STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Carolina Health and Rehabilitation Center	2575 W 5th Street Greenville, NC 27834

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews with staff, residents, and a family member, the facility failed to ensure linens were available for 4 of 4 residents who were interviewed or their family member was interviewed regarding linens (Residents # 9, # 10, # 11, and # 12).The findings included:a. Record review revealed Resident # 9 was last admitted on [DATE] and a readmission Minimum Data Set (MDS) assessment, dated 4/12/26, coded Resident # 9 as cognitively intact. Resident # 9 was interviewed on 5/12/26 at 10:35 AM and again on 5/14/26 at 8:42 AM and reported the following. Within the last two to three weeks, her bed linens needed to be changed because she had gotten jelly on the linens during breakfast. The staff did not have any bed linens to change them, and she had to wait for them to be replaced until later that night. Resident #9 indicated obtaining washcloths and towels was also a problem. She had watched the nurse aides cut up towels to make washcloths and therefore she purchased her own towels or washcloths for personal use.b. Record review revealed Resident # 10 was admitted to the facility on [DATE] and her last quarterly MDS assessment, dated 3/29/26, coded the resident as moderately cognitively impaired. Resident # 10 was interviewed on 5/12/26 at 11:15 AM and reported that linens were an everyday problem and that the staff did not have towels. She was wanting linens for a bath and hygiene purposes. During a follow up interview on 5/12/26 at 12:07 PM, Resident # 10 reported she had incontinence care that morning and was pleased with that but wished to have a bath. According to Resident # 10, because of linens not being available, the staff could only provide incontinence care and not a full bath that morning. The resident reported a lack of linens had been a problem for awhile.c. Record review revealed Resident # 11 was admitted to the facility on [DATE] and a Social Worker's note, dated 5/5/26, noted Resident # 11 was alert and oriented. Resident # 11 was observed to have a dirty pillowcase on 5/12/26 at 12:01 PM and was interviewed. He reported linens were a problem and that there had been no washcloths or towels that morning. Resident # 11 indicated he had kept a used washcloth from yesterday, let it dry out, and used it that morning to wash his face. Resident # 11 reported a lack of linens tended to happen every other week but did not specify when the linen problem started.d. On 5/12/26 at 12:25 PM an interview was conducted with a Family Member of Resident # 12 who reported she had noticed there would be the same food stains on the bed sheets from day to day. The family member did not specify that she had reported the problem to anyone or how long the problem had been occurring.Nurse Aide (NA) # 4 was interviewed on 5/12/26 at 11:31 AM about linens and reported the following information. She routinely went to the linen room to obtain linens in the morning to place on her linen cart. NA #4 indicated there were no towels or washcloths when she arrived for work that morning in the linen room to place on her linen cart. A few of her assigned residents had linens in their rooms and she used those, but not all her residents had linens. Therefore, she just had to wait until linens were available. NA # 4 pointed to rooms on her assignments that had unmade beds and said she was unable to make beds because there were no sheets. She further reported they had been told that one of the dryers had been broken but there had been a problem with having enough linens for a long time. It was observed at the time of the interview with NA # 4 that there were no linens on her linen cart.NA # 5 (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was interviewed on 5/12/26 at 11:35 AM and reported the following information. She had been working at the facility for about a month and having enough linens had always been a problem. Since 7:00 AM that morning she had not had any washcloths or towels and therefore she had been cleaning residents' faces with incontinence wipes. She also could not find bed sheets. NA #5 indicated someone had said the dryer was broken. Problems with having enough linens had been a problem in the past and the problem had been reported. NA # 5 did not specify to whom the problem had been reported. The staff would be told to use what they had. NA # 5 did not specify who told staff this. During a follow up interview with NA # 5 on 5/12/26 at 11:45 AM, NA # 5 reported that she knew Resident # 10 was wanting a bath, but she could not bathe her without the linens.NA # 6 was interviewed on 5/12/26 at 11:55 AM and reported the following information. She had not had washcloths or towels since 7:00 AM that morning. NA #6 indicated there had been one or two residents who had some washcloths or towels in their drawers and she had used those. Some of her residents were independent and she was unsure what they were doing. If push came to shove she would use the incontinence wipes but some of the residents did not like incontinence wipes on their face. NA #6 stated she had worked for six months at the facility and having enough linens had always been a problem. The previous day one of the nurses had said something to her about unmade beds but she had not had linens to make the beds. The issue of not having sufficient linens had been reported because they had meetings and the issue was brought up. NA # 6 did not specify which staff attended the meetings or specific details of the linen discussion.NA # 7 was interviewed on 5/12/26 at 12:20 PM and reported she had six washcloths and six towels when she started her shift that morning and she was responsible for providing care to eight residents. NA # 7 did not specify that