STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlotte Health & Rehabilitation Center	1735 Toddville Road Charlotte, NC 28214

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and resident and staff interviews, the facility failed to treat a resident in a respectful and dignified manner when 1 of 2 staff (Nurse Aide (NA) #1) failed to provide incontinent rounding resulting in urine saturated pants, mechanical lift pad and wheelchair seat for 1 of 3 reviewed for dignity and respect (Resident #56). Resident #1 indicated it made him feel bad to have to sit in urine-soaked pants. Findings included:Resident #56 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia (complete paralysis on one side of the body) and hemiparesis (neurological condition characterized by weakness on one side of the body) following cerebral infarction affecting the left non-dominant side and acute kidney failure.The resident's Care Plan dated 02/11/25 identified incontinence care as a focus area. The resident was assessed as incontinent of bowel and bladder with severe physical impairment. Interventions included assistance from two staff members for toileting, hygiene, and incontinence care, with the goal of keeping the resident as clean and dry as possible.The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the resident was cognitively intact. The assessment further indicated the resident was dependent on two staff members for toileting, personal hygiene, and lower body dressing and was assessed as always incontinent of urine and bowel. Resident #56 was assessed with clear speech, understood by staff and had the ability to understand others.An interview conducted on 01/16/26 at 11:58 PM with Resident #56 revealed on 01/12/26 Nurse Aide (NA) #1 assisted him into his wheelchair at approximately 2:00 PM and did not return to check on him until approximately 8:00 PM. The resident stated his brief and pants were soaked with urine during that time and even through the supper meal when he felt he was wet. He stated staff were supposed to check on him every two hours but did not and did not come into the room until approximately 8:00 PM. When asked how the incident made him feel, the resident stated it made him feel bad having to sit in wet pants. He stated he did not tell staff that he had urinated because he didn't want to bother them.An interview conducted on 01/16/26 at 12:15 PM with NA #1 revealed she was assigned to Resident #56 on 01/12/26 from 7:00 AM to 11:00 PM. She stated she transferred the resident to his wheelchair between 2:00 PM and 3:00 PM and did not check his incontinence status again until 8:00 PM when the resident activated his call light. NA #1 stated the residents' brief, pants, wheelchair seat, and lift pad were saturated with urine. She stated she did not perform routine incontinence checks because she believed the resident was alert and could request assistance as needed. The interview further revealed NA #1 cared for Resident #56 on a regular basis and was familiar with him. An interview conducted on 01/16/26 at 12:36 PM with NA #2 revealed NA #1 was assigned to Resident #56 on 01/12/25 and responsible for completing two-hour incontinence rounding. NA #2 stated the resident was not consistently able to notify staff when he needed to be changed and required routine monitoring. NA #2 stated she left at 3:00 PM and did not observe the resident to be wet at that time. She stated she felt like he was unable to consistently notify (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff because he would be observed incontinent without alerting staff that he had went to the restroom. She stated he was dependent upon staff to provide incontinence rounding. An interview conducted on 01/21/26 at 3:12 PM with Nurse #1 revealed at approximately 8:00 PM on 01/12/26 she responded to Resident #56 yelling for help and found him on the floor. Nurse #1 stated the resident's pants, wheelchair seat, and lift pad were saturated to the extent that a mechanical lift could not be safely used. Four staff members were required to assist the resident back into bed. Nurse #1 stated her shift had started at 7:00 PM, but she had not checked on Resident #56 or gone into his room prior to the incident. She stated she was unsure if or when the Nurse Aide had completed incontinence checks on the prior shift.An interview conducted on 01/20/26 at 11:00 AM with the Director of Nursing revealed the resident should have received incontinence care during the period between 2:00 PM and 8:00 PM and should not have been left saturated with urine. The DON stated residents should be provided with incontinence care every two hours in the facility and no resident should feel upset due to sitting in incontinence.During an interview conducted on 01/16/26 at 1:19 PM, the Administrator stated it was the facility's expectation that residents be rounded on every two hours and changed as needed to maintain dignity and comfort.

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident and staff interviews, the facility failed to maintain a clean floor and failed to maintain baseboards in good repair in a resident's room and bathroom (Resident #27). Additionally, the facility failed to maintain a window screen in a resident's room (Resident #109). The deficient practice affected 2 of 19 rooms on 2 of 4 halls observed for environmental concerns.Findings included: 1. An interview was conducted with Resident #27 on 1/12/2026 at 12:53 PM and she stated her room and bathroom had not been swept or mopped for some time. Resident #27 could not recall when the room had last been thoroughly cleaned. Resident #27 pointed out that there was debris on the floor at the head of her bed which resulted when the bed hit the wall when adjusting the head of the bed position. Resident #27 stated she told housekeeping but could not remember exactly when or to whom she had reported the issue about the debris. An observation of Resident #27's room and bathroom on 1/12/2026 at 1:00 PM revealed approximately a half cup of white plaster-like debris that ranged in size from dime size pieces to a white powdery substance on the floor at the head of Resident #27's bed. There were two white plaster like patches on the wall approximately six inches by six inches at the head of the bed which appeared to have been previous areas of repair. An observation in Resident 27's bathroom revealed one section of baseboard approximately four inches along the left wall and another section of baseboard approximately three inches long under the sink had pulled away from the wall by approximately one inch. There was also one section of baseboard approximately three inches long observed under the left side of the Packaged Terminal Air Conditioner (PTAC) unit which had pulled away from the wall by approximately one inch. Housekeeper #1 was observed on the hall on 1/12/2026 at 1:30 PM but was not observed cleaning Resident #27's room. Subsequent observations in Resident #27's room on 1/13/2026 at 8:45 AM, 1/14/2026 at 2:00 PM, 1/15/2026 at 4:45 PM and 1/16/2026 at 2:30 PM revealed the debris remained untouched under Resident #27's bed and the baseboards remained in disrepair. A telephone interview on 1/20/2026 at 10:31 AM with Housekeeper #1 revealed she had worked at the facility for 3 1/2 years. Housekeeper #1 stated she swept/mopped the residents' rooms/bathrooms twice a day and as needed. Housekeeper #1 disclosed that Resident #27's room was part of her routine assignment on the hall and she cleaned the room each morning and then rechecked the room before the end of her shift for any additional housekeeping needs. Housekeeper #1 indicated she had never noticed the debris under the head of the bed in Resident #27's room and Resident #27 had never told her about it. Housekeeper #1 stated the beds were heavy and she was unable to move them by herself. Housekeeper #1 reported she had been notified on 1/16/2026 in the afternoon that there was debris under the head of Resident #27's bed and she had cleaned up the debris immediately. A review of the Work Order Log from December 15, 2025 to January 15, 2026 revealed no work orders which reported the bed in Resident #27's room hitting the wall when the head of the bed position was changed or the sections of baseboard pulling away from the wall. (continued on next page)

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	During a facility tour with the Administrator, Maintenance Director and the Dietary Services/Housekeeping Director on 1/16/2026 at 2:30 PM, Resident #27's room was visited and the debris was observed on the floor under the head of the bed. The Maintenance Director also observed the baseboard in Resident #27's bathroom and under the PTAC unit pulling away from the wall. An interview with the Maintenance Director on 1/16/2026 at 2:33 PM revealed the floors were [AGE] years old and that the facility was aware new flooring/baseboards were needed. The Maintenance Director stated the facility had started to replace flooring in the facility but was unsure when Resident #27's room was scheduled to have flooring/baseboards replaced. The Maintenance Director explained that the debris at the head of Resident #27's bed was plaster from the patched areas being knocked off when the bed hit the wall when the head position of the bed was changed. The Maintenance Director stated staff could place work orders in the computer through The Equipment Lifecycle System (TELS) but many times just told him in person about issues noted. During an interview with the Dietary Services/Housekeeping Director on 1/16/2026 at 2:37 PM, she stated the residents' rooms/bathrooms should be swept/mopped at least daily. The debris in Resident #27's room should have been noticed and cleaned up by housekeeping. A virtual interview was conducted with the Director of Nursing (DON) on 1/20/2026 at 11:00 AM and she expressed that the residents' rooms and bathrooms should be cleaned at least once a day. The DON stated the debris under Resident #27's bed should have been noticed and immediately cleaned up by housekeeping. An interview with the Administrator on 1/16/2026 at 3:30 PM revealed the residents' rooms and bathrooms should be kept clean and in good repair which included the flooring and baseboards. The Administrator stated the debris in Resident #27's room should have been observed and cleaned up immediately. 2. An observation conducted in Resident #109's room on 1/12/26 at 12:05 PM revealed a window screen with a large, vertical tear approximately 12 inches long on the right side of the left window panel. The window was not latched. An additional observation of Resident #109's room was conducted on 1/14/26 at 10:58 AM. The window screen had a large, vertical tear approximately 12 inches long on the right side of the left window panel. The window was closed and latched. A third observation was conducted in Resident #109's room during a facility tour on 1/16/26 at 2:05 PM with the Dietary Manager, Maintenance Director, Regional Nursing Consultant, and Administrator in attendance. The window screen had a large, vertical tear approximately 12 inches long on the right side of the left window panel. The window was closed and latched. The Maintenance Director stated he did weekly random room checks to keep up with any maintenance concerns and expected all staff to make a maintenance request for any repairs. The Maintenance Director had not checked this room and was not aware of the tear in the screen. He stated he did not recall any maintenance requests to fix the screen. A review of the maintenance work order log was completed and no concerns regarding the window screen in room [ROOM NUMBER] were noted. An interview with the Director of Nursing (DON) on 1/20/26 at 11:06 AM revealed she had the (continued on next page)

