #1 came with a crash cart. (A crash cart is a wheeled container carrying medicine and equipment for use in an emergency resuscitation.) The other nurse, Nurse #4, connected the AMBU bag (Artificial Manual Breathing Unit), and Nurse #3 continued with chest compressions. Nurse #3 confirmed that Resident #24 was not moved to the floor, and a rigid surface was not placed under Resident #24. Nurse #3 indicated she alternated her position during CPR with another staff member prior to the arrival of emergency medical services (EMS). Nurse #3 did not know who called 911. Nurse #3 confirmed CPR continued until the arrival of EMS, who then took over. Nurse #3 indicated she had signed training in-services when she started work at the facility but did not say training was provided on performing CPR. Nurse #3 confirmed she had previous training as a nurse on performing CPR. Nurse Aide (NA #8), employed by an agency, did not respond to requests for an interview. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse #4 was interviewed on [DATE] at 10:49 AM and provided the following information. Nurse #4 was an agency nurse employed at the facility for two weeks. Nurse #4 came into the facility at approximately 10:45 AM on [DATE] and had no assignment other than to obtain signatures from nurses on in-service documents. As Nurse #4 was entering the building, he passed Nurse #3 in the hallway, who told him that Resident #24 had an oxygen saturation rate of 88% and that the physician needed to be called. Nurse #4 returned to his car to obtain his stethoscope. When Nurse #4 came back into the facility a few moments later, NA #1 told him Resident #24 was unresponsive. Nurse #4 did not recall an overhead page for Code Blue being made over the facility's intercom system. Nurse #4 ran to get the crash cart from the 400 hall and brought it to Resident #24's room. Nurse #4 connected the AMBU bag to the oxygen concentrator and started providing ventilation to Resident #24. Nurse #4 confirmed that the tube feeding was turned off and that Resident #24 was flat on the bed. Nurse #4 recalled two crash carts were brought to the room and NA #1 assisted with CPR, switching out with Nurse #3. Nurse #4 denied that Resident #24 was put on the floor and denied that he put a rigid surface underneath Resident #24 before initiating CPR. Nurse #4 confirmed NA #1 called 911. When EMS arrived, they took over providing CPR to Resident #24. NA #1 was interviewed on [DATE] at 11:42 AM and provided the following information. NA #1 was sitting at the nursing station on [DATE] at approximately 11:00 AM. NA #1 heard a commotion in the 300 hallway. NA #8 was talking to someone who was in a room. NA #8 came down the hallway, talking to herself, saying she needed to get the man in the red shirt. NA #1 stopped NA #8 and asked her what was going on. NA #8 told her she needed to get the man in the red shirt. NA #1 asked NA #8 if she meant Nurse #4. NA #8 replied yes, because it was an emergency. NA #1 asked what the emergency was, to which NA #8 replied Resident #24 was not breathing. NA #1 ran to find Nurse #4, who was just coming into the building. NA #1 told Nurse #4 that Resident #24 was not breathing. NA #1 denied that she heard anyone use the intercom system to page a Code Blue overhead. Nurse #4 ran to get a crash cart, and NA #1 ran to get another crash cart. NA #1 arrived at the room of Resident #24 with a crash cart, and Nurse #4 was behind her with another crash cart. Nurse #4 dialed 911 on his personal cell phone and handed it to NA #1 telling her to speak to 911. NA #1 went back to the nurses' station and looked in the electronic medical record to locate the code status of Resident #24. NA #1 saw the code status of Resident #24 was full code, so she hollered down the hall to notify Nurse #4 about the resident's code status. After talking with the 911 operator, NA #1 went to Resident #24's room and switched places with Nurse #3 and began chest compressions. NA #1 stated she did not recall if there was a rigid surface underneath Resident #24 and denied that Resident #24 was put on the floor. NA #1 stated she continued chest compressions until EMS arrived to take over. The MDS Coordinator was interviewed on [DATE] at 9:52 AM. The MDS Coordinator explained that she was the manager on duty on [DATE]. The MDS Coordinator stated that she was verbally told by someone that CPR was initiated for a resident on the 300-hallway. The MDS Coordinator discovered that two nurses, and a nurse aide had initiated CPR on Resident #24 and confirmed that EMS had been called. The MDS Coordinator stated she went to make copies of the documentation the EMS would need when they arrived at the facility. The MDS Coordinator stated she handed an EMS employee the resident's paperwork when they arrived and gave them quick information about the resident after they all went to the room. The MDS Coordinator explained that the EMS supervisor asked Nurse #3 how long it had been since Resident #24 had respirations and was told 20 minutes after she was found. The MDS Coordinator revealed that EMS made continued attempts to revive Resident #24 but were unsuccessful. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Documentation on the EMS record dated [DATE] for a call received at 11:12 AM revealed the following information. EMS arrived and found Resident #24 lying on the bed, supine, and unresponsive. EMS took over from the facility staff and placed a LUCAS device on Resident #24 for continued compressions. (A LUCAS machine is a portable, automated device that performs continuous chest compressions during CPR. It consists of a back plate that slides under the patient and a piston-based compression module that is placed on the chest.) Resuscitation attempts were made by EMS, but Resident #24 was pronounced dead at 11:46 AM. A phone interview was conducted on [DATE] at 1:08 PM with the Lead Paramedic who responded to the EMS call on [DATE] for Resident #24. The Lead Paramedic stated he did not recall the facility using a board or rigid surface underneath Resident #24 during compressions when EMS arrived. The Lead Paramedic stated he did recall one of the other paramedics in the room reporting to him that the facility did not have a board on the mattress underneath. The Lead Paramedic confirmed the LUCAS device used by EMS had a rigid back plate placed underneath Resident #24 prior to the start of chest compressions. The Interim Director of Nursing (DON) was interviewed on [DATE] at 10:30 AM and reported the following information. It was her expectation that if a resident coded then a Code Blue would be announced over the intercom. There were directions near the phone regarding how to page overhead if needed. Nurses should use a backboard when providing chest compressions because using a backboard creates a hard surface making the compressions more effective. An interview was conducted with the Regional Clinical Director and the Administrator on [DATE] at 9:48 AM. The Regional Clinical Director stated that during CPR, the most important component was the chest compressions and that having a rigid surface underneath the resident didn't make that much difference. The Regional Clinical Director revealed that she was a former CPR instructor. The Administrator stated that not using the overhead intercom system to call a Code Blue was only a delay of seconds or minutes, not rising to the level of a delay in response for Resident #24. A phone interview was conducted with the Physician on [DATE] at 4:40 PM. The Physician stated that there was no way of knowing what the underlying event was that caused Resident #24 to stop breathing, making the correlation of the potential success of CPR also unknown. The Physician further stated that a catastrophic event does not have a correlation with the success of CPR even if performed with expert procedures. Observations were made of facility crash carts on [DATE] at 9:41 AM, which revealed all necessary equipment was available, to include backboards on both carts. A representative from the American Heart Association was interviewed on [DATE] at 2:52 PM regarding the course material taught for basic life support. The representative identified herself as the person who is called by instructors when they have material and content questions. This representative reported the following information. Ideally individuals are to be moved to a hard surface which is typically the floor to do CPR. If that is not reasonable, then another hard surface can be used such as a table. The material content included the information that doing compressions on an individual on a soft surface would further push them into the soft surface whereas compressions on a hard surface help create adequate blood flow to the heart with compressions. The facility Administrator was informed of Immediate Jeopardy on [DATE] at 6:10 PM. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility provided the following credible allegation of immediate jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. Resident #21 & Resident #24 suffered related to this deficient practice. Nurse #1, Nurse #2, Nurse #3, Nurse #4, NA #1, and NA #2 failed to ensure basic lifesaving support was provided effectively when CPR was administered to residents who lost signs of life and compressions were performed without the residents being on a rigid surface for both Resident #21 and Resident #24. Additionally, the facility staff failed to do the following for Resident #21: 1) ensure staff knew how to announce a Code Blue to obtain assistance when a resident was without signs of life; 2) ensure the resident's code status was in the facility's electronic record; and 3) ensure emergency equipment was in a place which would not delay resuscitation efforts. Resident #21 and Resident #24 expired. All facility residents have the potential to be affected by failing to ensure the code status was in the medical record. An audit will be completed by the Social Service Director/Designee