she had reported a problem with having less linens than the number of assigned residents.NA # 8 was interviewed on 5/12/26 at 12:22 PM and reported the following information. She had worked at the facility for seven months and having enough linens had been a problem for all that time. She did not have washcloths and towels when she started to work that morning and still did not. She was waiting until the facility got some or was using incontinence wipes for baths. NA # 8 did not specify if she had told anyone while she was waiting for linens that there was a problem.NA # 9 was interviewed the following day on 5/13/26 at 8:10 AM and showed the surveyor that she had seven washcloths, no towels, no sheets, and no pillowcases on her linen cart at that time. NA #9 reported that when she first arrived there were not even seven washcloths, but someone had put out seven washcloths between 7:00 AM and 8:10 AM. While interviewing NA # 9, the Assistant Director of Nursing (ADON) was observed to approach the cart and put a small stack of towels on the linen cart.NA # 5 was interviewed on 5/13/26 at 8:12 AM and showed the surveyor her linen cart which was observed to have cut up towels for washcloths. NA # 5 reported she had to cut the towels in order to have washcloths because there had been no washcloths or towels when she arrived at 7:00 AM.During an interview with NA # 10 on 5/13/26 at 10:15 AM, NA # 10 reported the following information. She only worked on an as needed basis at the facility, and she did not like to work at the facility specifically because of the linen problem. She would have to scavenge around in rooms to find linens. It had been a daily problem for months finding linens. NA # 10 indicated she would get wet wipes run them under hot water and then use them as washcloths when there were none. A nurse once instructed her to use a pillowcase to clean someone, but she did not want to do that and therefore sometimes she cut up towels. NA # 10 did not specify how the problem had been reported or that she had done so herself but reported that both the Administrator and the Director of Nursing (DON) knew. NA # 10 did not specify how the Administrator and DON had known. On 5/12/26 at 12:09 PM a linen cart on the 400 hall was observed with no towels or washcloths. Another linen cart located on the 400 hall was observed to have no towels or washcloths on 5/12/26 at 12:10 PM. On 5/12/26 at 12:17 PM there were three linen carts in a cubby hall near an exit on the 200 hall and there were no washcloths and towels.Laundry Employee # 1 was interviewed on 5/12/26 at 11:40 AM and it was observed at that time that there were no linens in the linen room. Laundry Employee # 1 reported that one of the dryers (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was broken and she could not dry all the linens that needed to be dried. Laundry Employee # 1 reported that the dryer had been working when she left the previous day at 2:00 PM but was not working when she returned that morning (on 5/12/26). The Rehabilitation (Rehab) Director was interviewed on 5/14/26 at 12:50 PM regarding whether the therapists had enough linens to work with rehab residents on performing their activities of daily living. The Rehab Director reported having sufficient linens was a problem and at times an occupational therapy session had to be moved or rescheduled to a later time until linens could be obtained. At those times, the therapists would not be able to find linens on the carts, and they would go to the linen room where sometimes there were none there either. The Rehab Director indicated this happened about twice per week. The Rehab Director did not specify how long this had been an issue. She (the Rehabilitation Director) had not reported the issue directly to the Administrator but stated she knew that the Administrator had been told about the issue.On 5/14/26 at 1:30 PM, the Director of Nursing (DON) was interviewed and reported that she thought someone had said there was a problem with the dryer the previous week, and that may have contributed to some linen problems, but she had not been aware of any continuous problems. The DON indicated if the staff had let her know that there was a problem with having towels or washcloths, then she would have purchased some herself to meet any immediate needs.On 5/12/26 at 11:45 AM the Administrator was notified regarding some of the staff's comments and observations about a lack of linens. The Administrator reported that no one had reported a problem to him so that he was aware, and he had made rounds that morning.During a follow up interview with the Administrator and the Corporate Nurse Consultant on 5/12/26 at 5:30 PM, the Administrator and the Corporate Nurse Consultant indicated they had not been aware of on-going linen problems. The Administrator reported that periodically they checked all rooms for hoarded linens to see if unused linens were placed in drawers rather than being placed back in circulation to avoid problems with linen availability.On 5/13/26 at 8:40 AM the Corporate Nurse Consultant reported that they received a shipment of linens that morning that staff were putting out. The Corporate Nurse Consultant also reported that the Environmental Services Manager had suddenly quit and that the Maintenance Director was filling in for this position.The Maintenance Director was interviewed on 5/14/26 at 3:20 PM and reported the following information. He used to order linens and then the Environmental Services Manger took over ordering around December 2025. About two months ago, the Environmental Services Manger went on a leave of absence and had ordered linens right before her leave. This was the last time linens were ordered. The Maintenance Director indicated they just found out during the current week that the Environmental Services Manger would not be