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	expectation that all nursing staff would make a maintenance request for repairs in resident spaces to include screens in disrepair and any general maintenance concerns. An interview with the Administrator on 1/16/26 at 4:18 PM revealed she expected all staff to alert maintenance staff to any issue and to fill out work orders for the concern.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review and staff interviews, the facility failed to submit the results of an investigation of an allegation of alleged employee to resident abuse that included the date/time of the alleged incident, the patients full name/room number, details of the allegation, names of the accused and any witnesses, name of facility staff who investigated the allegation, results of the investigation, and any corrective action that was taken by the facility to the Division of Health Service Regulation (DHSR) within 5 working days of the allegation for 1 of 3 sampled residents reviewed for abuse (Resident #113).The findings included:A review of the facility's policy titled Abuse/Neglect/Misappropriation/Crime, Patient Protection effective date 10/17/2023 read, in part a zero tolerance for mistreatment, abuse, neglect, misappropriation of property, or any crime against a patient of the facility. The policy also indicated all suspected or witnessed incidents of abuse, neglect, theft, and/or exploitation or any reasonable suspicion of a crime against a patient brought to the attention of the center's administration will result in internal investigation, appropriate and timely reporting to the State Survey Agency. A review of the facility's policy entitled Abuse/Neglect/Misappropriation/ Crime, Reporting Requirement/Investigations effective date 2/5/2023 read, in part the Administrator must thoroughly investigate and file a complete written report of the investigation to the State Agency within 5 working days of the incident. The written follow-up investigative reporting documented must contain sufficient details to demonstrate a thorough investigation was conducted. The report must include but is not limited to the date of occurrence, name of the resident staff, or individuals involved, location of and the description of the injury to the resident, location and description of the occurrence, immediate action taken to protect the resident from further injury, mechanisms in place to prevent recurrence of the incident, and documentation of reports to Adult Protective Services, law enforcement, or the Department of Health Professions, as appropriate.A review of the initial allegation report submitted by the facility to the Division of Health Service Regulation (DHSR) revealed an allegation of employee to resident abuse. The allegation details noted, in part that Resident #113 stated he was beat up by a staff member the previous evening (6/5/25). The report continued Resident #113 was severely cognitively impaired and disoriented and he was unaware of who the staff member was. The initial allegation report description included a head-to-toe skin assessment was completed on Resident #113 with no signs of injury, and a facility investigation was initiated. The initial allegation report noted there were no details of physical or mental injury or harm. The report indicated the facility was made aware of the incident on 6/6/25 at 11:30 AM, the initial report was submitted to DHSR via fax transmission on 6/6/25 at 12:20 PM and law enforcement was notified on 6/6/25 at 12:00 PM. The initial allegation report was completed and signed by the Director of Nursing (DON).A review of Resident #113's Electronic Medical Record (EMR) revealed a Medical Director's note on 6/6/25 stating Resident #113 was seen for a follow up visit and stated he was beaten up yesterday. The note further revealed Resident #113 endorsed being agitated and difficult to deal with. The Medical Director's note continued upon further questioning, nursing staff reported that Resident #113 liked to roll out of bed and scream for help and Resident #113 had baseline intermittent confusion and agitation toward staff. A review of a copy of an email correspondence from Health Care Personnel Investigations copied to DHSR Complaint Intake Unit was conducted. The email was addressed to the Administrator and DON on 6/17/25 revealed a five-day investigation report associated with the 24-hour report submitted on 6/6/25 had not been received by DHSR. The email indicated the facility should fax the 5-day investigation report as soon as possible. An interview with the Administrator on 1/16/26 at 10:30 AM revealed she did not know which staff member reported the initial allegation and she was (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unable to find the email sent from DHSR on 6/17/25 regarding the 5-day report not being received by DHSR. She stated she did not have any records of fax transmittals for the 5-day report to DHSR and stated the report was not sent to DHSR. A review of the facility's 5-day investigation folder revealed a summary written by the Administrator on 6/10/25. The summary stated Resident #113 reported he had been beat up by a staff member and a head-to-toe assessment was completed with no signs of abuse. The summary revealed Resident #113 was unable to specify when the alleged incident occurred when asked shortly after it was reported. The summary noted body audits were completed on the hallway for residents with a BIMS (Brief Interview for Mental Status) score of 12 or below with no issues noted. Interviews were completed on the hallway for residents with a BIMS score or higher with no issues noted. The summary concluded that the facility was unable to substantiate abuse as Resident #113 had cognitive impairment and there was no evidence of abuse. The investigation folder did not reveal the staff member who reported the alleged abuse and did not include any witness statements.An interview with the DON on 1/26/26 at 11:02 AM revealed she did not recall the alleged incident involving Resident #113. She stated she sent the initial allegation report to DHSR, and the 5-day investigation was completed although she was not sure if it had been submitted to DHSR. The DON stated sending the 5-day investigation report to DHSR may have been missed and she did not recall receiving an email from the State Agency on 6/17/25 to remind the facility to submit the 5-day investigation report. The DON stated the Administrator typically sent all the reports to DHSR and she would cover if the Administrator was out of the office. She stated gathering as many witness statements as possible for the full investigation was a good idea moving forward to have for any abuse investigation. The DON could not recall which staff member alerted management to Resident #113's allegation.A second interview with the Administrator on 1/16/26 at 4:23 PM revealed she had the expectation that all reports be submitted to DHSR within proper timeframes and the investigation should have been more thorough.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff, Adult Protective Services (APS) Intake Social Worker, Medical Director and Resident Representative interviews, the facility failed to implement an effective discharge planning process for Resident #95 in order to sufficiently prepare the resident for a safe and orderly discharge that ensured his needs were met, home health services were coordinated, a safe discharge location was identified, and necessary medical supplies were provided. This deficient practice was identified for 1 of 3 residents reviewed for discharge (Resident #95).The findings included:The hospital Discharge summary dated [DATE] indicated Resident #95 was admitted to the hospital and treated for a urinary tract infection related to a diagnosis of benign prostatic hyperplasia (enlarged prostate) with urinary obstruction requiring self-catheterization and a history of reusing catheters. Resident #95 was also assisted with finding nursing home placement due to recent eviction from his home. Resident #95 was discharged to the facility on [DATE] with instructions to continue self-catheterization until a surgery that was scheduled for urinary obstruction (blockage that inhibits the flow of urine).Resident #95 was admitted to the facility on [DATE] with diagnoses including benign prostatic hyperplasia with urinary obstruction, homelessness, substance abuse, and cognitive communication deficit. A discharge planning note dated 11/07/25 completed by the Social Worker (SW) indicated Resident #95 was moderately cognitively impaired, unable to make his own decisions and his Resident Representative (RR) would be his decision maker. Resident #95 was recently evicted from his home and was homeless at the time of admission to the facility. During a discussion with the RR today concerning discharge plans it was determined Resident #95 returning to the community was not feasible. The RR requested assistance with completing a Medicaid application and finding long term placement for Resident #95 in a facility closer to where she lived.The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #95 was moderately cognitively impaired, exhibited no behaviors or rejections of care, walked independently, was occasionally incontinent of bladder and required partial to moderate assistance with bathing, and supervision with toileting. He was not coded for a urinary catheter device. The MDS further indicated Resident #95 and a legally authorized representative were participating in discharge planning with active discharge planning noted to already be occurring for the resident to return to the community. The following MDS question was noted to be skipped: Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community? The care plan dated 11/08/25 indicated Resident #95 had problem areas including impaired communication with the potential for poor health literacy and signs and symptoms of acute delirium. The interventions included providing a safe and supportive environment, assisting with reading/comprehending written communications from the physician and pharmacy as needed. The care plan also noted Resident #95's stay at the facility was expected to be short term, discharge planning was ongoing, and updates would be made to the discharge plan as needed. A review of the medical record revealed a Centers for Medicare and Medicaid Services (CMS)-10123 Notice of Medicare Non-Coverage (NOMNC) letter was issued to Resident #95 on 11/26/25 explaining Medicare Part A coverage for skilled services were ending on 11/28/25. The form was signed by the SW and Resident #95. A discharge planning note dated 11/27/25 written by the SW revealed Resident #95 was discharging from the facility to a homeless shelter on 11/28/25. Therapy recommended home health services for safety awareness; however services could not be arranged due to the discharge location. The clinical team deemed the discharge was against medical advice (AMA), AMA paperwork was completed and signed, and a report was made to APS.A Release of Responsibility Unauthorized Discharge form dated (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/28/25 signed by the SW indicated Resident #95 was discharged