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with staff and Physician the facility failed to 1) ensure the plan of care for wounds following cancer surgery was clarified when two different providers were involved in overseeing the wounds (Resident # 8) and 2) Nurses who were responsible for wound care could access the Wound Physician's plan of care (Resident # 8) and therefore implement and follow it 3) that residents received wound care for skin cancer wounds (Resident # 8) and diabetic ulcer wounds (Resident # 1). This was for 2 of 3 sampled residents who had wounds which were not pressure related (Resident #8 and Resident #1). The findings included:1a. Record review revealed Resident # 8 was admitted to the facility on [DATE]. The resident's current diagnoses included a diagnosis of squamous and basal cell carcinoma. Resident # 8's annual Minimum Data Set assessment, dated 9/6/25, coded Resident # 8 as cognitively intact. Under wounds the resident was coded as having a lesion which included cancer.During an interview with Resident #8 on 10/15/25 at 10:38 AM Resident # 8 reported that he thought the nurses were supposed to be putting ointment on his back after having skin cancer lesions removed.Review of dermatology reports, dated 9/17/25, revealed Resident # 8 had basal cell carcinoma to the left upper back and squamous cell carcinoma to his right inferior upper back. According to the dermatology reports, Resident # 8 underwent [NAME] surgery for these areas on 9/17/25 and closure on 9/18/25 during a second visit. (Mohs surgery is a procedure used to treat skin cancer. This surgery involves cutting away thin layers of skin. Each thin layer is looked at closely for signs of cancer. The process keeps going until there are no signs of cancer.) On 9/17/25 the Dermatologist noted the plan following the procedure was for mupirocin topical ointment (an antibiotic) to be applied to the sites with a bandage daily for two weeks. The Dermatologist's notes regarding the 9/18/25 closure included that he again discussed with the resident the post care instructions.Interview with the current facility Wound Nurse (Nurse # 13) on 10/17/25 at 1:30 PM revealed the following information. The facility had difficulty getting the Dermatologist to send records and notes to them regarding the care of the wounds after the surgery. The facility Wound Physician had been seeing the resident on a weekly basis. Review of the Wound Physician notes revealed the following:On 9/26/25 the Wound Physician saw the resident and documented the following information. The resident had a wound on the right upper back, and the etiology was a neoplasm. The area was 0.5 cm (centimeters) X 1.5 cm X 0.2 cm. There was a post-surgical wound also to the upper back which measured 4.5 cm X 0.3 cm X depth not measurable. The wound bed included 30% necrotic tissue and 70 % granulation tissue. For both of these wounds, the treatment plan was for Dakin's to be applied once daily and if saturated, soiled, or dislodged. (Dakin's solution is a dilute sodium hypochlorite solution which is commonly known as bleach.) The resident also had a post-surgical wound to his left back which measured 0.9 cm X 0.8 cm X 0.2 cm and the plan for this wound was for a superabsorbent gelling fiber with silicone once per day and as needed. The Wound Physician also noted the resident should be placed on an antibiotic for ten days.On 9/26/26 an order was entered into the electronic record for wound care to the resident's back which included cleansing with Full Strength Dakin's daily and applying a hydro cellular foam dressing.On 10/2/25 the Wound Physician noted the treatment plan for dressing changes would remain the same.According to a dermatology report, dated 10/3/25, the resident returned to the Dermatologist. According to the report on this date the resident underwent repair of the wound to his left inferior back which included staples being placed in the wound. The dermatologist noted that topical antibiotics were recommended to be applied. Some of the Dermatologist's notes were unclear. At one point in the narrative note, the Dermatologist noted the plan was for mupirocin (a topical antibiotic) to be applied to the resident's scalp daily with bandage change.On 10/10/25 the Wound Physician again saw Resident # 8 and documented the following. The wound on his upper right back measured 1.3 cm X 1.2 cm X 0.2 cm. The treatment plan for this wound should change from the previous plan of Dakin's application to applying a Xeroform gauze once daily. He (the Wound Physician) was signing off on and relinquishing care to dermatology for the wound to his upper back. The treatment plan for the left back was to be xeroform gauze once daily and as needed with a superabsorbent gelling fiber with silicone.Review of Resident # 8's TAR (Treatment Administration Record) revealed the order which had been entered for Dakin's to be used for wound care to the resident's back on 9/26/25 remained in effect on the TAR through 10/15/25.On 10/16/25 an order was written for a xeroform occlusive gauze (which is impregnated with a blend of petroleum and Bismuth tribromophenate which is non-adhering and moisture retentive) to be applied to all

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with resident, staff, responsible party (RP), Physician, Physician Assistant, Nurse Practitioner, and Hospice Nurse the facility failed to, 1) ensure the Wound Physician's unclear plan of pressure sore treatment for a resident (Resident # 17) was clarified 2) ensure a dressing was changed when a resident's (Resident # 17's) dressing saturated through to the pillowcase and the resident voiced pain from the pressure sore 3) ensure treatment orders were obtained and initiated when residents (Resident # 1 and Resident # 18) were identified with pressure sores (4) ensure nurses knew they were responsible for pressure sore care for residents (Resident # 1 and Resident # 26) and that care was completed and 4) ensure a nurse could access the treatment cart and supplies to change a pressure sore dressing (Resident # 26). Resident # 17 was found with multiple maggots in the pressure sore after staff reported Resident # 17 had drainage through to the pillowcase with accompanying odor and after the resident had requested for the dressing to be changed the day prior to the maggots being found. According to a diagnostic entomologist's interview, wound drainage is an attractant for flies. Resident # 17 reported she almost died when she saw the maggots crawling out of her pressure sore and was scared her foot was rotten. This was for 4 of 6 sampled residents reviewed for pressure sore care (Residents # 1 #17, #18, and # 26). The findings included: 1. Resident # 17 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease, end stage renal disease, diabetes, congestive heart failure, chronic pain syndrome, and chronic wounds. Review of Resident # 17's quarterly Minimum Data Set assessment, dated [DATE], revealed Resident # 17 was cognitively intact and was receiving care for pressure sores. Review of Resident # 17's record revealed the Wound Physician visited regularly and oversaw the plan of care for the resident's pressure sores. Within the Wound Physician's [DATE] report the Wound Physician noted the following locations and duration of the pressure sores. Right heel; Stage 4 (deep wounds that may impact muscle, tendon, ligaments and bone); greater than 310 days in duration Left heel; Stage 4; greater than 224 days in duration Left buttock; Shifting wound; greater than 2 days in duration Right buttock; Shifting wound; greater than 2 days in duration (When an individual shifts in position, there can be a shearing force as the skin is pulled in different directions and thereby causing a wound). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	a. On [DATE] the Wound Physician further documented the following information regarding the pressure sore to Resident # 17's right heel. The wound bed was 100% granulation tissue. It measured 2 cm (centimeters) X 2 cm X 0.2 cm. At the time the resident was not having pain in the right heel pressure sore and there was no sign of infection. There was no notation of odor from the pressure sore. The treatment plan for the right heel pressure sore included unclear directions regarding the frequency of the dressing changes. The primary dressing was to be changed daily and also if saturated, soiled, or dislodged with placement of calcium alginate and silver in the pressure sore wound bed. The secondary dressing was to be a gauze island dressing and be changed three times per week. Around the peri-wound, skin prep was to be applied three times per week. The Wound Physician noted this order was to be in effect for 30 days. On [DATE] the Wound Physician documented the following regarding Resident # 17's right heel pressure sore. The wound bed was 20 % slough and 80 % granulation tissue. It measured 2.5 cm X 2 cm X 0.2 cm. At the time the resident was not having pain in the right heel pressure sore and there were no signs of infection. There was no notation of odor from the pressure sore. The treatment plan for the right heel pressure sore again included unclear directions regarding the frequency of the dressing changes. The primary dressing was to be calcium alginate with silver applied daily and as needed if saturated, soiled, or dislodged for 16 days. The secondary dressing was to be a gauze island dressing applied three times per week with skin prep applied to the peri-wound three times per week. Review of the record revealed no clarification orders were obtained from the Wound Physician on [DATE] or [DATE] when his plan of care was to be for a primary dressing change of daily and a secondary dressing change of three times per week. During an interview with the Wound Physician on [DATE] at 1:25 PM the Wound Physician reported his intent must have been to perform the dressing changes three times per week since you could not change the primary dressing daily if the secondary dressing was being changed only three times per week. The Wound Physician also reported that the staff could reach out to him for clarification at any point and he did not recall them doing so regarding Resident # 17's dressing change orders. Review of Resident # 17's August and [DATE] TARs (Treatment Administration Records) revealed an order which had originated on [DATE] was in place on the August and [DATE] TARs. The directions on this order were also unclear. They included to clean the right heel pressure sore with normal saline and apply calcium alginate with silver. Skin prep was to be applied to the peri wound. The pressure sore was to be wrapped with kerlix and secured with tape. This was to be done Monday, Wednesday, and Friday. Within the same order on the TAR, there were directions which contradicted how often the dressing should occur. Specifically, this same order also read, change every other day. PRN (as needed) soilage. The August and September TAR were set up for the dressing to be changed on Monday, Wednesday, and Friday. There was a X in the box where nurses would initial on Tuesdays, Thursdays, Saturdays, and Sundays if the dressings were to be done on those days. Review of the [DATE] TAR revealed Nurse # 7 documented he changed Resident # 17's right heel pressure sore dressing on Monday ([DATE]); Wednesday ([DATE]); Friday ([DATE]); Monday ([DATE]); and Wednesday ([DATE]). There were no other documented dressing changes to the resident's right heel on Resident # 17's [DATE] TAR except on these dates. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Nurse # 7 was interviewed on [DATE] at 3:35 PM and reported the following information. He had never changed Resident # 17's dressings. He had cared for Resident # 17 and signed on her MAR (Medication Administration Record) and just kept going and signed on the TAR. He thought the former Wound Care Nurse (Nurse #15) had been in the facility when he worked and she had changed the dressing on the dates his signature appeared. Review of Nurse # 15's timecard revealed she had not clocked in to work on Monday ([DATE]) and therefore had not been present to change Resident # 17's dressing when Nurse # 7 thought it was changed on Monday ([DATE]). According to the assignment sheets, Nurse Aide (NA) # 7 had cared for Resident # 17 on Wednesday [DATE] during the 7:00 AM to 3:00 PM shift. NA # 7 was interviewed on [DATE] at 10:55 AM and reported the following information. She recalled taking care of Resident # 17 around five times. Every time she worked with Resident # 17 her right heel pressure sore would drain onto the pillowcase below her heel. She would let the Wound Care Nurse know. The dressing would be in the same condition at 3:00 PM when she left and she did not know what had occurred after she left work. According to the assignment sheets, Nurse Aide # 3 had cared for Resident # 17 on the 3:00 PM to 11:00 PM on [DATE] (Wednesday). NA # 3 was interviewed on [DATE] at 1:25 PM and reported he did not recall Resident # 17. According to the assignment sheets, NA # 4 had cared for Resident # 17 on the shift which began at 11:00 PM on [DATE]. NA # 4 was interviewed on [DATE] at 7:13 AM and reported she did not recall Resident # 17. According to the assignment sheets, NA # 9 cared for Resident # 17 on the [DATE] from 7:00 AM to 3:00 PM. NA # 9 was interviewed on [DATE] at 3:00 PM and reported the following information. She routinely took care of Resident # 17. The week of [DATE] she noted there was a bad smell in the resident's room, and she thought it was coming from one of the resident's wounds. One day that week Resident # 17 told her she wanted to go sit on the porch. She (NA # 9) thought the resident might be trying to get away from the odor in the room because it was so noticeable. On the morning of [DATE] she had assisted the resident and saw that there was drainage from her heel on the pillowcase. There was about a pickle jar size of drainage that had gone through the dressing and onto the pillowcase. She assisted the resident to the bathroom and then to her chair. She let the former Wound Nurse (Nurse # 15) know that the resident's dressing needed to be changed. She left the room. Later Resident # 17 told her there were maggots in her foot. After Nurse # 15 had been in the room with other nurses she (NA # 9) no longer noticed the bad smell, she had smelled that week. After that the room smelled like bleach. Review of progress notes did not reveal a notation that maggots were found in the resident's pressure sore wound bed. There was a SBAR (situation, background, assessment, and recommendation) note completed on [DATE] at 11:17 AM by the former DON (Director of Nursing). The note indicated there had been a decline in the resident's right heel wound and the family and NP (Nurse Practitioner) were notified. It did not note what the decline was. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident # 17 was interviewed via phone on [DATE] at 9:55 AM and reported the following information. There had been a day while she resided at the facility that maggots were found in her right heel wound. Prior to this the wound care nurse had been changing her dressing every two days. The day before the maggots were found in the wound, her foot had been hurting her more. There had also been a funny smell in her room. She had wanted the bandage changed and had asked the Wound Care Nurse if she could change the dressing. The Wound Care Nurse had told her No, that she would not change it because it was changed the day before. On the day that the maggots were found she saw the Wound Care Nurse turn her face away from the wound as she started to care for it. She asked the Wound Care Nurse what was wrong and then she (Resident # 17) looked down at her foot and saw maggots crawling out of her foot. There were a lot and at least more than 10. They took her to the shower room and cleaned them up and later she went to dialysis. They also placed her on an antibiotic. Resident # 17 further reported that when she saw the maggots crawling from her foot wound that she almost died and thought to herself, My foot is rotten. She further reported it had scared her and was very upsetting to see them crawling from her foot. Nurse # 14, who was the Unit Manager for Resident # 17's unit, was interviewed on [DATE] at 3:58 PM and reported the following information. She had been at the nursing station when Nurse # 15 (the former wound care nurse) asked her to come to the room. When she entered the dressing had already been removed and the wound was open. The floor was covered with maggots and Nurse # 14 described it as horrific to the point that she did not even want to think about it. They called the former DON into the room. The NP was informed, and the resident was taken to the shower and cleaned. The resident was scheduled to go home the next day and was saying this was not supposed to be happening. The former DON was interviewed on [DATE] at 8:34 AM and reported the following information. She recalled that Resident # 17's dressings were due to be changed on Monday, Wednesday, and Friday. Nurse # 15 (the former wound care nurse) had experienced scheduling problems. Nurse # 15 had not reported to work on Monday ([DATE]) when Resident # 17's dressings were due to be done that Monday. After the maggots were found she (the former DON) had looked into the matter, and Nurse # 15 had reported to her (the former DON) that she had changed the dressing on Tuesday ([DATE]). Then when it was due on [DATE] she did not change it again because her (Nurse # 15's) intent was to change it again on Thursday ([DATE]). Nurse # 15 had acknowledged to her (the former DON) that the resident had requested for the dressing to be changed on [DATE] (Wednesday). She (the former DON) had also talked to Resident # 17 after the maggots were found and the resident reported she had requested the dressing to be changed because her foot was hurting and had drainage on [DATE]. She (the former DON) had told Nurse # 15 that the resident's dressing should have been changed on [DATE] (Wednesday). Disciplinary action was taken with Nurse # 15 which ended in her being terminated from employment. Attempts were made to interview Nurse # 15 on [DATE] at 11:30 AM and again on [DATE] at 8:57 AM and Nurse # 15 could not be reached for interview. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview with the facility Wound Physician on [DATE] at 2:30 PM revealed he recalled receiving a call from the facility the day before the resident was scheduled to go home. (This would have coincided to [DATE]). It was the evening when he was called. He was told about the maggots and recommended that the resident go to the hospital for antibiotics, but the resident was wanting to go home the next day and declined to go to the hospital. He had not seen Resident # 17 during the week the maggots were found. He attempted to look at all her wounds on [DATE] before she went home but she had multiple wounds which required getting back in bed for assessment, and she did not want to get back in bed for an assessment. If he had noticed an odor from the wound the previous week, he generally placed that information in his notes. Therefore, he must not have noticed an odor since he had not documented one. A foul wound odor can represent an infection of the wound. Generally, maggots only target necrotic tissue in a wound bed. As he recalled, the resident had been making some progress in her wounds while he had been seeing her over the weeks. She had both arterial and vascular problems which were problematic in the development and healing of her wounds. A vascular consultation had been done while he was caring for her, and she was not a surgical candidate for an operation to increase blood flow to the pressure sores because of the severity of her vascular disease. The Wound Physician stated if a resident's wound was oozing through a dressing, then it was his expectation that the dressing be changed. Review of a Nurse Practitioner note, dated [DATE], revealed the resident was being discharged home. The NP noted the resident was given an antibiotic prescription upon discharge and the resident was to be followed at a local wound clinic thereafter. Interview with the NP on [DATE] at 4:50 PM revealed that she did recall looking at the heel wound before the resident was discharged on [DATE] and there were no maggots or concerns at that time from the maggots being in the wound. On [DATE] at 10:58 AM a diagnostic entomologist, who serves as the director of the North Carolina State University Plant Disease and Insect Clinic, was interviewed about maggot development and reported the following information. There are different species of flies but the number one suspect that generally is attracted to wounds is the Blow fly. Drainage from wounds and any decay in a wound would attract them. They can lay a few eggs up to several dozen at one time. There are different species of Blow Flys and therefore times for the eggs to develop into maggots also varies. It can happen in less than 24 hours in some species. The eggs are small and elongated and are visible to the eye. It takes from one to two weeks for the egg being laid to an adult fly stage. The Administrator was interviewed on [DATE] at 9:58 AM and reported he had just become employed at the facility during the week of [DATE]. He did know the former DON had scheduling problems with the former treatment nurse, but he was not made aware of specific details in regards to Resident # 17 or if the former treatment nurse was not doing dressings. 1b. Review of the Wound Physician's note for [DATE] revealed Resident # 17's left buttock wound had been present for greater than 2 days. It measured 3.1 cm X 2 cm X 0.2 cm and was 100 % granulation tissue. The Wound Physician noted the area had developed from the resident shifting. The Wound Physician also noted Resident # 17 had a right buttock wound from shifting which measured 3.0 cm X 2.1 cm X .3 cm and included 70 % granulation tissue and 30 % slough. The Wound Physician's treatment plan on [DATE] for both these wounds was for calcium alginate with silver to be applied daily and as needed if saturated, soiled, or dislodged for 30 days. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE] the Wound Physician's note revealed Resident # 17's left buttock wound measured 2 cm X 2 cm X 0.2 cm and was 100 % granulation tissue and the right buttock wound was 2 cm X 2.1 cm X 0.3 cm and was 100 % granulation tissue. Both wounds were noted at goal. The Wound Physician's treatment plan continued to be for daily dressing changes to both areas with calcium alginate and silver. Review of Resident # 17's August and [DATE] TARs revealed the buttock wound orders were transcribed on [DATE]. The left buttock wound order on the TARs included unclear instructions. The order on the TARs for the left buttock directed to apply the calcium alginate with silver every Monday, Wednesday, and Friday and to change the dressing daily. The order on the TAR for the right buttock wound directed that the dressing should be changed three times per week. Both of the wounds were scheduled on the TARS to be changed Monday, Wednesday, and Friday. There was a X under Tuesday, Thursday, Saturday, and Sunday where nurses would initial if done. Review of the [DATE] TAR revealed Nurse # 7 documented he changed Resident # 17's buttock pressure sore dressings on Monday ([DATE]); Wednesday ([DATE]); Friday ([DATE]); Monday ([DATE]); and Wednesday ([DATE]). There were no other documented dressing changes to the resident's buttock pressure sores that month. Nurse # 7 was interviewed on [DATE] at 3:35 PM and reported the following information. He had never changed Resident # 17's dressings. He had cared for Resident # 17 and signed on her MAR (medication administration record) and just kept going on the TAR. He thought the former wound care nurse (Nurse #15) had been in the facility when he worked and she had changed the dressings on the dates his signature appeared. Review of Nurse # 15's (the former wound care nurse) timecard revealed she had not clocked in to work on Monday[DATE] and therefore had not been present to change Resident # 17's dressings when Nurse # 7 thought it was changed on Monday ([DATE]) During an interview with the current Wound Care Nurse (Nurse # 13) on [DATE] at 12:30 PM the nurse reported that she had checked with both physicians who covered residents at the facility, and they were agreeable to any plan of care by the Wound Physician. The Wound Physician was the physician who saw the residents on a weekly basis. Interview with the Wound Physician revealed that on the day of his weekly evaluation his plan of care is uploaded to a resident's electronic record, but he does not put the orders into the resident's electronic record. The staff are responsible for that process. The staff can view his notes and plan of care by looking at his uploaded notes or they can access his notes through a portal as well. 2. Record review revealed Resident # 1 was admitted to the facility on [DATE] after being hospitalized from [DATE] to [DATE] with pneumonia, septic shock, diabetic ketoacidosis, and encephalopathy. Resident # 1 also had diagnoses which included history of stroke, congestive heart failure, diabetes, peripheral artery disease, chronic obstructive pulmonary disease, and hypertension. The hospital Discharge summary, dated [DATE], noted the resident had developed a sacral pressure sore while hospitalized . Review of Resident # 1's admission nursing assessment, completed by the interim DON, revealed the resident's skin was intact. The assessment was signed by the interim DON on [DATE]. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of orders revealed no treatment orders for the resident's pressure sore on [DATE]; [DATE]; [DATE]; [DATE] and [DATE]. Interview with the interim DON on [DATE] at 10:40 AM revealed she was the Unit Manager at the time Resident # 1 was admitted . The other Unit Manager and the former DON had helped put orders in for the resident and she (the interim DON) had told Nurse # 5 that Resident # 1 had arrived and he was responsible for the resident. Nurse # 5 had been working on the 3:00 PM to 11:00 PM shift when the resident was admitted . Interview with Nurse # 5 on [DATE] at 4:40 PM revealed a Medication Aide was working on the hall to which Resident # 1 was admitted . He (Nurse # 5) was assigned to another hall. He had not been told that he was responsible for Resident # 1. He did not know anything about the resident having a pressure sore when he was admitted and he did not clarify what orders were to be done for the pressure sore. Interview with Nurse # 6 on [DATE] at 2:54 PM revealed she recalled seeing a dressing on the resident's bottom that was still intact from the hospital. She knew there was a treatment nurse. She could not find anything in the computer about the resident's history and there were no orders showing that a dressing needed to be done. On [DATE] the former Wound Care Nurse (Nurse # 15) documented a skin assessment noting that the resident had an 8.5 cm X 10 cm unstageable pressure sore to his sacrum. There was no indication in the record if Nurse # 15 did a treatment on that date ([DATE]) and what the treatment involved. On [DATE] the facility Wound Physician evaluated Resident # 1 and noted he had two pressure sores which had been present for greater than 5 days (indicating they were present upon admission). One of the pressure sores was on the left buttock and measured 1.2 cm X 1.1 cm X 0.2 cm. The wound bed had 85 % granulation tissue and 15 % slough and was documented by the Wound Physician to be a Stage III pressure sore. The second pressure sore was located on the resident's sacrum and measured 4.5 cm X 3.8 cm and was not measurable. The wound bed had 90 % necrotic tissue and 10 % granulation tissue. The Wound Physician documented the pressures sore was a Stage 4 after debridement of the necrotic tissue. The Wound Physician noted his treatment plan for the pressure sores was for calcium alginate with silver to be applied daily and as need if saturated, soiled or dislodged for both pressure sores. Review of orders revealed these orders were not put into the electronic record in order to populate on Resident # 1's TAR (Treatment Administration Record) until [DATE]. There were no dressings documented on the TAR from [DATE] through [DATE]. The first documented dressing changes to both the sacral and buttock pressure sore was on [DATE]. According to the TAR, the pressure sores were scheduled to be done on day shift. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 8:34 AM with the former DON who was employed during Resident # 1's admission, the former DON reported the following information. The former Wound Care Nurse (Nurse # 15) was not present after [DATE]. After that time, they were without a routine wound care nurse for an interim. During that time, the Nurses on the 300 hall were expected to cover dressing changes for Resident # 1 if a Medication Aide was assigned to the hall. If there was a nurse on Resident # 1's hall, then the nurse was supposed to do dressing changes. Review of assignment sheets revealed the following Medication Aides/ Nurses were responsible for the resident on the following dates and shifts (day shift 7:00-3:00 PM and evening shift 3:00 PM-11:00 PM): On [DATE] MA (Medication Aide) # 1 was assigned for the day shift and evening shift. On [DATE] the nurse who covered MA # 1 for day shift was Nurse # 9. On [DATE] the nurse who covered MA # 1 for evening shift was Nurse # 6. On [DATE] MA # 2 was assigned for the day shift and evening shift. On [DATE] the nurse who covered MA # 2 for the day shift was Nurse # 9. On [DATE] the nurse who covered MA # 2 for the evening shift was Nurse # 5. On [DATE] MA # 1 was assigned for the day shift. On [DATE] the nurse who covered MA # 1 for the day shift was Nurse # 9. On 9/14 25 Nurse # 6 was assigned for the evening shift. On [DATE] MA # 2 was assigned for the day shift and the evening shift until 4:00 PM. On [DATE] the nurse who covered MA # 2 was Nurse # 3. On [DATE] at 2:54 PM Nurse # 6 was interviewed and reported she did not do dressing changes for Resident # 1. She thought there had been a treatment nurse who would have done that. On [DATE] at 11:00 AM Nurse # 9 was interviewed and reported the following information. She was never aware a treatment nurse was not in the facility. She had never been trained on doing wound care in the facility or told it was her responsibility, and she had not done wound care for the resident. On [DATE] at 1:33 PM Nurse # 5 was interviewed and reported he might have changed the dressing if someone had called him because it was soiled or in need of changing, but he could not access what type of dressing in the system he was supposed to be applying. He had trouble finding that information. If he had done the dressing, then he would have just looked at what was on the pressure sores and tried to replicate what he saw. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Nurse # 3 was interviewed on [DATE] at 1:21 PM and reported she had never done dressing changes for Resident # 1. She had not been told it was her responsibility to do dressing changes for the resident. She did not think it was realistic for her to have her own assignment on another hall, cover insulin coverage for the Medication Aide, and also do dressing changes even if she had been told. Continued review of Resident # 1's [DATE] TAR revealed blanks by the orders for the sacral and buttock pressure sore dressing changes on [DATE] and [DATE]. Review of staffing sheets revealed Medication Aide # 1 was assigned on the dayshift of [DATE] and the evening shift did not have a designated staff member. According to Resident # 1's MAR (Medication Administration Record), Nurse # 5 signed for medications on the evening of [DATE]. According to the assignment sheet Nurse # 18 covered MA # 1 on [DATE] during the day shift. Review of staffing sheets revealed MA # 1 was assigned on the day shift of [DATE]. Nurse # 9 was the nurse assigned to cover MA # 1 on [DATE]. Nurse # 5 was assigned to Resident # 1 on the evening shift of [DATE]. Interview with Nurse # 18 on [DATE] at 4:07 PM revealed she had never done dressing changes for Resident # 1. She had not been told it was her responsibility. On [DATE] Resident # 1 was again seen by the Wound Physician who noted the left buttock wound was 1.1 cm X 1.1 cm X 0.2 cm and had no signs of infection. The wound bed was 80 % granulation tissue and 20 % slough. The Wound Physician documented the sacral wound was 4.5 cm X 3.8 cm and no measurable depth. There were no signs of infection. The wound bed was 90 % necrotic tissue and 10 % granulation tissue. The Wound Physician noted both wounds were debrided. According to the record, Resident # 1 was transferred to another skilled care facility (Facility #2) on [DATE]. Review of Facility # 2's wound admission assessment note, dated [DATE], revealed there were no signs of infection in the pressure sore which was documented as one area on the coccyx measuring 5 cm X 3.5 cm X 0.2 cm and had slough covering the wound bed. During an interview with Resident # 1's Responsible Party on [DATE] at 12:15 PM, the RP reported there were days on which Resident # 1's pressure sores were not changed while he resided at the facility. The facility Wound Physician was interviewed on [DATE] at 2:30 PM and reported the following information. The last time that he saw Resident # 1 there had been no signs of infection. He felt his pressure sores were stable and there had been no harm if he had missed dressing changes. He had multiple medical conditions such as diabetes, congestive heart failure, chronic obstructive pulmonary disease, and diabetes which could contribute to oxygen problems to the wounds and/ or healing problems. 3. Record review revealed Resident # 18 was admitted to the facility on [DATE]. The resident had diagnoses which included Parkinson's disease, dementia, diabetes, anemia, osteoarthritis, and chronic obstructive pulmonary disease. Resident # 18's admission MDS (Minimum Data Set Assessment), dated [DATE] coded the resident as severely cognitively impaired and as dependent on staff for turning in the bed. The resident was coded as having one unstageable pressure sore. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE] (Monday) PA (Physician Assistant) #1 documented the following information in a progress note. The resident had been more confused, lethargic and with decreased oral intake over the weekend. The resident had new unstageable pressure sores to his left thigh and his right heel. The left thigh appeared bruised with significant redness and was questionable for infection. She would start the resident on an antibiotic and consult wound to follow. Interview with PA # 1 on [DATE] at 3:57 PM revealed the following information. When she saw the resident on [DATE] he was altered mentally, and she was suspicious of some sort of infection. The area of skin breakdown was on the left hip. The left hip looked bruised as well as having the sore on the hip. She had verbally spoken to the primary nurse. She did not recall which nurse this was. She told the nurse to keep the resident off the left hip, keep the area covered, and consult the facility wound nurse. According to staffing records, Nurse # 10 was assigned to care for Resident # 18 from 7:00 AM to 11:00 PM on [DATE] and on [DATE] from 7:00 AM to 3:00 PM. Nurse # 10 was interviewed on [DATE] at 12:35 PM and again on [DATE] at 12:00 PM and reported she did not recall the PA instructing her to keep the left hip wound covered or to keep the resident off his left side. She knew the resident did not have skin breakdown on [DATE] when she last worked with him prior to the date of [DATE]. The first she was aware of the area was on [DATE]. At that time the area on his left hip was covered but she did not know who had put the covering on the hip or when it had been done According to staffing records, NA (Nurse Aide) # 6 was assigned to care for Resident # 18 on [DATE] from 7:00 AM to 3:00 PM. NA # 6 was interviewed on [DATE] at 12:15 PM and reported she did not recall any area of skin breakdown on the resident while she cared for him on [DATE]. According to staffing records NA # 10 was assigned to care for Resident # 18 on the 3:00 PM to 11:00 PM shift on [DATE]. NA # 10 was interviewed on [DATE] at 4:20 PM and reported she did not reca