returning. When he used to order linens, he ordered monthly linens along with other supplies and chemicals. During the current week, one of the dryers had been broken for about three days and it took some time to get a repairman in to fix it. They were currently in the facility working on the dryer. The Maintenance Director stated typically, the facility kept linens in back up for times like that, but the backup supply had been depleted when the Environmental Services Manger had been out on leave. When he was ordering in past times, he typically liked to keep a backup supply of the following: 12 to 24 dozen washcloths, 6 to 7 dozen towels and a couple dozen of other linens. The Maintenance Director further reported he had ordered linens the week before last but they had not arrived. Currently while the dryer was broken, a sister facility had been trying to help with the drying of the linens.On 5/14/26 the Administrator had a personal emergency which required his absence and he was not available for further interview on 5/14/26 following the Maintenance Director's interview.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, Responsible Party (RP), Physicians, and Wound Nurse Practitioner, the facility failed to obtain supplies and implement the Wound Nurse Practitioner's treatment plan for a resident with a pressure sore. This was for 1 of 3 sampled residents reviewed for pressure sores (Resident # 4).The findings included:Record review revealed Resident # 4 was admitted to the facility on [DATE] and had diagnoses which included a history of surgery and radiation treatment for a brain tumor in 2015 which resulted in aphasia (inability to speak) and quadriparesis (muscle weakness in arms and legs.) Additionally, Resident # 4 had diagnoses of seizure disorder, hypertension, dysphagia (trouble swallowing), and gastrostomy placement (a tube inserted into the stomach for liquid nutrition to be given).Review of Resident # 4's care plan, last updated on 4/20/26, revealed staff identified Resident # 4 was at risk for pressure sores due to decreased mobility, incontinence, and being dependent on staff for positioning. This had been added to the care plan on 5/4/21 and remained part of the resident's active care plan. Although not all inclusive of interventions, the care plan noted Resident # 4 required a low air loss pressure relieving mattress on the bed to promote skin integrity.On 4/17/26 at 6:20 PM the facility Wound Nurse entered a nursing note that Resident # 4's Responsible Party (RP) had talked to her about a concern regarding a scab on the resident's foot. She (the facility Wound Nurse) had looked at the area and there was no need for treatment.The facility Wound Nurse was interviewed on 5/13/26 at 10:51 AM and reported the following information. Resident # 4's RP was present on 4/17/26 and had been concerned about an area on the resident's foot that was scar tissue. It was not an active wound. She (the Wound Nurse) had looked at Resident # 4's skin that day and saw no signs of open wounds on any part of her body. The resident's air mattress was working when she was in the room and was routinely checked by the nurses to make sure it was operating properly.Resident # 4's RP was interviewed on 5/13/26 at 11:29 AM and reported the following information. She had visited on both 4/17/26 and 4/18/26. On the afternoon of 4/18/26 Resident # 4's mattress seemed sunken in the middle of the bed. She mentioned it to Unit Manager # 1 who looked at it, performed some functions, and let her know it would take some time for the mattress to start to function completely again. She left that day but was called the following week and informed that Resident # 4 had a pressure sore. She was concerned the malfunctioning of the air mattress had contributed to the problem and the pressure sore had worsened in only a few short weeks.Unit Manager # 1 was interviewed on 5/13/26 at 2:58 PM and reported the following information. She recalled Resident # 4's RP mentioning the problem with the air mattress on 4/18/26. When she looked at it, the mattress was not totally deflated. She could still feel air in it. The electrical plug appeared to have come partially out of the wall socket and therefore she put it all the way back into the socket. After she did that, she could feel air start circulating. She checked the settings and she let the direct care nurses know to keep a check on it.Review of the manual for Resident # 4's low air loss mattress revealed the following information. The mattress had both air cylinders in conjunction with foam. On top of the air cells was a high-density foam coupled with a one-inch-thick gel infused memory foam layer. The mattress did not rely on air alone to provide pressure relief.On 4/19/26 at 11:38 PM Nurse # 4 entered the following information in a nursing note. Resident # 4 had a nickel size fluid filled blister present on her left buttock and one on her right buttock which had burst. Orders were obtained to cleanse the right buttock with wound cleanser, apply calcium alginate, and cover with border gauze. The left buttock was to be painted with betadine.Orders were entered on 4/19/26 into Resident #4's electronic medical record for the following: Clean the left buttock blister with wound cleanser and paint with betadine or skin prep every day. Clean the right buttock with wound cleanser and apply calcium alginate followed by a border gauze.Nurse # 4 was interviewed on 5/13/26 at 10:42 AM and reported the following information. On 4/19/26 a Nurse Aide had alerted her that something seemed wrong with Resident # (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4's air mattress. She looked at it. It was not completely without air but seemed lower in the top to the middle when compared to the bottom. A maintenance employee was in the facility, and he worked on it twice. The