from the facility AMA and noted on the section for the patient signature was refused to sign. The discharge instructions dated 11/28/25 completed by the SW and Nurse #5 indicated Resident #95 was discharged to a homeless shelter. Therapy recommended home health services for medication and household management; however services were not arranged because the address of the discharge location was unknown. The clinical team deemed the discharge was AMA, AMA paperwork was completed and a report was made to APS. The discharge instructions noted that Resident #95 had no devices/treatments and no education or medical supplies were provided. Resident #95 was provided medications and list of medication orders at the time of discharge. An interview conducted with the Physical Therapist on 1/14/26 at 1:30 PM revealed Resident #95 was admitted to the facility 11/05/25 and was receiving physical therapy for strengthening and to improve balance. The Physical Therapist indicated that on 11/26/25 Resident #95 was functioning independently and appropriate for discharge from the facility however his safety awareness was poor, so he recommended home health services to continue working on safety awareness. A phone interview conducted with the APS Intake Social Worker on 1/14/26 at 11:16 AM revealed there was not a report made by the facility or any record of Resident #95 in the APS system. A phone interview with Resident #95's RR on 1/15/26 at 11:19 AM indicated she operated a non-profit organization and was a patient advocate for individuals that were homeless. The RR revealed she had been working with Resident #95 for approximately 10 years to ensure he had housing, medical care, medications and medical supplies. The RR stated approximately one week before Resident #95 was admitted to the facility he was evicted from his home. She indicated a few days after Resident #95 was admitted to the facility she met with the SW to discuss Resident #95's discharge plans. She indicated the SW was aware Resident #95 was homeless and they agreed discharging Resident #95 back to the community was not feasible. The RR revealed she requested assistance with a Medicaid application and finding a facility closer to her for long term placement. The RR revealed she had no further follow up from the SW regarding the status of Resident #95's Medicaid application or transferring him to a closer facility. The RR indicated on 11/26/25 she received a phone call from the SW notifying her that Resident #95 was being discharged from the facility due to therapy services ending. She revealed the SW did not inform her that the decision could be appealed but did explain if Resident #95 remained in the facility after 11/28/25 he (Resident #95) would be responsible for payment. The RR indicated she made it very clear to the SW on 11/26/25 that Resident #95 did not have housing and all the local shelters were full. She revealed the SW offered no recommendations or assistance with placement and stated Resident #95 was able to remain in the facility but would have to pay five hundred dollars a day starting on 11/29/25. The RR indicated when she arrived at the facility on 11/28/25 at 8:00 AM, a nurse, she did not recall her name, handed her a bag with Resident #95's medications, a list of the medication orders and instructions to schedule a follow up visit with the primary care physician. The RR revealed the nurse did not provide any catheter supplies or further instructions related to Resident #95's care. The RR indicated she was unaware that Resident #95 was asked to sign an AMA form and that Resident #95 did not leave the facility AMA, but rather because the facility initiated discharge due to therapy services ending. The RR stated when they (she and Resident #95) left the facility, she was able to find a friend for Resident #95 to stay with until his surgery on 12/23/25. The RR indicated she went to the urology office to inquire about catheter supplies which they were able to provide and she brought those supplies to Resident #95. She revealed Resident #95 was able manage his personal care independently, but she visited him daily to ensure he had food, catheter supplies and was taking his medications. She revealed Resident #95 had surgery for the urinary blockage on 12/23/25 and was released from the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospital the same day but the local homeless shelters were still full, and she was unable to find him housing. The RR stated since the surgery Resident #95 no longer had to self-catheterize but was living on the streets and remained on the waiting list for shelter placement. An interview was conducted with the SW on 1/14/26 at 5:36 PM. She stated when Resident #95 was admitted to the facility a Brief Interview for Mental Status (BIMS) was completed and indicated Resident #95 was moderately cognitively impaired, so she discussed discharge plans with his RR on 11/07/25. She indicated Resident #95 was homeless and the RR requested assistance with a Medicaid application and wanted to find a facility for long-term placement closer to where she lived. The SW stated she notified the Business Office Manager on 11/07/25 that Resident #95's RR requested assistance with completing a Medicaid application but wanted to wait until the application was approved before sending out referrals to other facilities regarding long term placement. The SW indicated she did not follow up with the Business Office Manager to confirm the Medicaid application was submitted or to check on the status of the application. The SW revealed she attended a clinical team meeting every morning along with therapy staff, the DON and the Administrator. She stated during the clinical team meeting on 11/26/25 she was notified by therapy that Resident #95's services were ending. The SW stated there was a follow up BIMS assessment completed for Resident #95 which indicated he was cognitively intact, but she was unsure who conducted the assessment or the date it was completed. The SW revealed she issued and reviewed the CMS-10123 NOMNC letter with Resident #95 on 11/26/25 and explained the appeal process. The SW revealed Resident #95 acknowledged understanding and stated he would not remain at the facility and would go to a homeless shelter. The SW indicated Resident #95 immediately called his RR while she was still in the room. She stated Resident #95 explained to the RR he was being discharged from the facility due to therapy services ending and she would need to pick him up from the facility on 11/28/25 and take him to a homeless shelter and the RR agreed. The SW indicated Resident #95 named two possible homeless shelters he would be going to but she did not call either of the shelters to see if they had any openings. The SW stated she was not aware Resident #95 was performing urinary self-catheterization, so catheter supplies were not provided. She further stated that the nurse was responsible for reviewing the discharge instructions and medications, so she was unsure if that occurred. The SW indicated because Resident #95 was unsure which homeless shelter he would be going to, she was unable to provide an address to arrange home health services. The SW revealed she informed the clinical team that home health services could not be arranged for Resident #95, and the clinical team determined the discharge was AMA. The SW revealed the AMA form was completed but Resident #95 refused to sign the form. She indicated it was the facility's policy to file an APS report whenever a resident was discharged AMA. The SW stated she informed the former SW Assistant to file a report for Resident #95 with APS and could not say why the report was not filed. The SW indicated she did not follow up with Resident #95 or the RR after the resident was discharged and was unsure of his status after leaving the facility.An interview conducted with the Business Office Manager on 1/16/26 at 12:30 PM revealed she did not recall being notified of a request from Resident #95's RR for assistance with a Medicaid application nor was there any documentation in her records that a Medicaid application was initiated for Resident #95.Several attempts made to contact the former SW Assistant were unsuccessful.A phone interview was conducted with Nurse #5 on 1/28/26 at 10:23 AM. Nurse #5 revealed she did not recall if she was assigned to Resident #95 on 11/28/25. She revealed she did not remember Resident #95 or what assistance he required with care. Nurse #5 also did not recall if she reviewed the discharge instructions with Resident #95 or his RR before they left the facility or if she gave them any medications or medical supplies. An interview was conducted with the Medical Director on 1/15/26 at (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2:30 PM. He stated on 11/28/25 he was informed by the DON that Resident #95 was discharged from the facility AMA but was unaware of any further details related to the discharge. The Medical Director indicated Resident #95's cognition varied and he was not consistently able to make decisions and manage his care independently. The Medical Director revealed Resident #95 was homeless and required self-catheterization due to a urinary blockage and there were concerns related to him reusing catheters. The Medical Director indicated discharging Resident #95 from the facility without housing and catheter supplies was not a safe discharge. During an interview with the Administrator on 1/16/26 at 4:09 PM she stated the SW was notified by therapy when a resident's Medicare Part A benefit was ending and then issued the CMS-10123 NOMNC letter to the resident and/or RR. She indicated the SW was also responsible for arranging any services and ordering the needed medical equipment for the resident prior to discharge. The Administrator revealed she was aware Resident #95 was discharged from the facility AMA but did not recall who notified her or when. The Administrator indicated she was not aware of any other details related to Resident #95's discharge, why it was determined to be AMA or if Resident #95 was agreeable to leaving the facility AMA. She stated discharging a resident with no arranged housing and without needed medical supplies was not a safe discharge.