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, the facility failed to ensure a diabetic resident who received all of his nutrition by way of enteral feeding (an enteral feeding is a method of providing nutrition for individuals who are unable to eat by mouth and involves using a feeding tube to deliver nutrients and fluids directly into the stomach or small intestine) received enteral feedings as ordered during two consecutive days. This was for 1 of 2 sampled residents who received enteral feedings (Resident #1).The findings included:Record review revealed Resident # 1 was admitted to the facility on [DATE] after being hospitalized from [DATE] to 9/10/25 with pneumonia, septic shock, diabetic ketoacidosis, and encephalopathy. The resident's Discharge summary, dated [DATE], noted the resident had severe dysphagia and had experienced recurrent pneumonia while hospitalized . The resident was made NPO (nothing by mouth) and a gastrostomy tube (the tube inserted into the resident's stomach to provide nutrition) was placed while hospitalized and started on enteral feedings.Review of nursing notes revealed an entry documented by the Interim Director of Nursing (DON) on 9/10/25 at 6:30 PM noting at 6:30 PM Resident # 1 had arrived by stretcher to the facility. Review of facility admission orders on 9/10/25 revealed an order was entered into Resident # 1's electronic record for Osmolite (a calorie dense formula) 1.5 cal Oral Liquid 300 ml (milliliters) via PEG (percutaneous endoscopic gastrostomy tube) four times per day with a bolus flush of 90 ml of water before and after each bolus feeding.This Osmolite enteral feeding order appeared on Resident # 1's Medication Administration Record (MAR) with the scheduled times as 10:00 AM, 2:00 PM, 6:00 PM, and 10:00 PM. There was no indication on the MAR that the resident received an enteral feeding on 9/10/25 after he arrived at the facility. None of the bolus feedings were initialed as administered.Interview with the interim Director of Nursing (DON) on 10/16/25 at 10:40 AM revealed she was the Unit Manager at the time Resident # 1 was admitted on [DATE]. The other Unit Manager and the former DON had helped put orders in the electronic record for the resident and Nurse # 5 had been told that Resident # 1 had arrived and he was responsible for the resident. Nurse # 5 had been working on the 3:00 PM to 11:00 PM shift when the resident was admitted . According to the interim DON, there was a medication aide (MA) assigned on the hall to which Resident # 1 was admitted , and Nurse # 5 was working on the adjacent hall. The nurse who worked on the adjacent hall was responsible for covering the Medication Aide's hall by providing nursing care for care tasks that the Medication Aide was not certified to do.Interview with Nurse # 5 on 10/15/25 at 4:40 PM revealed he had been working on the hall adjacent to the hall where Resident # 1 was admitted on [DATE]. There was a Medication Aide (MA #2) working on Resident # 1's hall on the evening of 9/10/25. He had not been told anything about the resident being admitted and he never saw a resident being rolled by on a stretcher to MA #2's hall. He had been busy with residents on his own hall and had been in rooms. The current Interim DON (former Unit Manager) had not spoken to him and no one else had told him that he was responsible for Resident # 1. Around 8:30 PM on 9/10/25 MA # 2 came to get him because Resident # 1 was bleeding from his gastrostomy tube site. That was the first time that he was aware the resident was there and his responsibility and he was able to get the bleeding to stop. He looked in the electronic record and could not find orders or the resident's discharge summary to know what needed to be done for the resident. He attempted to call the former DON but could not get in touch with her. He did not give an enteral feeding to the resident because he could not access any orders to know what to give. Nurse # 6 had cared for Resident # 1 starting at 11:00 PM on 9/10/25 through 7:00 AM on 9/11/25. Nurse # 6 was interviewed on 10/16/25 at 2:54 PM and reported the following information. She could not see orders or the hospital discharge summary either when she looked on her shift for Resident # 1. It seemed to her as if orders might not have been confirmed in the electronic system. Nurse #6 indicated it did show up on the MAR for her to flush the resident's gastrostomy tube and she had done that. She did not give an enteral feeding to the resident. Review of the Resident # 1's orders revealed on 9/11/25 (the day following admission) an order was entered at 3:37 PM for the same enteral feeding and flush (Osmolite 1.5 cal Oral Liquid 300 ml via PEG with a bolus flush of 90 ml of water before and after each bolus feeding with one change. The enteral feeding was to be given every six hours. Resident # 1's MAR reflected the scheduled times were changed to 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM.Review of the MAR revealed Medication Aide # 1 signed twice on 9/11/25 that the enteral formula was administered. The first time was by the first order which had the enteral feeding scheduled at 10:00 AM, 2:00 PM, 6:00 PM, and 10:00 PM. By this order MA # 1 initialed by the 10:00 AM

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with staff the facility failed to ensure a working system to evaluate nurses' competency in skills, facility procedures, and knowledge. This was for 3 of 3 nurses reviewed for competency validation (Nurses # 2, # 6, and # 5). The findings included:A list of nurses' hire dates revealed Nurse # 5, Nurse # 6, and Nurse # 2 had been hired since [DATE]. 1a. Record review revealed Resident # 1 was admitted to the facility on [DATE] after being hospitalized from [DATE] to [DATE] with pneumonia, septic shock, diabetic ketoacidosis, and encephalopathy. Resident # 1 also had diagnoses which included history of stroke, congestive heart failure, diabetes, peripheral artery disease, chronic obstructive pulmonary disease, neuropathy, anxiety, hypertension and gastrostomy tube placement.Review of nursing notes revealed the resident was admitted to the facility on [DATE] at 6:30 PM.Review of facility [DATE] admission orders and [DATE] hospital records noting when medications were last given before transfer to the facility revealed the following information: Resident # 1 was ordered to have Fingerstick Blood Sugars at bedtime. He had medications which included Atorvastatin (for hyperlipidemia), Alprazolam (for anxiety), gabapentin (for neuropathy), Carvedilol (for hypertension) that were due to be administered the evening of [DATE] and which had not been administered prior to transport from the hospital. He was also due to have an enteral feeding administered on the [DATE] evening shift. Nurse # 5 was interviewed on [DATE] at 4:40 PM and voiced a problem with the training and orientation he had received while at the facility and problems he had encountered when trying to help care for Resident # 1 after he was admitted . During the interview Nurse # 5 reported the following information. On the evening shift of [DATE] he learned from Medication Aide # 2 that he was the responsible nurse for Resident # 1. The resident had been admitted to the hall where Medication Aide # 2 worked. He learned he was the responsible nurse covering for duties the MA could not do when MA # 2 reported the resident was bleeding from his gastrostomy site. No one had told him prior to that time anything about the resident. He looked in the electronic record, and he could not find orders or medical history. He tried calling the former DON (Director of Nursing) but could not get in touch with her on [DATE]. He had trouble finding supplies to get the bleeding to stop, but was able to finally do so. His shift ended at 11:00 PM but he was still present shortly after that time when another nurse (Nurse # 6), who was a new nurse, had come to him for help because she did not seem to know what to do and the resident was bleeding again around the gastrostomy site. He again was able to get the bleeding to stop but was worried about the resident. Since he could not get in touch with the former DON, he texted the NP (Nurse Practitioner) to please check on the resident first thing in the AM. Nurse # 5 showed the surveyor the text in his personal phone which had Resident # 1's name and information about him bleeding and which he had sent to the NP. According to Nurse # 5, he had never been trained not to text the NP and did not know if there was a secure messaging communication application used to send nonemergency messages to the NP. Nurse # 5 reported nothing was covered regarding that when he was hired. He reported he had a lot of years of experience as a nurse and felt he was a good nurse, but the training had been poor when he was hired about procedures and where to locate things. He left that night ([DATE]) knowing that Resident # 1 had not had any orders done for him, but he did not know what else to do given he could not access the resident's orders. Since the resident was not actively bleeding and he had alerted the NP by personal text, he felt okay to go home. Nurse # 6 had cared for Resident # 1 starting at 11:00 PM on [DATE] through 7:00 AM on [DATE]. Nurse # 6 was interviewed on [DATE] at 2:54 PM and reported the following information. She could not see orders or the hospital discharge summary in the electronic record either when she looked on her shift for Resident # 1. It seemed to her as if orders might not have been confirmed in the electronic system. It did show up on the MAR for her to flush the resident's gastrostomy tube and she had done that. She did not give medications or given an enteral feeding. The resident had no complaints of pain and slept through the night shift.Further review of Resident # 1's record and review of staffing records revealed Nurse # 5 would have been responsible for dressing changes for Resident # 1's pressure sores and diabetic ulcers on [DATE] when MA # 2 was assigned to care for the resident.During a follow up interview with Nurse # 5 on [DATE] at 1:33 PM Nurse # 5 reported a problem about having training regarding where to find wound care orders. According to Nurse # 5, he may have done wound care for Resident # 1 if someone would have let him know that the dressing was soiled or in need of changing but he did not know how to access the exact orders for the care. He would have just looked at what was on the wound and tried to replicate what he saw. 1b. Resident # 21