second time he replaced the motor, and it was working. It was fully functional by 9:00 or 10:00 AM that morning after he worked on it.The Maintenance Employee was interviewed on 5/13/26 at 9:10 AM and validated he had worked on the air mattress and restored it to fully functioning order on 4/19/26. He had checked on it before he clocked out at 3:00 PM and it was continuing to work fine.On 4/20/26 at 5:35 PM the facility Wound Nurse entered a nursing entry noting the following information. Resident # 4 had a large MASD (moisture associated skin damage) area across her buttocks. Treatments were in place, the RP was notified, and the resident's air mattress was functioning properly.During an interview with the facility Wound Nurse on 5/13/26 at 10:51 AM the Wound Nurse reported the following information. When she assessed Resident # 4 on 4/20/26 her buttocks were dark and it appeared as if the skin had been sheared. She thought it might be moisture related but sent a photograph to the Wound Nurse Practitioner who reported the wound looked like a [NAME] Ulcer and to obtain labs to determine more about the resident's status. (A [NAME] Ulcer is rapid, unavoidable skin breakdown that often appears in the final weeks or days of life.)On 4/20/26 Resident # 4's care plan was updated to reflect that she had developed a wound to her right and left buttocks. Although not all inclusive, some of the interventions included referring the resident to the facility's Wound Physician and providing treatments per the treatment administration record.On 4/23/26 the Wound Nurse Practitioner (NP) documented she initially saw Resident # 4 and included the following information in her note. Resident # 4 had a pressure ulcer to her bilateral buttocks which measured 6.5 cm (centimeters) X 13 cm X 0 and was 60 % slough (unhealthy tissue in a wound bed) and 40 % granulation tissue (healthy tissue in a wound bed.) The Wound NP further noted, Patient presents with acute onset of bilateral ulcer in a butterfly distribution, first noted approximately three days ago (4/20/26) with rapid progression to eschar (dead tissue in a wound bed) formation. The wound's characteristics and accelerated deterioration are atypical for a standard pressure injury particularly given the patient's prior history of intact skin and low incident of wound development. While currently classified as an unstageable pressure injury, the sudden presentation raises concern for underlying systematic or perfusion related etiology. Recommend further medical evaluation to assess for contributing factor such as acute illness, vascular compromise, or end of life changes. The Wound NP further noted that the recommended plan should be to clean the wound with Dakin's solution and apply Calcium Alginate with Silver to the base of the wound. Then silicone bordered gauze should be applied. (Dakin's solution is an antiseptic used for wounds and helps prevent infection. The silver component of calcium alginate with silver has antimicrobial qualities.)The Wound NP's 4/23/26 recommendation was not entered as an order into Resident # 4's electronic medical record.Review of the record revealed the 4/23/26 wound treatment plan was not initiated. The previous orders, dated 4/19/26, remained in effect and the Treatment Administration Record (TAR) reflected the 4/19/26 treatment orders continued.On 4/27/26 a significant change Minimum Data Set assessment was completed. The assessment coded Resident # 4 as severely cognitively impaired, totally dependent on staff for bathing, hygiene, and turning in bed, incontinent of bowel and bladder, and as having an unstageable pressure sore.On 4/30/26 the Wound NP again documented she saw Resident # 4 and made the following notations. The pressure sore measured 5.5 cm X 14.5 cm X .4 cm and was 90 % slough and 10 % granulation tissue. She had debrided (the removal of dead or infected skin tissue from a wound to promote healing) 100 % of the wound. The Wound NP further noted that further clinical assessment and review of her labs indicated Resident # 4 was medically stable and without signs consistent with end-of-life skin failure. She (the Wound NP) had learned that the air mattress had been malfunctioning prior to the onset of the wound and given that information the wound was consistent with inadequate pressure offloading. The Wound NP also noted the treatment plan should be changed again to the following: Cleanse with [NAME] (a saline-based wound cleanser containing pure hypochlorous acid), apply Santyl and calcium alginate to the base of the wound and (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then secure a silicone bordered gauze over the wound. (Santyl is a chemical debriding agent utilized to remove unhealthy tissue while preserving healthy tissue).The Wound NP's 4/30/26 recommendation was not entered as an order into Resident # 4's electronic medical record.Review of the record revealed the Wound NP's 4/30/26 wound treatment plan was not initiated. The previous orders, dated 4/19/26, remained in effect and the TAR reflected the 4/19/26 treatment orders continued.On 5/4/26 the Wound NP again documented she saw Resident # 4. The Wound NP noted the following information. Resident # 4's pressure ulcer measured 5.5 cm X 13.5 cm X 1.2 cm with 90 % slough and 10 % granulation. She (the Wound NP) again debrided the wound. The treatment plan was the same as noted on 4/30/26.Review of the record revealed the Wound NP's 4/30/26 and 5/4/26 wound treatment plan was not initiated. The previous orders, dated 4/19/26, remained in effect and the TAR reflected the 4/19/26 treatment orders continued.The facility Wound Nurse was interviewed on 5/13/26 at 12:55 PM regarding why the Wound NP's treatment plan was not initiated and reported the following information. She (the Wound Nurse) enters the orders into a resident's