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and record reviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of wounds (Resident #40), and medications. This deficient practice was identified for 2 of 19 sampled residents (Resident #75).The findings included:1. Resident #40 was admitted to the facility on [DATE] with diagnoses including pressure ulcer of the sacral region, stage 4 (full-thickness tissue loss with exposed bone, tendon or muscle).A care plan was initiated 01/18/24 and revised 07/21/25 with a focused area of chronic wound stage 4 to sacrum. The stated goal was sacrum wound would show signs of healing through the review period. Interventions included alternating air mattress, regular assessment of skin, staff to turn and reposition resident regularly, and enhanced barrier precautions for wound care.A review of the Wound Care Provider note dated 12/29/25 revealed Resident #40 had been evaluated and noted Resident #40 had a Stage 4 Pressure Ulcer.Resident #40's physician order dated 01/04/26 was reviewed and revealed a treatment order for a Stage 4 pressure ulcer.A review of Resident #40's January 2026 Treatment Administration Record (TAR) revealed treatment for a stage 4 coccyx (the base of the spinal column) pressure ulcer had been completed daily.A quarterly Minimum Data Set (MDS) dated [DATE] was reviewed and did not indicate Resident #40 had a diagnosis of a pressure ulcer. Resident #40 was not coded for an unhealed pressure ulcer, was not coded for a stage 4 pressure ulcer, or that pressure ulcer care was provided.An interview with the Wound Nurse was conducted on 01/14/26 at 2:26 PM. The Wound Nurse stated that Resident #40 had a stage 4 wound to his coccyx which had been present on admission. He received wound care daily, had not developed any new wounds since admission and was seen by the wound care provider weekly.An interview with the MDS Coordinator was conducted on 01/16/26 at 11:58 AM. She confirmed she had completed Resident #40's 01/05/26 MDS. She indicated Resident #40 had a diagnosis of a Stage 4 pressure ulcer to his sacrum which was being treated daily. The MDS Coordinator explained that the MDS was completed incorrectly and the pressure ulcer was overlooked and should have been coded.An interview with the Corporate MDS Coordinator was conducted on 01/16/26 at 2:52 PM. The Corporate MDS Coordinator stated that all MDS assessments should be coded correctly for relevant diagnoses and health issues.An interview with the Corporate Nurse Liaison was conducted on 01/16/26 at 2:55 PM. The Corporate Nurse Liaison stated that all MDS assessments should be coded correctly for relevant diagnoses.2. Resident #75 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus with hyperglycemia (high blood sugar).A review of Resident #75's physician admission orders dated 12/15/25 revealed an order for Insulin glargine solution (long-acting insulin and hypoglycemic medication used to manage blood glucose levels) 100 units per milliliter. Inject 50 units subcutaneously (under the skin) daily in the evening for diabetes.A review of Resident #75's December 2025 Medication Administration Record (MAR) revealed Resident #75 received insulin injections daily as ordered. A care plan was initiated 12/21/25 with a focused area for diabetes mellitus. The stated goal was Resident #75 would have no complications related to diabetes mellitus through the review period. Interventions included administering medication as ordered, monitoring symptoms of hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar), therapeutic diet as ordered, and labs as ordered.Resident #75's admission Minimum Data Set (MDS) dated [DATE] was reviewed and did not indicate insulin injections or hypoglycemic medications had been received. An interview with the MDS Coordinator was conducted on 01/16/26 at 11:58 AM. The MDS Coordinator confirmed she completed the 12/21/25 MDS for Resident #75. The MDS Coordinator stated Resident #75 received insulin daily and the MDS assessment should have included both insulin injections and the use of hypoglycemic medication. She stated the insulin injections and hypoglycemic medication had been (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	overlooked and the MDS had been coded incorrectly.An interview with the Corporate MDS Coordinator was conducted on 01/16/26 at 2:52 PM. The Corporate MDS Coordinator stated that all MDS assessments should be coded correctly for relevant medications.An interview with the Corporate Nurse Liaison was conducted on 01/16/26 at 2:55 PM. The Corporate Nurse Liaison stated that all MDS assessments should be coded correctly for relevant medications.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, the Operations Manager for the transportation provider, and Medical Director, Nurse Aide (NA) #8 failed to report Resident #114's pain to Nurse #11 prior to transferring the resident to another Skilled Nursing Facility (SNF) and as a result no assessment was completed. The deficient practice occurred for 1 of 3 residents reviewed for quality of care (Resident #14). The findings included: Resident #114 was admitted to the facility on [DATE] with diagnoses including chronic pain, bed confinement, morbid obesity, muscle weakness, abnormalities of gait and mobility. A review of the facility's fall and injury reports from 6/17/2025 through 7/31/2025 revealed no falls documented for Resident #114. A review of the admission Minimum Data Set (MDS) dated [DATE] revealed that Resident #114 was cognitively intact. Resident #114 was coded for bilateral lower extremity range of motion impairment, and a manual wheelchair and walker for mobility. Resident #114 reported no pain in the past 5 days and no falls prior to MDS assessment. A physician order dated 6/25/2025 specified Tramadol 50 milligrams (mg) every 12 hours and hold for sedation.On 1/15/2025 at 3:43 PM an interview with the Physical Therapist was completed. The Physical Therapist stated Resident #114 could not complete the initial Physical Therapy assessment on admission due to pain and fatigue and he could not start working with Resident #114 until 7/18/2025. The Physical Therapist reported only working on bed mobility and stretching with Resident #114 because she could not tolerate getting out of bed due to pain. The Physical Therapist stated Resident #114 began to complain of increased pain in her left hip on 7/23/2025 and he notified the Medical Director. The Physical Therapist reported that the Medical Director asked him to continue to monitor. The Physical Therapist stated he had to discontinue therapy services because Resident #114 had reached her potential and was unable to progress.A review of Resident #114's pain assessments documented on the Treatment Administration Record for the month of July 2025 revealed pain was assessed twice a day- on day shift and night shift. Resident #114's last report of pain was on 7/28/2025 on dayshift rated a 7 out of 10 with 10 being the highest level of pain. The pain level charted for the day of discharge on [DATE] was zero (0) and was documented by Nurse #11. A review of the Medication Administration Record (MAR) for the month of July 2025 revealed Resident #114 last received Tramadol 50 mg on 7/30/25 at 9:58 AM. There was no documentation of pain medication given on 7/31/2025. A phone interview was completed on 1/15/2026 at 10:48 AM with Nurse Aide (NA) #8. NA #8 reported she was assigned to Resident #114 on 7/31/2025 and transferred her to a wheelchair to be transported to another SNF. NA #8 stated she and NA #3 transferred Resident #114 from her bed to a manual wheelchair using a mechanical lift. NA #8 reported while raising Resident #114 in the mechanical lift, Resident #114 yelled out that her left leg was hurting. NA #8 stated she and NA #3 worked quickly to lower Resident #114 in the manual wheelchair to ease her pain. NA #8 reported that Resident #114 stopped complaining of pain once she was in the wheelchair. NA #8 stated she did not inform the nurse or anyone of Resident #114's complaint of pain. NA #8 stated Resident #114 always complained of pain with positioning but never yelled or screamed. NA #8 reported she did not think of getting the nurse, she wanted to expedite the transfer to limit the amount of time Resident #114 was in pain. NA #8 reported that once Resident #114 was in the manual wheelchair, the Transportation Driver pushed Resident #114 out of the room to the transportation van. NA #8 reported that she and NA #3 did not escort Resident #114 and the Transportation Driver to the van. An interview with NA #3 on 1/15/2026 at 10:57 AM revealed that she had just started working with the facility and did not recall assisting NA #8 with transferring Resident #114. A review of progress note dated 7/31/2025 at 4:45 PM written by Nurse #11 revealed that Resident #114 was discharged to another (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SNF with all belongings via transport company. Report was given to SNF that there were no concerns/issues noted at time of discharge. A call was placed to Nurse #11 on 1/15/2026 at 10:47 AM, who was assigned to Resident #114 on 7/31/2025. The number was no longer in service, and Nurse #11 no longer worked for the facility. A review of the incident report dated 8/5/2025 revealed that Resident #114 was discharged from the facility to another Skilled Nursing Facility (SNF) on 7/31/25 and upon arrival to the next SNF Resident #114 complained of pain. The facility became aware on 8/1/2025 that an x-ray revealed a left closed displaced femoral neck fracture (the upper thigh bone broke at the connection with the hip) of the left hip and sent to the hospital. The facility initiated an investigation on 8/1/2025 with chart review, interviews and skin observations. A review of the hospital records revealed that Resident #114 was sent to the emergency room on 8/1/2025 at approximately 3:40 AM with a complaint of left hip pain. The impression of the x-ray of the left hip on 8/1/2025 revealed there was an acute impacted fracture (a type of bone break where the ends of the fractured bone are driven into each other, causing compression without complete separation) through the femoral neck. Mild to moderate degenerative disease was noted.An interview with the Operations Manager for the Transportation Driver was completed on 1/15/2026 at 3:21 PM. The Operations Manager stated the transportation driver that transported Resident #114 to the new SNF was not available and could assist with information regarding Resident #114's transport on 7/31/2025. The Operations Manager stated he recalled the incident because the facility had contacted the transportation company to review the video of the Transportation Driver transferring Resident #114 into the van. The Operations Manager stated the company retains video for 72 hours and completed a report for the facility. The Operations Manager stated the Transportation Driver rolled Resident #114 on a hydraulic lift and locked the wheelchair in place inside the van. The Operations Manager reported Resident #114 was never removed from the wheelchair by the Transportation Driver and there were no observations of Resident #114 experiencing a fall or impact during the video while with the Transportation Driver. The Operations Manager stated the Transportation Driver reported Resident #114 did not complain of pain to the driver.An interview with the Director of Nursing (DON) was completed on 1/20/2026 at 11:00 AM. The DON stated that NA #8 should have paused Resident #114's transfer to the wheelchair when she complained of pain and informed Nurse #11. The DON reported that if NA #8 had informed Nurse #11 of Resident #114's pain, Nurse #11 could have assessed Resident #114 to provide pain medication, contact the provider, and inform the transferring facility of the pain. An interview with the Medical Director on 1/16/2026 at 3:49 PM was completed. The Medical Director stated Resident #114 had chronic pain and it was not uncommon for someone with chronic pain to experience pain after working with physical therapy. The Medical Director stated he did not provide new orders for Resident #114 because Resident #114 had chronic pain and the staff had not reported a fall, impact or significant change in Resident #114.An additional interview with the Medical Director was completed on 1/23/2026 at 10:43 AM. The Medical Director reported based on his impression of the results for the x-ray completed by the hospital on 8/1/2025 Resident #114 could have obtained the left hip fracture prior to admission to this facility or anytime during the transfer to the new SNF and while at the new SNF. A review of the Past Noncompliance (PNC) document revealed the plan was not acceptable for PNC and did not meet the requirements for PNC.