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and a pharmacy consultant interview, the facility failed to have effective systems in place for the return of controlled medications to the pharmacy for 4 of 4 medication carts (100-hall, 200-hall, 300-hall, 400-hall). Findings included:Documentation of instructions on the Shift Change Controlled Substance Inventory Count sheets revealed every controlled substance medication and count sheet added or removed from the medication cart must be documented on the form.Documentation on the Shift Change Controlled Substance Inventory Count sheet, dated as initiated on [DATE] for the 100-hall medication cart, revealed the following information. The inventory count sheet indicated 32 cards/containers of controlled medication and count sheets were removed from the 100-hall medication cart on [DATE] on the 7:00 AM to 3:00 PM shift.Documentation on the Shift Change Controlled Substance Inventory Count Sheet, dated as initiated on [DATE] for the 200-hall medication cart, revealed the following information. The inventory count sheet indicated 22 cards/containers of controlled medication and count sheets were removed from the 200-hall medication cart on [DATE] during the 7:00 AM to 3:00 PM shift. Of the 22 cards/containers of controlled medication and count sheets, there were 11 empty cards of unknown residents and unknown medications, not documented on the inventory count sheet.Documentation on the Shift Change Controlled Substance Inventory Count Sheet, dated as initiated on [DATE] for the 300-hall medication cart, revealed the following information. The inventory count sheet revealed 14 cards/containers of controlled medication and count sheets were removed from the 300-hall medication cart during the 7:00 AM to 3:00 PM shift on [DATE]. Documentation on the Shift Change Controlled Substance Inventory Count Sheet dated as initiated on [DATE] for the 400-hall cart revealed the following information. The inventory count sheet indicated 10 cards/containers of controlled medication and count sheets were removed from the 400-hall cart during the 3:00 PM to 11:00 PM shift on [DATE].Review of four return packing slips dated [DATE] revealed a total of 46 cards of controlled medications were returned to the facility pharmacy. The 46 cards of controlled medications were for 27 residents, who either currently resided in the facility or had been discharged from the facility since 8/2025, representing all the hallways in the facility.Nurse #14, a Unit Manager, was interviewed on [DATE] at 3:58 PM and reported the following information. She was concerned about the number of controlled medications being stored on the medication carts after residents were discharged . The nurses were required to count numerous medications every shift, which should have been returned to the pharmacy. Nurse # 14 felt this practice created room for mistakes in the accounting of the controlled substances.An interview with the former DON (Director of Nursing) on [DATE] at 8:34 AM revealed that when she worked as the DON, she did not have the time to send back the controlled medications to the pharmacy when residents were discharged . She was always too busy, and her job responsibilities had been overwhelming.An interview was conducted with the Regional Clinical Director on [DATE] at 9:31 AM. The Regional Clinical Director reported that the discontinued controlled medication cards were removed from each of the four medication carts over the weekend ([DATE]) and returned to the pharmacy on [DATE]. The Regional Clinical Director stated the facility was without effective nursing leadership, resulting in discontinued controlled medication cards being left on the medication carts rather than being sent back to the pharmacy. An interview was conducted with the consultant pharmacist on [DATE] at 2:24 PM. The consultant pharmacist stated that she was unsure of the facility's exact procedure for the removal of discontinued or expired residents' controlled medications. The consultant pharmacist stated that ideally, the facility should remove the narcotics from the medication carts and put them under a double lock until the controlled medication can be returned to the pharmacy. The consultant pharmacist indicated that the controlled medications should be sent back to the pharmacy at the next delivery/pick up time that day or the next day. The consultant pharmacist confirmed that the nurses should be counting the number of medication cards and the number of narcotics on each card at the change of each shift to reconcile narcotic usage. The Consultant Pharmacist also indicated that shift change substance inventory count sheet should be signed by the oncoming nurse and off going nurse with the total number of medication cards, number of new medication cards, and number of medication cards removed.An interview was conducted with the Regional Clinical Director on [DATE] at 2:30 PM. The Regional Clinical Director stated that the discharged residents with controlled medications should have their controlled medications returned to the pharmacy. The Regional Clinical Director revealed that the process was for the Director of Nursing to reconcile the controlled

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, facility Wound Physician and staff interviews, the facility failed to administer four doses of an antibiotic as ordered by the physician for a resident's wound infection. This was for 1 of 7 residents whose medications were reviewed (Resident # 26).The findings included:Resident # 26 was admitted to the facility on [DATE] with diagnoses which included dementia, cerebral infarction (a condition where blood flow to the brain is interrupted), moderate protein calorie malnutrition, and immunodeficiency (a condition in which the immune system is weakened). Resident #26's care plan dated 7/28/25 revealed a focus for pressure ulcer development with the goal of remaining free from infection. The interventions included administering medications and treatments as ordered, and following the facility policies/protocols for treatment/prevention of skin breakdown. Resident #26's significant change Minimum Data Set (MDS) dated [DATE] revealed he was cognitively impaired. Resident #26 was dependent upon staff for all activities of daily living (ADL) and transfers. Review of the Wound Physician's progress note dated 10/17/25 documented he performed a debridement (a procedure that involves removing dead, infected, or damaged tissue from a wound) on Resident #26's right hip pressure wound and removed devitalized tissue (dead or non-viable tissue that has lost its blood supply and ability to function) and necrotic muscle level tissues (dead muscle that results from causes like trauma or infection, and is characterized by cell death, inflammation, and a loss of normal function) were removed and healthy bleeding tissue was observed. Hemostasis (the process by which the body stops bleeding) was achieved and a clean dressing was applied. Physician's order dated 10/17/25 included Amoxicillin-Potassium Clavulanate 875 milligrams (mg) to be given every 12 hours by mouth for a bacterial infection of a pressure wound. Review of Resident # 26's Electronic Medical Record (EMR) revealed he was prescribed Amoxicillin-Potassium Clavulanate 875 mg to be given every 12 hours by mouth for a bacterial infection of a pressure wound on 10/17/25. Review of the October 2025 Medication Administration Record (MAR) for Resident #26 revealed the antibiotic was scheduled to begin on 10/17/25 at 9:00 pm and thereafter scheduled to be administered at 9:00 am and 9:00 pm on the MAR. Interview with Medication Aide #1 on 10/26/25 at 1:46 pm revealed Resident # 26's Amoxicillin-Potassium Clavulanate 875 mg was delivered on 10/17/25 for her to administer the evening dose but did not recall the time the facility received the medication. Medication Aide #1 stated she removed the Amoxicillin-Potassium Clavulanate 875 mg from the pharmacy package for Resident #26's evening dose. Review Resident #26's MAR revealed all the doses of Amoxicillin-Potassium Clavulanate 875 mg were initialed as administered as scheduled at that date and time. Interview with the Regional Clinical Director on 10/22/25 at 9:55 am revealed there were no medications removed from the facility's back up medication supply on 10/17/25. On 10/21/25 at 5:30 pm Resident #26's antibiotic supply was observed with Nurse #15. The antibiotic medication package contained 24 tablets which indicated that 4 tablets had been administered from the antibiotic medication package of 28 tablets. The amount of antibiotics on hand did not reconcile with the documentation on the MAR. On this same date and time, the MAR documentation showed 8 doses had been signed off as administered. The antibiotic medication package count should have indicated 20 tablets remained in the antibiotic medication package if it had been administered correctly. On 10/22/25 at 12:47 pm Resident #26's antibiotic supply was observed with Nurse #16. The antibiotic medication package contained 22 tablets which indicated 2 tablets had been administered from the antibiotic medication package of 28 tablets. The amount of antibiotics on hand did not reconcile with the documentation on the MAR. On this same date and time, the MAR documentation showed that 10 doses had been signed off as administered. The antibiotic medication package count should have indicated 18 tablets remained in the antibiotic medication package if it had been administered correctly. In a phone interview with the facility Wound Physician on 10/24/25 at 2:23 pm he stated he saw Resident #26 on 10/17/25 for wound care. The facility Wound Physician indicated the pressure wound on Resident #26's right hip was completely infected and therefore ordered the antibiotic Amoxicillin-Potassium Clavulanate 875 mg to be administered twice a day on 10/17/25 with Resident #26's first dose to begin that same evening. It was his expectation that Resident #26 received his Amoxicillin-Potassium Clavulanate 875 mg as ordered to prevent further worsening of the bacterial infection in the pressure wound. During an interview on 10/24/25 at 2:30 pm the Regional Clinical Director was interviewed regarding the inability to reconcile the number of antibiotics on hand versus the doses documented as administered. According to the Regional Clinical Director the facility had not been able to

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Clayton Rehabilitation and Healthcare Center	204 Dairy Road Clayton, NC 27520

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview with resident and staff the facility failed to provide palatable food to a resident when a burnt, blackened piece of toast was served to a resident. This was for 1 of 5 residents reviewed for dietary services provided to residents (Resident # 27). The findings included.Resident # 27 was admitted to the facility on [DATE] and had a current diet order for a regular diet. Resident # 27's quarterly Minimum Data Set Assessment, dated 9/12/25, coded the resident as moderately cognitively impaired.On 10/18/25 at 8:45 AM Resident # 27 was observed eating her breakfast meal and had completed a portion of it. She was observed with a piece of toast on her plate which she had not yet eaten. She picked up the toast and both sides were observed black from being burnt. The entire piece of toast was approximately 75 % black. Resident # 27 reported she was going to try to eat it. Resident # 27's roommate spoke up and reported the resident did not need to eat the toast. On 10/18/25 at 8:57 AM the Administrator was asked to view the resident's toast with the surveyor and informed the resident that the dietary department could get her a piece of toast that was not burnt.During an interview with the Facility Dietary Manager (DM) and a Regional Corporate Dietary Manager on 10/16/25 at 5:00 PM the DM reported that the dietary department had some new staff, and they were also experiencing problems with having enough oven space to cook because one of the ovens was broken. They tried to get trays to residents on a time schedule while dealing with these issues. According to an interview with the Administrator on 10/18/25 at 4:45 PM, the burnt toast should not have left the dietary department and been served to the resident.