electronic medical record after the Wound NP changes the plan, but she waits until she can obtain the supplies before she changes the order to the most recent plan. She had trouble getting the supplies for all the items which the Wound NP wanted in the treatment plan for Resident # 4, and therefore she did not enter the orders on 4/23/26, 4/30/26, or 5/4/26. There was a personal representative through their supplier who told her to quit coming to him directly. Some of the items ordered had just arrived the previous week and had not arrived in time for her to enter the orders. The facility's supply manager also had trouble obtaining items and she had to get the Director of Nursing involved. The Wound Nurse thought the Santyl came from the pharmacy. The Wound Nurse did not specify that she had consulted with the Wound NP about the facility's inability to obtain the recommended supplies.The Central Supply Manager was interviewed on 5/13/26 at 3:25 PM and reported the following information. She routinely ordered supplies once per week on Mondays and every staff member was aware of that. There were certain items which she could access online and order without having approval from the corporation's representative. For instance, she could order Dakin's solution without a corporate representative's approval. For some other items, there would be a notice that said access denied if she attempted to order and she must go through a corporate representative to get the request to go through. The Wound Cleanser [NAME] was an example of that. The corporate representative also must be able to see the order in the electronic system to know for whom the item was prescribed before they approved the order to be sent. She first received a request for Dakins on 4/30/26 and it was ordered on 5/4/26 (Monday) and sent on 5/5/26. She had never been requested to order calcium alginate with silver. The Central Supply Manager indicated she had received a request for the Vashe wound cleanser on 4/30/26 and she was blocked from ordering it. The corporation's representative had requested a list of residents who needed this item and the list was emailed. She knew that the list of residents who needed the Vashe was sent to the corporation's representative, but the facility did not receive the Vashe until 5/12/26.On 5/13/26 at 2:06 PM the Director of Nursing (DON) was interviewed and reported the following. The Wound Nurse should be entering the wound care orders into a resident's electronic medical system after the Wound NP sees the resident and changes the plan of treatment. If the supplies were not available, then the Wound Nurse should ask the provider to give approval to continue use of the current treatment until the new treatment items arrive. Then this order should be entered into the electronic record. The DON explained the supplier must see the resident's specific order to send the supplies. Since the treatment orders had not been entered into the electronic system, this had partially contributed to the problem of not receiving the treatment supplies. Some items were supplied through their corporate supplier, and others came through a third-party supplier. At the time of the interview, the DON was not sure which supplier sent the Santyl. The DON indicated the best practice was that the supplier would also be called in addition to entering the treatment orders. As she recalled, the Wound Nurse had come to her about the problem of not knowing who to ask about getting some needed supplies around 4/30/26 or 5/1/26. She (the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON) had learned that the order needed to be in for any supplier to send wound supplies.On 5/7/26 at 4:36 AM Nurse # 2 entered a nursing entry noting the following change in condition for Resident # 4. She had 2 episodes of vomiting, chills, and was not responding per her baseline. Her blood pressure was 72/44, temperature 97.2, pulse 94, and respirations 20. Orders were received to send Resident # 4 to the hospital for evaluationReview of hospital records for the hospital admission initiated on 5/7/26 revealed the following information. The records included a picture of the resident's wound upon admission. It appeared in a butterfly shape extending from the left buttock to the right buttock. It was documented to be boggy and with odor. A CT (computerized tomography) exam was done on 5/7/26 noting that Resident # 4 had myositis (a rare condition where the body's immune system attacks healthy muscle tissue causing inflammation). There was also a 4.4 cm X 2. 8 cm X 1.0 cm intramuscular fluid collection in the left gluteal (buttocks) area suggesting abscess or developing abscess. Findings also suggested cellulitis of the buttocks, a question of a kidney infection, a distended gallbladder, suspected thromboembolic disease (blood clots) in the pulmonary artery (the artery that carries blood from the heart to the lungs in order for the blood to become oxygenated.) At time of survey, Resident # 4 remained hospitalized .The Wound NP was interviewed on 5/14/26 at 11:20 PM and reported the following information. She did not think that failing to implement her treatment plan had caused Resident # 4's pressure sore to worsen. The treatment plans, which had never been implemented, were intended to help debride the wound faster but she was physically doing that when she visited. Therefore, changing the orders to her treatment plan may have hastened the debriding process but overall did not hurt the outcome of the wound. The Wound NP was also interviewed about the origin of the pressure sore and whether it was an avoidable wound and reported the following. Originally, she had thought the pressure sore might have been due to end of life, but the resident's labs did not reflect an unstable condition. The resident did have contributing factors such as