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F 0689 Level of Harm - 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 observations, record review, and resident, staff and Nurse Practitioner interviews, the facility failed to provide a safe transfer for a dependent resident that required the use of a mechanical lift. After the fall, Resident #56 was complaining of unbearable left hip pain and was transferred to the emergency department (ED) by emergency medical services (EMS) for further evaluation. A computed tomography (CT) scan obtained in the ED revealed Resident #56 had a nondisplaced greater trochanteric fracture of the left femur (the hard boney protrusion on the upper outer side of the thigh bone). An orthopedic evaluation completed in the ED determined non-operative management of the fracture was appropriate due to Resident #56's non-weightbearing status prior to the injury. Resident #56 was discharged back to the facility with orders for oxycodone/acetaminophen 5-325 milligrams (mg) one tablet administered every 12 hours for pain. This deficient practice was identified for 1 of 5 residents reviewed for accidents (Resident #56).The findings included: 1. Resident #56 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke) with left hemiplegia (paralysis) and hemiparesis (weakness). The quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #56 was cognitively intact, had impairment to the upper and lower extremities on one side and was dependent on staff for transfers. The care plan dated 1/06/26 indicated Resident #56 required assistance with activities of daily living related to chronic health issues, utilized a manual wheelchair for mobility, and required 2-person assistance with the use of a mechanical lift for all transfers. A review of the medical record revealed Resident #56 was not taking anticoagulant medication. The incident report dated 1/12/26 at 8:00 PM completed by Nurse #1 indicated Resident #56 was sitting in the wheelchair transferring with the assistance of the Nurse Aide and he fell to the floor hitting his head. Resident #56 was complaining of left hip pain and assessed for injury. Resident #56 was observed to have an abrasion to his lower left leg, but no other injury was noted, and his vital signs were within normal limits. Resident #56 was transferred from the floor into bed with staff assistance and pain medication was administered but ineffective. The on-call provider was notified and Resident #56 was transferred to the ED for further evaluation. A phone interview with Nurse #1 on 1/21/26 at 3:12 PM indicated she was assigned to Resident #56 on 1/12/26 from 7:00 PM to 7:00 AM. Nurse #1 revealed at approximately 8:00 PM she was down the hall administering medications and heard Resident #56 yelling for help and responded to his room. She indicated NA #1 was in Resident #56's room and Resident #56 was sitting on the floor in front of the wheelchair. She revealed NA #1 reported to her that Resident #56 slid out of the wheelchair onto the floor. Nurse #1 indicated the lift pad was still in the wheelchair and soaked with urine. She stated Resident #56 was complaining of left hip pain and had an abrasion to his left lower leg. Nurse #1 revealed she assessed Resident #56 and he had no other visible injuries. Nurse #1 revealed she was unsure if it was safe to use the mechanical lift to transfer Resident #56 from the floor to the bed, so she, NA #1 and two other staff members, she did not recall their names, lifted Resident #56 off the floor and into bed. Nurse #1 indicated Resident #56 was administered pain medication but reported the hip pain was unbearable. She stated she notified the on-call provider and orders were received to transfer Resident #56 to the ED for further evaluation. Nurse #1 revealed Resident #56 did not report to her the fall occurred during a transfer with the mechanical lift and that he was unable to recall any details related to the fall. A statement written by NA #1 dated 1/13/26 revealed Resident #56 was sitting in his wheelchair with a lift pad underneath him and his pants and the lift pad were soaked in urine. NA #1 was repositioning the lift pad under Resident #56 when he slid out of the wheelchair with the lift pad and onto (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the floor. A phone interview was conducted with NA #1 on 1/15/2026 at 5:02 PM. She stated she was assigned to Resident #56 on 1/12/26 from 7:00 AM to 3:00 PM and again from 3:00 PM to 11:00 PM due to a call out. NA #1 indicated at approximately 8:00 PM Resident #56 requested assistance with incontinent care and was ready to get into bed. She stated Resident #56 was sitting in his wheelchair with a lift pad underneath him and his pants and the lift pad were soaked in urine. She stated the lift pad needed to be repositioned because it was pulled up under his bottom. NA #1 revealed she was standing beside the wheelchair repositioning the lift pad when Resident #56 and the lift pad slid out of the wheelchair down to the floor. NA #1 indicated Resident #56 started yelling and Nurse #1 responded to his room. She indicated Resident #56 was complaining of terrible pain to his left hip. NA #1 stated she assisted Nurse #1 along with two other staff members, she did not recall their names, to lift Resident #56 off the floor and into bed. NA #1 stated Resident #56 was transferred to the ED for further evaluation and was diagnosed with a left hip fracture. She indicated when she was transferring a resident with the mechanical lift, she positioned the lift pad under the resident and hooked it to the lift before she got a second person to assist with the transfer. NA #1 revealed she was unsure why Resident #56 was reporting the lift sling broke while she was transferring him with the mechanical lift. She stated the lift pad was not hooked to the mechanical lift yet and the lift was sitting in the doorway to his room and the lift pad was not hooked to the lift. NA #1 indicated she did not recall if the lift pad that Resident #56 was sitting on at the time of the incident was labeled with his name and she was not aware Resident #56 had his own lift pad. The EMS prehospital care report dated 1/12/26 revealed EMS responded to the facility for a resident that sustained an injury during a witnessed fall from the mechanical lift. Facility staff reported to EMS that one staff member was using the mechanical lift to transfer Resident #56 from the wheelchair to the bed when a strap on the lift pad broke and he fell approximately two feet to the floor and was complaining of left hip pain. Resident #56 was alert and awake and confirmed he had fallen from the mechanical lift. Resident #56 reported hitting his head on the mechanical lift and hitting his left leg on the side of the bed before landing on the floor. Resident #56 was observed to have abrasions to the left knee and shin and was complaining of left hip pain. Resident #56's vital signs were within normal limits, and he was transferred by ambulance to the ED for further evaluation, The ED records dated 1/12/26 revealed Resident #56 presented to the ED for evaluation due to left hip pain after a fall. Resident #56 was being transferred with a mechanical lift at the nursing facility when one of the straps on the lift pad broke and he fell approximately two feet to the floor landing on his left side. A computed tomography (CT) scan obtained in the ED revealed Resident #56 had a left nondisplaced fracture of the greater trochanteric femur (the hard boney bump on the top outer side of the thigh bone) and noted osteopenia (weakening of the bones). The orthopedic evaluation noted due to Resident #56's non-weightbearing status prior to the injury, the fracture would be managed non-operatively and he was safe for discharge. Resident #56 was discharged back to the facility with orders for oxycodone/acetaminophen 5-325 mg one tablet administered twice a day and to schedule a follow-up appointment at the trauma clinic in 2-3 weeks. A review of Resident #56's physician orders and medication administration record (MAR) revealed the following: 3/12/25 oxycodone-acetaminophen 5-325 mg one tablet administered every 12 hours as needed for pain. The MAR indicated it was administered on 1/12/26 at 8:05 PM. 1/13/26 oxycodone-acetaminophen 5-325 mg one tablet administered every 24 hours as needed for pain. The MAR indicated it was administered on 1/13/26 at 4:52 PM. 1/13/26 oxycodone-acetaminophen 5-325 mg one tablet administered two times a day (9:00 AM and 9:00 PM) for pain. The MAR indicated it was administered on 1/13/25 at 9:00 PM, 1/14/26 at 9:00 AM and 9:00 PM, 1/15/26 at 9:00 AM and 9:00 PM, and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1/16/26 at 9:00 AM. An interview was conducted with Resident #56 on 1/15/26 at 2:25 PM. Resident #56 stated on 1/12/26 after dinner, he called for assistance with incontinence care and NA #1 responded to his room. He revealed NA #1 was lifting him out of the wheelchair with the mechanical lift when he heard fabric ripping and the left front strap on the lift pad broke. Resident #56 stated he fell approximately 2 feet to the floor, hitting his head on the lift mast and his left leg on the side of the bed before landing on the floor on his left side. He indicated he was having severe left hip and tailbone pain. Resident #56 revealed a lot of staff members responded to his room and they picked him up off the floor and put him into bed. He stated the nurse administered pain medication, but it was not helping and he went by ambulance to the ED for further evaluation. Resident #56 revealed x-rays and a CT scan were obtained in the ED and he was diagnosed with a left hip fracture. Resident #56 indicated he was experiencing pain at times but was receiving scheduled pain medication twice a day and overall, his pain was managed. Resident #56 stated the lift pad that broke was labeled with his name in black marker and he had not seen it since the incident. An interview conducted with NA #6 on 1/16/26 at 10:30 AM revealed she assisted with Resident #56's shower today. NA #6 indicated Resident #56 had his own lift pad and it was labeled with his name, but she was unable to find it in his room or in the laundry room. NA #6 revealed the laundry aides told her they had not seen Resident #56's lift pad in the laundry room this week. An interview was conducted with Laundry Aide #1 on 1/16/26 at 12:15 PM. She revealed clean lift pads were stored in the laundry room and available to nursing staff as needed. She stated the lift pads were shared for all the residents, however Resident #56 had his own lift pad and it was labeled with his name in black marker. Laundry Aide #1 revealed she had not seen Resident #56's lift pad in the laundry room this week. A phone interview was conducted with the Nurse Practitioner on 1/21/26 at 1:00 PM. She stated Resident #56 was transferred to the ED on 1/12/26 