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, Responsible Party interview, and staff interview the facility failed to ensure the dietary electronic system worked in a manner that allowed for a resident to be served her preferences when the preferences were offered on the menu as an option and when the resident had impairment of her communication skills and could not verbally voice preferences when meals were served. This was for 1 of 5 sampled residents reviewed for dietary services (Resident # 4). The findings included:Record review revealed Resident # 4 was admitted to the facility on [DATE] and had a diagnosis of dementia and protein calorie malnutrition.Review of Resident # 4's quarterly MDS (Minimum Data Set) assessment, dated 9/24/25, revealed Resident # 4 was moderately cognitively impaired, had highly impaired hearing, and was non-verbal. Resident # 4's care plan, dated 9/12/25, reveled the resident could communicate by writing.A review of the resident's current diet order revealed Resident # 4 was ordered a regular mechanical soft diet.Observation on 10/15/25 at 1:15 PM revealed Resident # 4 was served a peanut butter and jelly sandwich for an entree with carrots, potatoes, and a cookie on the side while dining in the dining room. Other residents in the dining room were observed to receive either hamburger steak or chicken fried steak in the dining room. According to the posted menu, there was an alternate entree of thyme chicken which was to also be available that day. It was confirmed with a Corporate Regional Manager that Thyme Chicken was available. No one was observed to try to communicate with Resident # 4 and offer her one of the entrees that had meat. Observation on the next consecutive day (10/16/25) at 12:55 PM revealed Resident # 4 was served a peanut butter and jelly sandwich again, potato salad, salad, and fruit cocktail while in the dining room. Other residents were served lasagna as the main entree. An alternate meal entree was listed on the dining room menu board as an egg salad sandwich. On 10/16/25 at 1:03 PM the Corporate Regional Dietary Manager (DM) was asked to look at Resident # 4's tray and reported Resident # 4 was supposed to get a peanut butter and jelly sandwich in addition to a main entree. The Corporate Regional DM was interviewed about the resident getting the same peanut butter and jelly sandwich the previous day and reported Resident # 4 must not have liked the steak the previous day or the lasagna served that day.On 10/17/25 at 10:35 AM Resident # 4's Responsible Party (RP) was interviewed and reported that the resident had special communication needs, and some staff did not try to communicate with her. She could understand sign language, write some, and could use a communication board. Food choices had been a problem with her since staff did not always communicate effectively with her when she was served food. The peanut and jelly sandwich was requested to be an addition to an entree and not to replace an entree. The RP reported that the resident did like chicken and would have eaten chicken on 10/15/25 if it had been offered to her. The RP used sign language with Resident # 4 and confirmed she would have eaten an egg salad sandwich also if offered. The RP reported she had discussed food concerns with facility staff before, and that the facility would say that she did not like beef and pasta, and that limited what they could offer her on some days. According to the RP the resident did like certain kinds of beef. Some types of beef were harder for her to swallow. Also, she liked Lasagna but she had trouble for some reason swallowing macaroni noodles.During an interview with the Dietary Manager and the Corporate Regional DM on 10/16/25 at 5:00 PM these employees reported the following information. They use a computer system to track a list of likes and dislikes. In Resident # 4's case, she had a long list of beef dislikes. When the computer system recognized beef was served as the main entree on 10/15/25 and 10/16/25 the system then recognized the peanut butter and jelly sandwich as an alternative entree for the resident, and it did not print out information that the resident should be offered chicken on 10/15/25 or an egg salad sandwich on 10/16/25. The peanut butter and jelly sandwich was intended to be a side supplement to a main entree, but the system had not been recognizing this.

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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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on record review, observation and interviews with residents and staff, the facility failed to deliver meal trays at regular consistent, scheduled times while experiencing a problem with a broken oven. This issue affected 2 of 3 halls two halls reviewed for mealtime deliveries (200 hall and 400 hall). This deficient practice had the potential to affect multiple residents for meal delivery.The findings included:Review of facility meal delivery times revealed the hall scheduled to receive the latest carts was the 400 Hall. Delivery to this hall was scheduled for the following times:Breakfast 8:10 AMLunch 1:10 PMDinner 6:10 PM Review of Resident # 8's annual Minimum Data Set assessment, dated 9/6/25, revealed Resident # 8 was cognitively intact. During an interview with Resident #8, who resided on the 400 Hall, the resident reported that meals were late. Specifically, at times he received his evening meal after 7:00 PM. On 10/15/25 the surveyor arrived at the 400 Hall at 1:20 PM. Interview with NA #5 revealed the lunch trays had just arrived one minute ago at 1:19 PM and they were going to start handing the trays to residents. On 10/16/25 at 8:37 AM it was observed that the breakfast trays arrived at the 400 Hall. Resident #8 was observed served breakfast at 8:42 AM. On 10/16/25 at 1:25 PM it was observed the lunch trays arrived at the 400 Hall. Resident #8 was served his meal at 1:28 PM. Dietary Aide #1, who was observed delivering the lunch trays, was interviewed on 10/16/25 at 1:25 PM about time the meal carts were arriving to the hall and reported the kitchen was experiencing a problem. They had two ovens. Each oven had three racks and one of the ovens was broken. They were cooking all the meals on three racks, and this ran them late getting the meals out by the delivery times. Review of facility meal delivery times revealed the 200 Hall received their meals at the following times. Breakfast Cart #1- 7:40 AM and Cart #2-7:50 AMLunch Cart #1-12:40 PM and Lunch Cart #2 12:50 PMDinner Cart #1-5:40 PM and Dinner Cart #2-5:50 PM Record review revealed Resident #3 was cognitively intact according to a quarterly Minimum Data Set assessment completed on 9/29/25 and resided on the 200 Hall. Interview with Resident #3 on 10/16/25 at 8:50 AM revealed the delivery of meals depended on the dietary department. At times they seemed to be on time and at other times she received the dinner meal at 7:00 PM. The Facility Dietary Manager and a Regional Corporate Dietary Manager were interviewed on 10/16/25 at 5:00 PM and reported the following information. There was only one working oven in the kitchen. According to the Facility Dietary Manager the problem with the oven started around 9/8/25 or 9/9/25 and had been problematic for over a month. Their goal was to have meals out within five minutes of the delivery times to the hall, but not having enough space to cook the meals was a problem. That evening (10/16/25) for the dinner meal both entrees were to be cooked in the oven along with numerous other items. This included rolls, chicken, brownies, oven browned potatoes, cookies, and pork chops. They were trying to accomplish cooking all those items in one oven and still getting the trays out to all the halls at a regularly scheduled time. When the menu called for most items to be baked or warmed in the oven then this affected their ability to stay on schedule. The Dietary Manager replied she was aware there had been some complaints about late trays on the 400 Hall, which was the last hall to receive trays.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to ensure the medical record was accurate and complete regarding the application of dressing changes for Residents # 8, # 17, and # 26. This was for 3 of 6 sampled residents with wounds which required dressings.The findings included: 1. Resident # 17 was admitted to the facility on [DATE]. Review of Wound Physician notes, dated 8/22/25, revealed the following information. Resident # 17 had pressure sores to her left heel, right heel, and left lateral calf. The resident had shifting wounds to the left and right buttocks. (When an individual shifts in position, there can be a shearing force as the skin is pulled in different directions and thereby causing a wound). The resident had venous wounds to her right posterior calf and left posterior calf. The resident had a skin tear to the left posterior medial calf. The resident was ordered dressing changes for all these wounds. Review of Resident # 17's September TAR 2025 (Treatment Administration Record) revealed Nurse # 7 signed on the following dates that he applied dressings to the following areas: Right heel: 9/1/25; 9/3/25; 9/5/25; 9/8/25; and 9/10/25 Left Buttock: 9/1/25; 9/3/25; 9/5/25; 9/8/25; and 9/10/25 Right Buttock: 9/1/25; 9/3/25; 9/5/25; 9/8/25; and 9/10/25 Left Heel: 9/1/25; 9/3/25; 9/5/25; 9/8/25; and 9/10/25 Left posterior medical/calf: 9/1/25; 9/3/25; 9/5/25; 9/8/25; and 9/10/25 Left lateral calf: 9/1/25; 9/3/25; 9/5/25; 9/8/25; and 9/10/25 Left Posterior calf: 9/1/25; 9/3/25; 9/5/25; 9/8/25; and 9/10/25 Right Posterior Calf: 9/1/25; 9/3/25; 9/5/25; 9/8/25; and 9/10/25 Left Heel: 9/1/25; 9/3/25; 9/5/25; 9/8/25; and 9/10/25 During an interview with Nurse # 7 on 10/19/25 at 3:35 PM, it was revealed the TAR was not accurate. Nurse # 7 reported the following information. He had never changed Resident # 17's dressings as the TAR reflected. He had cared for Resident # 17 and signed on her MAR (medication administration record) and just kept going on the TAR. He thought the former wound care nurse (Nurse #15) had been in the facility when he worked and she had changed the dressings on the dates his signature appeared. The Regional Clinical Director, The Regional Director of Operations, and the Administrator were interviewed on 10/27/25 at 5:10 PM. The Administrator reported that nurses should not be signing on the TAR for dressings that they did not actually do. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review revealed Resident # 8 was admitted to the facility on [DATE]. Review of physician notes revealed both the Wound Physician and a dermatologist followed Resident # 8 for squamous and basal cell carcinoma to his back. Resident # 8 underwent [NAME] surgery for these areas on 9/17/25 and closure on 9/18/25 during a second visit. During a follow up visit on 10/3/25 the surgical site was stapled and wound care directions continued. Review of Resident # 8's October 2025 TAR (Treatment Administration Record) revealed an order to cleanse Resident # 8's surgical wound site with Dakin's Solution daily and apply a hydrocellular foam dressing. The date of 10/10/25 was blank indicating the dressing was not performed. Interview with Nurse # 20 on 10/27/25 at 2:30 PM revealed the TAR was incomplete. The nurse reported that she had done the dressing change to the resident's back wound but did not document the dressing. 