being in a vegetative state, requiring a tube feeding, and impaired mobility which placed her at risk for pressures sores. When she learned the air mattress had not been fully functional before the pressure sore developing, this was suspicious to her that maybe the malfunctioning of the air mattress had contributed. The Wound NP stated she could not say whether the pressure sore was avoidable.Resident # 4's physician was interviewed on 5/13/26 at 10:38 AM and reported the following information. He had not had an opportunity to review all the problems Resident # 4 had been diagnosed with at the hospital on 5/7/26 but he did not think that being on an air mattress that lost air for a short amount of time would have caused her to have developed the pressure sore.The facility's Medical Director was interviewed on 5/14/26 at 2:05 PM and the results of Resident # 4's 5/7/26 CT scan were shared with him as he was interviewed about his opinion on whether Resident # 4's pressure sore was avoidable. The Medical Director reported the following. He had not personally seen the resident or reviewed her record, but it was his opinion that it was unlikely that being off the air mattress would have caused the pressure sore. If the resident had an abscess in her muscle, then the abscess could have been causing pressure and friction on the outer skin which resulted in the formation of blisters with which the resident initially presented. Therefore, according to the Medical Director, if that was the case, then the pressure ulcer would not have been avoidable.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with staff and Responsible Party, the facility failed to 1) identify in their accident investigation that an assigned staff member had not been on duty when Resident # 2 fell and thereby evaluate how this might have contributed to the accident occurring in order to take corrective action and 2) failed to toilet Resident # 2 at bedtime as directed by the resident's care plan in order to try and prevent future falls. This was for 1 of 3 sampled residents reviewed for falls (Resident # 2).The findings included:Resident # 2's hospital Discharge summary, dated [DATE], noted Resident # 2 was alert and oriented times two (indicating she knew who she was and where she was). Resident # 2 had diagnoses, which although not inclusive, included Alzheimer's disease and multiple myeloma.Record review revealed Resident # 2 resided at the facility from 4/23/26 until her discharge on [DATE].Record review revealed Resident # 2's admission Minimum Data Set assessment had not been completed and finalized due to her short residency.Resident # 2's facility care plan, which was initiated on 4/23/26, identified Resident # 2 was at risk for falls. On 4/23/26 an intervention was added to the care plan directing staff to place common items within reach of the resident.On 4/26/26 at 2:05 AM Nurse # 1 entered the following information in a nursing note. Resident # 2 was found on the floor. Her call light had been on. She had been needing to go to the bathroom, but the Nurse Aide did not make it in time.A review of a facility's investigative report regarding the incident revealed the following information. The fall occurred on 4/25/26 at 11:20 PM. Nurse # 1 had heard a loud commotion from the hallway and upon her arrival to the resident's room, Nurse # 1 found the resident lying on her left side on the floor. Resident # 1 was assessed and found to have no injuries or complaints of pain. Resident # 1's bed had a soiled incontinence pad. Resident # 2 reported she needed to go the bathroom bad and the call light had been pressed, but the Nurse Aide had not come fast enough. Resident # 2 had then attempted to go the bathroom on her own.Nurse # 1 was interviewed on 5/14/26 at 9:18 AM and again on 10:41 AM. Nurse # 1 reported the following information. She (Nurse # 1) had arrived just a few minutes late to work for her shift which began at 11:00 PM on 4/25/26. She had been no more than 5 minutes late and was counting the medication cart. She heard a crash as if someone had hit the floor. She went to the room and found Resident # 2 on the floor. After she assessed the resident, she asked for help to get Resident # 2 off the floor. She was told by some of the Nurse Aides that Resident # 2 was not their resident, to which she responded someone was going to help her get Resident # 2 off the floor. She did not recall which Nurse Aides had responded and told her that Resident # 2 was not their assigned resident. Eventually two Nurse Aides helped, and she did not recall who they were. Resident # 2 said she was trying to get to the bathroom. Resident # 2's call light had been on when she fell. Nurse # 1 did not specify how long the call light had been activated.According to an interview with the DON (Director of Nursing) on 5/14/26 at 9:20 AM, Nurse Aide (NA # 1) had been assigned to care for Resident # 2 beginning at 11:00 PM on 4/25/26 and had clocked into work at 11:41 PM on 4/25/26.Nurse Aide (NA) # 1 was interviewed with the Director of Nursing (DON) and Nurse Consultant on 5/14/26 at 10:20 AM. NA # 1 was interviewed regarding whether she had alerted anyone that she would be late for work on 4/25/26 in order that staff know as they were making assignments. NA # 1 reported the following information. She had tried calling the facility but could not get an answer. She then texted a coworker but found when she arrived at work that the coworker had not been on duty, and therefore no one had gotten the message that she was late. She never knew that Resident # 2 had fallen because she was not at work when she fell.During the interview with Nurse # 1 on 5/14/26 at 10:41 AM, Nurse # 1 was interviewed regarding whether she was aware that NA # 1 was going to be late in order that someone else monitor her residents and respond to call lights