due to a fall from the wheelchair and was diagnosed with a left hip fracture. The NP indicated she was not aware of any reports from staff or Resident #56 that the fall occurred during a transfer with the mechanical lift. She stated Resident #56 was at his baseline and his pain was managed well. A phone interview conducted with the Director of Nursing (DON) on 1/22/26 at 3:15 PM revealed she was on vacation when the incident occurred with Resident #56. The DON revealed the Administrator informed her of the incident when she returned to work on 1/19/25. The DON indicated NA #1 should not have attempted to reposition the lift sling under Resident #56 without the assistance of a second person to ensure the resident was safe. The DON stated she was not aware that Resident #56 or any staff reported that Resident #56's fall was due to a strap on the lift pad breaking while he was being transferred with the mechanical lift. A phone interview was conducted with the Administrator on 1/22/26 at 1:58 PM. She stated Nurse #1 notified her on 1/12/26 that Resident #56 fell from the wheelchair to the floor and was transferred to the ED for further evaluation. The Administrator revealed she investigated the incident and interviewed NA #1 and determined NA #1 was attempting to reposition Resident #56's lift pad, it was soaked in urine and Resident #56 slid out of the wheelchair with the lift pad down to the floor. The Administrator stated she was not aware of any reports from staff or Resident #56 that he fell from the mechanical lift due to a strap on the lift pad breaking and based on her investigation Resident #56 slid out of the wheelchair landing on the floor. The Administrator stated she could not speak to whether NA #1 should have requested the assistance of a second staff member when repositioning Resident #56's lift pad.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff, Resident Representative and Medical Director interviews, the facility failed to follow hospital discharge orders for a resident to perform urinary self-catheterization (Resident #95) and failed to keep a urinary catheter drainage bag from touching the floor to reduce the risk of infection (Resident #9) for 2 of 3 residents reviewed for urinary catheters. The findings included: 1. The hospital Discharge summary dated [DATE] indicated Resident #95 had a urinary obstruction which required self-catheterization. Resident #95 was discharged from the hospital to the facility on [DATE] and the hospital discharge orders indicated Resident #95 was to continue self-catheterization. There were no further details regarding self-catheterization in the discharge summary. Resident #95 was admitted to the facility on [DATE] with diagnoses including benign prostatic hyperplasia (enlarged prostate) with urinary obstruction. A nurse's note dated 11/05/25 written by Nurse #6 indicated Resident #95 was admitted to the facility from the hospital and required self-catheterization due to urinary obstruction. During a phone interview with Nurse #6 on 1/15/26 at 11:13 AM she stated she was assigned to Resident #95 on 11/05/25. Nurse #6 indicated when a resident was admitted to the facility the admission nurse or a nurse manager was responsible for reviewing the hospital discharge summary and entering the orders in the electronic medical record (EMR). She stated Resident #95 was admitted to the facility from the hospital and received report from the hospital nurse before he arrived and was informed he was performing self-catheterization due to a urinary blockage. Nurse #6 revealed she immediately notified the Director of Nursing (DON) that Resident #95 was self-catheterizing and needed physician orders and catheter supplies and the DON responded that she would handle it. Nurse #6 stated she only worked at the facility as needed and was unsure what occurred after she notified the DON or if Resident #95 was provided with catheter supplies. A review of the physician orders revealed no orders for Resident #95 to perform self-catheterization. A physician's note dated 11/06/25 written by the Medical Director indicated Resident #95 had a diagnosis of benign prostatic hyperplasia (BPH) with urinary obstruction which required self-catheterization. Resident #95 received education on proper catheter hygiene to prevent infection and would continue to perform self-catheterization as needed. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #95 was moderately cognitively impaired, occasionally incontinent of urine and independent with toileting hygiene. The MDS was not coded for intermittent catheterization. The care plan dated 11/08/25 indicated Resident #95 required assistance with activities of daily living due to chronic health conditions and recent hospitalization but was usually continent of bladder and independent with toileting. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note dated 11/14/25 written by Nurse #7 revealed Resident #95 became increasingly belligerent and repeatedly requested to self-catheterize due to pain with urination. Resident #95 reported he was self-catheterizing prior to admission and insisted it needed to be done. Nurse #7 observed Resident #95 urinating into the toilet and provided education that self-catheterization was not required because he was able to urinate. Nurse #7 notified the Medical Director that Resident #95 was complaining of pain when urinating and orders were given to obtain a urinalysis. A phone interview conducted with Nurse #7 on 1/15/26 at 11:19 AM indicated she was assigned to Resident #95 on 11/14/25 from 7:00 AM to 7:00 PM. She stated Resident #95 was complaining of pain and insisting that he needed to self-catheterize. Nurse #7 indicated she observed Resident #95 urinating in the toilet without difficulty and explained to him self-catheterization was not indicated. She stated she notified the Medical Director and was given an order to obtain a urinalysis. Nurse #7 revealed she was not aware that Resident #95 required self-catheterization and there were no physician orders or supplies in his room indicating to her otherwise. A review of Resident #95's medical record revealed laboratory results for a urinalysis obtained on 11/14/25 were received on 11/16/25 and the results were negative. Resident #95 was discharged from the facility to an unknown location on 11/28/25. A phone interview conducted with the Resident Representative (RR) on 1/15/26 at 11:19 AM revealed Resident #95 had been self-catheterizing for approximately two years due to a urinary blockage that required surgery. She stated Resident #95 had a history of homelessness and was discharged to the facility after being hospitalized for a urinary tract infection due to reusing catheters. The RR revealed Resident #95 reported to her about a week after he was admitted to the facility that they were not providing catheter supplies. The RR indicated she went to Resident #95's urologist's office and was able to obtain approximately 15 catheters which she brought to Resident #95. She stated Resident #95 was discharged from the facility on 11/28/25 and no catheter supplies were provided when he was discharged . During an interview conducted with the Medical Director on 1/15/26 at 2:30 PM he indicated Resident #95 had a diagnosis of BPH with urinary obstruction and was performing self-catheterization upon admission to the facility. The Medical Director stated he was unable to recall if he signed orders in the electronic medical record (EMR) for Resident #95 related to self-catheterization but was not aware of any concerns related to nursing staff not knowing Resident #95 was self-catheterizing or that catheter supplies were not being provided. The Medical Director revealed he did not recall the date or the name of the nurse, but he was notified that Resident #95 was complaining of painful urination and he ordered a urinalysis however he did not recall the nurse questioning whether Resident #95 was supposed to be self-catheterizing. A phone interview with the DON on 1/20/26 at 3:20 PM revealed when a resident was admitted to the facility from the hospital the admission nurse reviewed the hospital discharge summary and entered the medication and treatment orders in the electronic medical record (EMR) for the Medical Director to approve and sign. The DON stated when a resident was admitted with orders to perform self-catheterization, orders were entered in the EMR for the Medical Director to review and sign, the resident was assessed to ensure they were able to self-catheterize safely using proper technique, and the resident was provided with catheter supplies. The DON revealed when Resident #95 was admitted to the facility on [DATE] the admission nurse position was vacant, and the nurse assigned to the resident when they were admitted was responsible for reviewing the hospital orders and entering them in the EMR. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON indicated she was unsure why the orders for Resident #95 to self-catheterize were overlooked, and she did not recall Nurse #6 informing her that he was self-catheterizing and needed supplies. 2. Resident #9 was admitted to the facility on [DATE] with a diagnosis of unspecified neuromuscular dysfunction of the bladder and urinary tract infection. A review of Resident #9's care plan dated 06/26/24 revealed a focused area of urinary catheter. The stated goals were Resident #9 would remain free from complications related to an indwelling catheter. Interventions included providing catheter care every shift, empty drainage bag as needed, monitor for signs of urinary tract infection, and enhanced barrier precautions. Resident #9 had a physician's order dated 03/31/25 for an indwelling urinary catheter 16 French 10 milliliter balloon for neuromuscular dysfunction of the bladder. A significant change Minimum Data Set (MDS) assessment completed 12/23/25 revealed Resident #9 was severely cognitively impaired and had an indwelling urinary catheter. An observation of Resident #9 occurred on 01/12/26 at 11:38 AM. Resident #9 was resting in bed and had an indwelling urinary catheter connected to a bedside drainage bag. The bedside drainage bag was observed positioned below the bladder level, attached to bed frame, and the bottom of the bedside drainage bag was observed touching the floor. An observation of Resident #9 occurred on 01/13/26 at 9:53 AM. Resident #9's was resting in bed and had an indwelling urinary catheter connected to a bedside drainage bag. The bedside drainage bag was observed positioned below the bladder level, attached to bed frame, and the bottom of the bedside drainage bag was observed touching the floor. An interview with Nurse Aide (NA) #1 occurred on 01/13/26 at 2:16 PM. NA #1 stated she was assigned to Resident #9 first shift (7:00 AM to 7:00 PM) on 01/12/26 and 01/13/26. NA #1 indicated Resident #9 was provided with catheter care during her shift, but she did