3.A physician's order for Resident #26 dated 10/19/25 included cleanse right ischium (a paired bone forming the lower and back part of the hip bone) with normal saline solution, pack with kerlix soaked in Dakins solution (a diluted, buffered bleached-base antiseptic used to clean and disinfect wounds to prevent infection), cover with dry border gauze dressing change every day and evening shift for Stage 3 pressure wound to ischium and as needed for soiled or dislodged dressing. A review of Resident #26's October 2025 Treatment Administration Record (TAR) recorded Resident #26's right ischium wound dressing was changed on 10/19/25 on the day shift (7:00 am until 3:00 pm) and was documented as completed by Nurse #3. During a phone interview with Nurse #3 on 10/23/25 at 2:10 pm, she stated she did not change Resident #26's wound dressing because his room was not on her assignment. Nurse #3 further stated the treatment nurse (Nurse #13) was at the facility and she changed the wound dressing for Resident #26. When asked by this surveyor why her initials were on the TAR for Resident #26's day shift wound dressing change, she replied, I do not know why my initials were on the TAR because I did not change the dressing. A review of Resident #26's October 2025 TAR recorded Resident #26's right ischium wound dressing was changed on 10/19/25 on the evening shift (3:00 pm until 11:00 pm) and was documented as completed by Nurse #1. During a phone interview with Nurse #1 on 10/23/25 at 2:32 pm, she stated she did not change Resident #26's wound dressing because the treatment nurse (Nurse #13) was at the facility and she changed the wound dressing for Resident #26. When asked by this surveyor why her initials were on the TAR for Resident #26's evening shift wound dressing change, she replied, I do not know why my initials were on the TAR because I did not change the dressing. In a phone interview with Nurse #13 on 10/21/25 at 2:53 pm, she stated Resident #26's right ischium wound dressing had not been changed since 10/18/25. Nurse #13 explained when she changed Resident #26's right ischium wound on 10/20/25 the dressing she removed from Resident #26's right ischium wound had her initials and was dated 10/18/25. On 10/27/25 at 5:10 PM, the Administrator reported that nursing staff should not be signing for nursing care that they did not complete.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with staff, Nurse Practitioner, Wound Physician, and hospice staff, the facility failed to ensure effective communication and coordination of care occurred with the hospice provider. On 10/17/25 Resident #26 was identified with a wound infection and facility nursing staff attempted to reach the hospice provider's on-call services on 10/17/25 and 10/18/25 to evaluate the resident and determine if an order was needed for an as needed (PRN) pain medication stronger than the resident's active PRN order for acetaminophen to have available to treat potential increased pain resulting from the wound infection. This deficient practice affected 1 of 2 sampled residents reviewed for coordination of hospice services (Resident #26).The findings included:The Hospice Facility and Services Agreement contract dated 8/1/22 stated, .facility shall timely communicate to Hospice all pertinent information concerning each hospice patient including but not limited to (i) a significant change in a patient's physical, mental, social, or emotion status occurs; (ii) clinical complications appear that suggest a need to alter the plan of care. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of the hospice are met, and open communication policies are set forth on a 24-hour per day basis. Resident #26 was admitted to the facility on [DATE] with diagnoses which included dementia, cerebral infarction (a condition where the blood flow to the brain is interrupted), moderate protein calorie malnutrition, and immunodeficiency (a condition in which the immune system is weakened). Review of Resident #26's Medication Administration Record (MAR) revealed an order dated 4/22/25 for Acetaminophen 325 milligrams (mg) give 2 capsules by mouth every 6 hours PRN for mild to moderate pain. Resident #26's care plan dated 7/28/25 revealed a focus for a terminal prognosis related to dementia and receiving hospice services with a goal of the resident's comfort will be maintained. Interventions included observing resident closely for signs/symptoms of pain, notify the physician immediately for breakthrough pain, and nursing staff to work cooperatively with the hospice team to ensure residents' physical and social needs were met and to provide maximum comfort for the resident. Another focus in the care plan included at risk for pain related to the presence of pressure injury with the goal of remaining free from pain. The interventions included anticipating the resident's need for pain relief, responding immediately to any complaints of pain, and observing for signs/symptoms of non-verbal pain. Review of Resident #26's Electronic Medical Record (EMR) revealed he was admitted into hospice services on 7/28/25. Resident #26's significant change Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired, received hospice care and was coded for pressure ulcers. Resident #26's MDS did not reveal any coding for pain and/or pain medications. Resident #26 was dependent upon staff for all activities of daily living (ADL) and transfers. A physician's order dated 9/16/25 included to cleanse Resident #26's right ischium (a paired bone forming the lower and back part of the hip bone) with cleanser, pat dry, apply alginate calcium with silver (absorbs wound exudate [a fluid, rich in cells and proteins that leaks from blood vessels into nearby tissues] and release silver ions to help reduce bacteria), and apply dry dressing every day shift for a Stage 3 pressure wound to the ischium. A progress note dated 10/17/25 documented by Nurse #13 revealed the Wound Physician saw Resident #26 and his wound appeared infected and had changed in color. The Wound Physician performed an incision and drainage at bedside with copious amounts of odiferous (emitting an odor), milky and reddish-brown drainage coming from pressure wound. The Wound Physician started Resident #26 on an antibiotic with first dosage ordered to be given on the evening of 10/17/25. In a phone interview with the facility Wound Physician on 10/24/25 at 2:23 pm he stated he was aware that Resident #26 was on hospice services. The Wound Physician indicated he saw Resident #26 on 10/17/25 for wound care and performed a debridement (a procedure that involves removing dead, infected, or damaged tissue from a wound) on the hip wound and the wound was infected. The Wound Physician further indicated in his opinion after the debridement procedure of the hip wound and daily dressing changes as ordered Resident #26 needed pain medication stronger than Acetaminophen. The Wound Physician stated because Resident #26 received hospice services, he did not prescribe any pain medication. During a phone interview with Nurse #13 on 10/21/25 at 2:53 pm, she stated Resident #26 had dementia and could not verbalize pain. Nurse #13 further stated the Wound Physician saw Resident #26 on 10/17/25 and lanced (procedure of making an incision into something with a sharp tool to drain pus) the pressure wound on his right hip because it was infected and ordered Resident #26 an antibiotic. Nurse #13 indicated she called the

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. (continued on next page)

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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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and staff interview the facility failed to maintain a kitchen oven in working condition which in turn affected meal delivery times. This was for 1 of 2 kitchen ovens (Oven # 1). The findings included:The Facility Dietary Manager (DM) and a Regional Corporate Dietary Manager were interviewed on 10/16/25 at 5:00 PM and reported the following information. There was only one working oven in the kitchen. According to the Facility DM the problem with the oven started around 9/8/25 or 9/9/25 and had been problematic for over a month. She thought she put a work order in but one of the maintenance employees was not in the facility all the time. They were trying to accomplish cooking multiple items in one oven which made it difficult to stay on scheduled meal delivery times. The DM was aware there had been some complaints about late trays on the 400 hall, which was the last hall to receive trays. On 10/20/25 at 12:40 PM Maintenance Employee # 1 and Maintenance Employee # 2 were interviewed and presented a timeline of events regarding the attempts to get the oven repaired. Review of the timeline and the interview revealed the following information. Maintenance Employee # 1 was working part time. The staff can enter a work order online so one of the maintenance employees will know if there is a maintenance issue. The first work order was entered into the system on 9/19/25 which indicated the top oven was not functioning properly. That date corresponded to a Friday. At that time Maintenance Employee # 2 had already left for the day, and Maintenance Employee # 1 did not know anything about the problem. On Monday (9/22/25) Maintenance Employee # 1 checked the oven and verified that it did have power, but the fan would not come on and the oven would not ignite. This was checked late in the evening around 5:30 or 6:00 PM because the dietary staff had been using the second oven which was in close proximity to the broken oven, and there needed to be a cooling down time for him to check the broken oven. The next two days, which were 9/23/25 and 9/24/25), were being observed by corporate staff as a holiday and therefore corporate was not contacted. On 9/25/25 (Thursday) Maintenance Employee # 2 called Corporate and was told that they would try to call a vendor, they would get back to him, and asked Employee # 2 to try to trouble shoot and fix the oven. Supplies were purchased. Attempts were made to fix the oven. On 10/2/25 Maintenance Employee # 2 was still trying to work on the oven and had found a schematic online but was not able to repair it. During the week of October 2nd a corporate holiday was again observed that week which delayed discussion about the oven. On 10/6/25 (Monday) a discussion was held again with corporate, who let the facility know that approval for a vendor to repair the oven had been obtained. On 10/6/25 Maintenance Employee # 1 made an appointment with Vendor # 1 to come and repair the oven. Maintenance Employee # 1 thought Vendor # 1 understood the type of oven the facility had. Vendor # 1 arrived on 10/10/25 (Friday) and reported they could not work on the type of oven the facility had. Vendor # 1 reported they only worked on a particular oven which had a similar brand name as the facility's oven. There had been miscommunication. On 10/13/25 (Monday) Vendor # 2 was contacted and asked to repair the oven. When contacted Vendor # 2 did not know a time and said that they would be out on Thursday but also named the date of 10/15/25 which corresponded to Wednesday. On 10/14/25 an email was received from Vendor # 2 verifying an appointment for 10/15/25 (Wednesday). On 10/15/25 Vendor # 2 rescheduled the appointment for 10/17/25 (Friday). On Friday (10/17/25) Vendor # 2 rescheduled the appointment for 10/21/25 (Monday). On 10/17/25 the corporate office contacted Vendor # 2 and asked for weekend service for Saturday due to the rescheduling. On 10/18/25 (Saturday) Vendor # 2 came to the facility to troubleshoot the oven and reported they needed parts. An appointment was rescheduled for 10/20/25 (Monday). The appointment had again been rescheduled for 10/21/25. The Regional Director of Operations along with the Administrator and the Regional Clinical Director were interviewed on 10/21/25 at 5:30 PM. The Regional Director of Operations reported they had learned from the Vendor's visit that the cost of repair outweighed the option to purchase a new oven. The Regional Director of Operations along with the Administrator and the Regional Clinical Director were interviewed again on 10/24/25 at 2:30 PM. The Regional Director of Operations reported the following. She felt that the facility DM was not remembering the date that the oven quit working correctly and that the first record of malfunction was on 9/19/25. After 9/19/25 they did work on trying to resolve the problem by working as the timeline of events given to the surveyor showed. This included working on it themselves and contacting more than one Vendor.