for help until NA # 1 arrived. Nurse # 1 reported she had not known this information. Nurse # 1 was further interviewed regarding whether she had checked on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident # 2 when she arrived at work and before Resident # 2 fell. Nurse # 1 responded she had just had time to count and check on five residents before the accident occurred and she had not checked on Resident # 2.During an interview with the DON on 5/14/26 at 9:20 AM and 10:37 AM the DON reported the following information. If a staff member was going to be late, then they should call and make sure to speak to an actual nurse at the facility in order that someone be aware of the need to cover their residents while they were not yet on duty. The DON indicated when she calls the facility at night, she was able to get through. Therefore, she (the DON) was unsure why NA # 1 was reporting she could not get in touch with someone.The DON and the Nurse Consultant were interviewed on 5/14/26 at 10:50 AM regarding their process of investigating falls and how they identified further interventions to prevent future accidents. The DON reported that falls were routinely discussed in a clinical meeting which was attended by her and other administrative staff members. The circumstances were discussed and an attempt was made to identify the root cause. After an incident, a resident's care plan was then updated to reflect interventions that might help to prevent future accidents. Resident # 2's fall had been discussed and her care plan updated. The DON indicated when a care plan was updated then the Kardex is automatically updated with information as well. The DON did not specify which day the clinical team had met to discuss the fall, if an optimal time for bedtime toileting was determined for Resident # 2, and whether it had been specified that the toileting responsibility was for staff on the 3:00 to 11:00 PM shift or the staff coming on duty at 11:00 PM. During the investigation of Resident # 2's fall, she had not spoken to Nurse # 1 about Resident # 2's fall and had not been aware that the assigned Nurse Aide was not present when the resident fell nor that the nurse had not been made aware of the Nurse Aide's absence. Therefore, they had not recognized this as a potential problem that may or may not have led to the fall occurring and thereby sought to take corrective action. The Nurse Consultant pointed out that even if Nurse Aide # 1 had been present on duty, the fall may still have occurred due to the resident's urgency to go to the bathroom and decision not to wait for assistance.Review of Resident # 2's care plan revealed following the 4/25/26 fall, a new intervention was created on 4/26/26 that reflected Resident # 2 had fallen on 4/25/26 and that direct care staff were to toilet Resident # 2 before bed.Resident # 2's Kardex was also noted to have an update that Resident # 2 had fallen on 4/25/26 and staff should toilet the resident before bed. It did not specify a particular time the toileting should occur and what time the resident generally went to bed. (A Kardex is a quick reference for direct care staff which gives instructions regarding resident care.According to assignment sheets NA # 2 was assigned to care for Resident # 2 on 5/3/26 during the 3:00 PM to 11:00 PM shift. NA # 2 was interviewed by phone on 5/13/26 at 7:50 PM and reported the following information. She did not recall having Resident # 2 and did not know anything about taking the resident to the toilet at bedtime.On 5/4/26 at 3:15 AM Nurse # 2 documented the following information in a nursing note. Resident # 2 was found on the floor and said she had been trying to go to the bathroom. Resident # 2 reported she had hit her head and had mild swelling. She was transferred to the hospital for evaluation.According to assignments, NA # 3 had been assigned to care for Resident # 2 on the shift which began at 11:00 PM on 5/3/26 and ended on 5/4/26 at 7:00 AM. NA # 3 was interviewed on 5/13/26 at 1:59 PM and reported the following information. She had checked on Resident # 2 around 12:00 AM and whispered to her that she was going to check her. She had been asleep. She was dry when she checked her and went back to sleep. Less than two hours later, she went by the room and found that she was on the floor. NA # 3 was interviewed regarding whether she knew anything about the resident needing to be toileted at bedtime and reported the resident wore briefs and she had not been aware of any toileting instructions for the resident.Nurse # 2, who had been assigned to care for Resident # 2 beginning at 11:00 PM on 5/3/26 until 7:00 AM on 5/4/26, was interviewed on 5/13/26 at 5:30 PM and reported the following information. The resident wore briefs and she did not know anything about directions that the resident should be toileted at bedtime. When she was found on the floor, Resident # 2 said she was trying to get her son and to go to the bathroom. Her brief had been dry when she was found. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident had some swelling on her head. She (Nurse # 2) called the RP (Responsible Party) who wanted Resident # 2 sent to the hospital for evaluation. Resident # 2's Responsible Party (RP) was interviewed on 5/12/26 at 3:40 PM and reported the following information. She had been concerned about Resident # 2 having two falls during the twelve days she resided at the facility and was worried the facility staff were not monitoring the resident. It was her understanding that Resident # 2's roommate had called for help on 4/25/26 when Resident # 2 fell. During the second incident, she wanted Resident # 2 checked at the hospital and the hospital determined Resident # 2 had not had any injury from the fall. She decided to take Resident # 2 home rather than have her go back to the facility.On 5/14/26 at 12:50 PM the Rehabilitation Director was interviewed regarding Resident # 2's physical ability to be toileted and reported the following information. Resident # 2 had been working with therapy and was able to scoot to a seated position and then stand and pivot to an upright position. Then she could walk with a walker to the bathroom, but she needed someone to go with her for safety.During an interview with the DON on 5/14/26 at 10:50 AM and 11:10 AM the DON validated that NA # 2, who reported she did not recall the resident or taking her to the bathroom, had been assigned to care for Resident # 2 on the 3:00 PM to 11:00 PM shift of 5/3/26. The DON was interviewed how the direct care staff knew that they were supposed to toilet the resident at bedtime given that three of three staff members were reporting they knew nothing about the toileting intervention to prevent falls. The DON reported the Kardex contained basic care information for the Nurse Aides to reference and every Nurse Aide should be referencing the Kardex when they started their assignments.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff and Physician, the facility failed to have effective systems in place to ensure ordered medications were acquired from the pharmacy and available for administration and the backup supply of medications was utilized for medications that had not been received from the pharmacy for 1 of 1 resident whose medications were reviewed (Resident #1).The findings included:Resident # 1 was admitted to the facility on [DATE] with diagnoses that included panhypopituitarism (a rare disorder when the pituitary gland stops producing most or all its essential hormones) and sleep apnea for which he was documented as wearing a CPAP (a continuous positive airway pressure) machine.Review of Resident # 1's orders, dated 3/23/26, revealed he was ordered to receive dexamethasone one (1) milligram (mg) every day for his panhypopituitarism. (Dexamethasone suppresses the immune system.)Review of Resident # 1's May Medication Administration Record (MAR) revealed on 5/6/26, Nurse # 5 did not document that she had administered the resident's dexamethasone as scheduled at 9:00 AM. Instead of a check mark, which would have indicated administration, there was a 9 by the dexamethasone dose. According to the MAR's legend, 9 corresponded to other. There was no explanation of other found on the MAR. Review of physician progress notes revealed on 5/6/26, Resident # 1's physician saw Resident # 1 due to the nursing staff noting that the resident was drowsier and mildly tachypneic (increased respirations). On 5/6/26 the physician left new orders for Resident # 1 after evaluating him. One of the orders was for an albuterol sulfate inhalation nebulizer treatment for one time only.On 5/6/26 an order was entered into Resident # 1's record for Albuterol Sulfate Inhalation Nebulization Solution; One inhalation one time only for wheezing/ shortness of breath for one day.Review of Resident # 1's MAR revealed Nurse # 5 indicated a 9 (other) by the albuterol sulfate inhalation nebulizer on 5/6/26 at 1:41 PM rather than checking that it was administered. There was no explanation of other on the MAR itself. At 1:41 PM Nurse # 5 wrote pharmacy aware in a electronic medication note. Nurse # 5 was interviewed on 5/13/26 at 4:33 PM and reported she did not recall why she did not give the dexamethasone to Resident # 1 on 5/6/26, but she did not have the albuterol to administer.Nurse # 6 was interviewed on 5/14/26 at 10:00 AM and reported the following information. He was orienting (process of introducing someone to a new job) Nurse # 5 on 5/6/26. Resident # 1 had missed his dexamethasone because the facility was out of Resident # 1's supply of the medication and the pharmacy had not refilled his supply. Therefore, the dexamethasone had not been given. Nurse # 6 indicated that sometimes the pharmacy was slow in sending things. The resident had also not received the albuterol nebulizer treatment because they were waiting for the pharmacy to send it also. Nurse # 6 did not specify what led to the pharmacy being slow in getting dexamethasone refilled or why he and Nurse # 5 did not obtain both dexamethasone and albuterol from the facility's backup supply.Review of Resident # 1's record revealed he was discharged to the hospital on 5/6/26 at 9:00 PM without receiving these two medications.The Director of Nursing (DON) who just began in her role in December 2025, was interviewed on 5/14/26 at 10:00 AM and reported the following information. Both the dexamethasone and the albuterol had been in the facility's back up supply on 5/6/26 and should have been pulled from the backup supply and administered to Resident # 1. She had made a copy of all the medications that were available in the backup supply and put the list as a reference in a book on each medication cart. That way, the nurses could reference the list if they needed something and easily know how to obtain it from back up. The DON indicated she had informed the nurses about the backup list placed on the medication carts. The DON did not specify when the list had been placed on the medication carts and the information shared with nurses, but according to the DON, the list had been in place when Resident # 1's missed his medications on 5/6/26. Resident # 1's Physician was interviewed on 5/14/26 at 2:05 PM and reported the following. The resident had no (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	negative outcome to either missed medication on 5/6/26 and he saw Resident # 1 on 5/6/26. Resident # 1 seemed drowsier and usually wore a CPAP machine. If he had not worn it correctly or been noncompliant, then there may have been a chance he was retaining some carbon dioxide. The Physician indicated the albuterol had been meant to see if Resident #1 would pep up with the treatment.