not notice Resident #9's urinary catheter bag was in contact with the floor during her rounds. NA #1 stated she was aware the urinary catheters are not supposed to be in contact with the floor to prevent infection. An interview with Nurse #1 on 01/16/26 at 10:18 AM. Nurse #1 stated she was the assigned nurse for Resident #9 on 01/12/26 and 01/13/26 from 7:00 AM to 7:00 PM. Nurse #1 reported that Resident #9's catheter was leaking so it was changed on 01/13/26. Nurse #1 verbalized she did not observe Resident #9's catheter bag touching the floor during her shift to prevent infection. An observation of Resident #9 occurred on 01/14/26 at 2:13 PM. Resident #9's was resting in bed and had an indwelling urinary catheter connected to a bedside drainage bag. The bedside drainage bag was observed positioned below the bladder level, attached to bed frame, and the bottom of the bedside drainage bag was observed touching the floor. An interview with NA #2 occurred on 01/14/26 at 2:37 PM. NA #2 stated she was assigned to Resident #9 on 01/14/26 from 7:00 AM to 7:00 PM. NA #2 indicated Resident #9 was provided with catheter care during her shift, but she did not notice Resident #9's urinary catheter bag was in contact with the floor during her rounds. NA #2 stated she was aware the urinary catheters were not supposed to be in contact with the floor to prevent infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Nurse #2 was conducted on 01/14/26 at 3:18 PM. Nurse #2 stated she was the assigned nurse for Resident #9 on 01/14/26 from 7:00 AM to 7:00 PM. Nurse #2 verbalized she did not observe Resident #9's catheter bag touching the floor during her shift. An interview was conducted with the Infection Preventionist/Staff Development Coordinator (IP/SDC) on 01/16/26 at 12:14 PM. The IP/SDC stated urinary catheter drainage bags, and the drainage valve should be kept off the floor because of germs to prevent contamination of the bag which could cause a urinary tract infection. The IP/SDC shared that urinary catheter bags should be hung on the side of the bed below the level of the bladder when a resident was in bed and the drainage valve should be secured. She stated that staff were provided with this training during the new hire process and during the facility's annual competency training. The Director of Nursing (DON) was unavailable for interview due to scheduled time off. An interview was conducted with the Corporate Nurse Consultant on 01/16/26 at 2:52 PM. The Corporate Nurse Consultant stated that urinary catheter drainage bags should not be on the floor for infection control reasons. She stated the urinary drainage bag should be hung on the bed frame and positioned below the level of the bladder but should not be touching the floor.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review, and staff interviews, the facility failed to label and date leftover food items stored for use, keep a food preparation area clean and orderly, store a scoop without the potential for cross-contamination, discard dented canned goods stored for use and maintain a pipe of a steamer appliance and floor tiles in good repair. These practices occurred in 2 of 3 reach-in coolers, 1 of 1 dry goods storage area, and 1 of 1 food preparation areas.The findings included:1. An initial tour of the main kitchen occurred 1/12/26 at 10:00 AM. The presence of the Dietary Manager (DM) was requested, but no kitchen staff were available for the initial tour. The following concerns were identified:a. Visible dirt and grime build up present on a knife holder on the wall next to the handwash sink. Seven knives were in the holder.b. Visible black buildup and food particles were present on the cooking range. A large white stain was observed on the left side of the gas stove approximately two feet in width. The white stain continued onto the floor next to the gas stove.c. Visible black buildup was on the oven door seals and window areas.d. Broken and missing floor tiles were observed under the right side of the oven and on the left side of the floor drain under the steamer appliance. The areas of missing tiles were approximately 4-6 inches (in.) wide and filled with standing water.e. A foam drinking cup was utilized as a scoop and was left in the cornmeal bin touching the cornmeal in the food preparation area.f. Items in the reach-in coolers that were open and not labeled with a use by date included:-Three 13-ounce (oz.) cans of whipped cream dated 12/24 -A resealable bag of provolone cheese slices dated 1/5 g. Item in the reach in cooler that was open, dated and past the use by date included: -One half full plastic preparation container of olives dated 12/22 with use by date of 12/25 h. Items in the dry storage area that were open, resealed and not labeled with a use by date included:-One 5-pound (lb.) bag of dry yellow cake mix dated 12/15 - One bag of crisped rice cereal dated 12/15 i. Items in the dry storage area that were open, resealed and not labeled with an open or use by date included:-One 5lb. container of cocoa powder -One 1lb. bag of strawberry gelatin An additional observation and kitchen tour occurred on 1/12/26 at 1:15 AM with the Dietary Manager Administrator, Dietician, and Senior Director of Operations for Food Service. All areas of concern from the initial kitchen tour were observed and addressed.A third kitchen tour with the Dietary Manager occurred on 1/15/26 at 11:02 AM. Two, 6lb. 9oz cans of sliced beets were observed with dents measuring approximately 2 inches in length along the rims. The cans were located on the rotation rack for use.An interview with the Dietary Manager on 1/16/26 at 2:47 PM revealed she had been in the Dietary Manager role for around four months. She stated she had been working with kitchen staff on the correct processes and procedures in the kitchen for labeling and storing food. The Dietary Manager stated the kitchen staff were not completing the labeling procedure with use by dates, which for perishable foods was anywhere from three to seven days past the open date. She stated the main cook in the kitchen typically oversaw the cleaning tasks in the kitchen, but she had been out on medical leave. The DM stated other staff members had been filling in on the cleaning duties and cleaning had fallen behind schedule.An interview with the Administrator on 1/16/26 at 4:18 PM revealed she had the expectation that the kitchen staff and managers would follow policies and procedures.2. An observation made on 1/12/26 at 10:15 AM revealed a large puddle of water under the food steamer next to the gas stove adjacent to the food preparation area. Water was observed dripping out a plastic pipe on the back of the appliance. The pipe was not located over the floor drain, and a large puddle of water was observed on the kitchen floor. A second observation was made during a kitchen tour with the Dietary Manager, Administrator, Dietician, and Regional Operations Director for Food Services on 1/12/26 at 1:15 PM. Water was (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed pouring out of a plastic pipe on the back of the steamer appliance as the steamer was in use. The pipe was not located over the floor drain, and a large puddle of water was observed on the kitchen floor. An interview with Dietary Manager on 1/12/26 at 1:16 PM revealed she had verbally reported the leaking appliance to the Maintenance Department multiple times.A review of the facility's electronic maintenance request system, which kept track of work orders, since 2/6/25 was conducted and there were no requests for the kitchen area.An interview with the Maintenance Director on 1/16/26 at 2:25 PM revealed he was not aware of the leaking pipe from the steamer. He stated the facility used an online maintenance tracking system and no one had entered any work orders. The Maintenance Director indicated no one from the kitchen staff informed him of the steamer leaking water onto the floor.An interview with the Administrator on 1/16/26 at 4:18 PM revealed she was not aware of the leaking pipe under the steamer appliance, and she had the expectation that the kitchen staff and managers would alert the Maintenance staff of any repair concerns.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on record reviews, observations and staff interviews, the facility failed to follow their infection control policies and procedures for Enhanced Barrier Precautions (EBP) when Nurse #4 did not wear Personal Protective Equipment (PPE) while providing gastric tube care for Resident #89. In addition, Nurse Aide (NA) #5 failed to wear PPE while providing tracheostomy (trach) care for Resident #5. This deficiency occurred for 2 of 10 staff members observed for infection control practices (Nurse #4 and NA #5).The findings included:A review of the facility's policy titled Enhanced Barrier Precautions, revised on 3/26/2024, indicated: Enhanced Barrier Precautions (EBP) referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) by using gowns and gloves during high-contact resident care activities. High-contact activities included dressing, bathing, transferring, providing hygiene, changing linens or briefs, assisting with toileting, device care or use (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, Peripherally Inserted Central Catheter (PICC) lines, midline catheters, and wound care if deemed chronic by a medical provider or if MDRO was present. a. An observation of feeding tube care for Resident #89 provided by Nurse #4 was made on 1/14/2026 at 11:00 AM. Resident #89's room had an enhanced barrier precautions sign posted outside the door with personal protective equipment (PPE) stored in a white plastic bin outside the door. Nurse #4 entered the room without wearing a gown. She washed her hands and put gloves on. She then stopped the feeding pump and used a syringe to flush the feeding tube. At 11:20 AM Nurse #4 reconnected Resident #89's feeding tube to the feeding pump. She then discarded any unused supplies and her gloves and proceeded to wash her hands with soap and water at the sink.An interview with Nurse #4 on 1/14/2026 at 11:23 AM revealed she was aware that Resident #89 was on enhanced barrier precautions. Nurse #4 stated that she only needed to wear a gown for residents that were on contact precautions.b. An observation of NA #5 providing trach care for Resident #5 was completed on 1/15/2026 at 1:28 PM. Resident #5's room had an enhanced barrier precautions sign posted outside the door stated staff should wear gown and gloves for personal protective equipment (PPE). PPE was stored in a white plastic bin outside the door. NA #5 was observed cleaning around Resident #5's trach with gloves and gauze. NA #5 did not wear a gown.An interview with NA #5 at 1:30 PM on 1/15/2026 was completed when NA #5 was exiting Resident #5's room. NA #5 stated she knew she should have had a gown on while providing trach care but did not plan to be in the room long.An interview with the Infection Preventionist was completed on 1/16/26 at 10:47 AM. The Infection Preventionist stated she completed rounds daily to ensure that all residents had the appropriate infection precaution signs posted and staff had available PPE. The Infection Preventionist reported that all staff were trained during orientation on proper use of PPE and proper PPE use was reviewed in monthly staff meetings on all shifts by the Infection preventionist and shift supervisors. The Infection Preventionist stated that the staff should wear the appropriate PPE according to the infection precaution signs posted for each resident.An interview with the Director of Nursing (DON) was completed on 1/20/2026 at 11:00 AM. The DON stated she expected all staff members to use the appropriate PPE according to the infection precaution sign posted for each resident.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, record review, and staff and Pest Control Technician interviews, the facility failed to maintain a pest free environment in 1 of 1 kitchen and 1 of 2 nourishment rooms observed for maintaining an effective pest control program.The findings included: A review of the facility's electronic maintenance request system since 2/6/25 was conducted. There were no work orders for broken or missing tiles or pest control treatment requests documented for the kitchen area or nourishment rooms.A review of the monthly pest control service report dated 3/7/25 and signed by the Maintenance Director read in part: kitchen area floor drains in need of cleaning. The floor drains in both kitchen and in the preparation area needed to be cleaned and replaced. Please clean around drain frequently to help prevent pest breeding sites. A review of the monthly pest control service report dated 4/8/25 and signed by the Maintenance Director read, in part: kitchen area floor tiles and baseboards were loose or missing. Floor tiles near dishwasher needed to be repaired to eliminate potential pest harborage and breeding site. Floor drains in kitchen needed cleaning. Please clean around drain frequently to help prevent pest breeding sites.A review of the monthly pest control service report dated 5/12/25 read, in part: kitchen area interior-excess water noted. This area needed to be dried, cleaned, and regrouted. Floor drains in need of cleaning. Please clean in and around drains frequently to help prevent pest breeding sites.A review of the monthly pest control service report dated 6/2/25 read, in part: kitchen area-floor tiles and baseboards were loose/missing. Floor tiles needed resealing and replacement. Please repair to eliminate potential pest control harborage and breeding sites. Floor drains needed cleaning. Kitchen had drainage issue, please fix. Please clean in and around drains frequently to help prevent pest breeding sites.A review of an additional pest control service report dated 7/1/25 and signed off by the Maintenance Director read, in part: kitchen in need of a complete overhaul once again documented today. When returning for regular service we will see if the kitchen is getting repaired on 7/2/25 as reported. Floor tiles or baseboard in kitchen loose or missing. Kitchen can never be pest free as long as the major issues exist. Please repair to eliminate potential pest harborage and breeding site.A review of the monthly pest control service report dated 7/7/25 and signed off by the Maintenance Director read, in part: kitchen area- floor tiles or baseboards were loose or missing. Although work has begun, the floor isn't to be completely repaired in kitchen. Please repair to eliminate potential harborage and breeding site. A review of the monthly pest control service report dated 8/5/25 read, in part: Maintenance Director not on site at time of service-checked kitchen and treated kitchen, found excess water beneath dishwasher.A review of the monthly pest control service report dated 9/10/25 read, in part: treated in kitchen to help prevent cockroaches, they were present due to standing water in kitchen. Excess water noted in kitchen. Pool of water in kitchen has been a constant for a year or more and needs to be repaired otherwise cockroaches will continue to have a breeding site. Keep areas dry and please repair. Floor drains in need of cleaning. Please clean floor drains as they could be a breeding site for small flies. Please clean in and around drains frequently to help prevent pest breeding sites.A review of the monthly pest control service report dated 11/13/25 and signed off by the Maintenance Director read, in part: customer reports seeing pests in kitchen due to quality of cleanliness in kitchen. Once again documented today sanitation in kitchen has not changed in over a year until kitchen is clean. They will continue to have issues.a. An observation of the main kitchen on 1/12/26 at 10:00 AM revealed three small, black flies flying near the handwashing sink next to the cooking area and standing water in missing tile areas to the left of the floor drain under the steamer. The presence of the Dietary Manager was requested, but no kitchen staff were available for the initial tourA second observation during a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlotte Health & Rehabilitation Center	1735 Toddville Road Charlotte, NC 28214

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tour with the Dietary Manager, Administrator, Dietician, and Regional Operations Director for Food Services of the main kitchen on 1/12/26 at 1:15 PM revealed a large trash can with food debris positioned next to the handwashing sink near the food service area. When a staff member threw food trash into the trash can, a large amount (estimated 20-30) small, back flies flew out of the trash can into the air near the food preparation area and handwashing sink. The surveyor alerted the touring group to the small, black flies near the food service area. The Administrator stated the facility would address the concerns.b. An observation of the 100 Hall Nourishment Room on 1/15/26 at 11:30 AM revealed three small, black flies flying around the room. The observation included standing water under the ice cooler near the door and approximately three floor tiles that had come loose from the floor under the ice cooler. Further observation of the 100- Hall Nourishment Room revealed approximately two to three floor tiles under the ice chest that had detached from the floor. There was standing water observed on the tiles and under the loose tiles to the left of and under the ice chest. An interview with the Pest Control Technician on 1/15/26 at 10:45 AM revealed the company he worked for was contracted to provide services at the facility monthly and when there were callbacks for pest sightings in between those visits. He stated the kitchen had multiple areas where the floor tiles were broken or missing and needed to be fixed which he had reported to the Maintenance Director each time he serviced the building as noted in his comments on the monthly reports. The Pest Control Technician stated he had documented the broken and missing floor tiles in the kitchen for a year and a half in his visit reports. He stated the broken tile areas and the missing grout between the tiles were causing water to pool, and therefore attracting pests such as roaches, maggots, and small black flies. The Pest Control Technician stated the broken floor tiles under the steamer appliance and under the oven were a few of the many areas with pooling water. He stated the facility's pest control coverage did not include fly treatment; however, he performed the additional fly treatment on 1/12/26 and earlier in the morning on 1/15/26 at the request of management. The Pest Control Technician stated he had encouraged the Maintenance Director over the past few months to add fly treatment to their standard pest control agreement, but the facility did not agree to it until 1/12/26. He stated his company had infrared pest traps, but the facility had not contracted with them for these products. An interview with the Senior Director of Operations for Food Service on 1/15/26 at 11:08 AM revealed a small fly treatment was completed by the pest control company on 1/13/26 and 1/15/26. She stated she hoped there was a plan for the broken tiles on the floor in the kitchen because of the standing water in those areas. The Senior Director of Operations for Food Service stated she was unaware of a plan to repair the floor tiles, but she stated a request to the facility's regional maintenance office had been made on 1/12/26.A tour and observation of the kitchen and the 100-hall nourishment room occurred on 1/16/26 at 2:05 PM with the Dietary Manager, Maintenance Director, Regional Nurse Consultant, and Administrator in attendance. Small black flies were still visible in the kitchen and in the 100-hall nourishment room. Standing water was visible under the floor tiles under the ice chest in the 100-hall nourishment room and in the broken and missing tile areas in the kitchen under the steamer appliance. The Maintenance Director, who had been employed at the facility for a couple of years, stated the Pest Control Technician gave him a chemical to treat the drains in the kitchen for small flies on 1/12/26. He stated he was not aware of the broken and missing floor tiles in the kitchen. The Maintenance Director stated he was not aware of the loose floor tiles in the 100-hall nourishment room and stated the standing water was from ice dropped onto the floor from the ice chest. He stated the kitchen staff had not logged a maintenance request into their electronic work order system. The Maintenance Director also stated he had not received any verbal requests for floor tile repair in (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	either the kitchen or the 100-hall nourishment rooms.An interview with the Dietary Manager on 1/16/26 at 2:47 PM revealed she had been in her position since September 2025 and since then she has worked to get the kitchen back on track as there had been no accountability for kitchen staff or processes. She stated she was not aware of the online maintenance request system used by the facility until very recently and had not logged any entries for the kitchen to include general maintenance concerns or pest concerns. The Dietary Manager stated she had sent many text messages to the Maintenance Director about the broken floor tiles and small flies in the kitchen since arriving at the facility and he was aware of the concerns. She stated the Pest Control Technician had started a treatment for small flies in the kitchen on 1/12/26.An interview on 1/16/26 at 4:18 PM with the Administrator revealed she had the expectation that the Maintenance and Kitchen staff would follow their policies to eliminate pests. She stated she expected all staff to put in maintenance requests for anything broken in the facility, such as floor tiles.