STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365351	A. Building B. Wing	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Galion Meadows Skilled Nursing and Rehabilitation	935 Rosewood Dr Galion, OH 44833

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to ensure a sanitary kitchen environment, failed to ensure proper food storage and labeling, failed to ensure adequate hand hygiene during meal service, and failed to maintain clean equipment in the food preparation and service areas. This had the potential to affect all residents in the facility. The facility census was 55.Findings include: Observation and interview during the initial kitchen tour on 05/17/26 between 8:19 A.M. and 8:44 A.M. revealed multiple cleanliness concerns. A black substance was present under the sink. Vents above the stove and food preparation areas had loose dust with additional dust collected on the ceiling light fixture. Dust was hanging around the sprinkler head above the food preparation area. The vent by the refrigerator and freezer was heavily coated in dust. A fan with a large amount of dust on the back was blowing directly onto clean dishes. These findings were confirmed at the time of observation with Dietary Aide #232 and Dietary Manager #284 at 8:45 A.M. Observation and interview on 05/17/26 between 8:19 A.M. and 8:44 A.M. revealed multiple food storage and labeling concerns. In the dry storage, two bags of pasta noodles and one bag of spaghetti were open with no open dates. In the refrigerator at 33 degrees Fahrenheit (F), a pitcher of lemonade had no label, open date, or expiration date. In the large refrigerator at 34 degrees F, an open bag of beef had no open date, open chicken base had no open date, sausage patties in a metal container had no label or open date, and multiple opened blocks and bags of cheese had no open dates or labels. In the freezer at 0 degrees F, opened hash browns, sausage patties, and three bags of Eggos had no open dates or labels. These findings were confirmed at the time of observation with Dietary Aide #232 at 8:45 A.M. Observation and interview on 05/17/26 between 8:19 A.M. and 8:44 A.M. revealed equipment concerns. A pipe behind the fan in the large refrigerator had visible mold with a wet box underneath where water was dripping. The freezer fan had ice buildup with ice chunks on boxes underneath. The juice spout had a visible substance present. These findings were confirmed at the time of observation with Dietary Aide #232 at 8:45 A.M. Observation on 05/18/26 at 11:30 A.M. during lunch meal service revealed multiple hand hygiene violations. Dietary staff #280 grabbed the outside of the bun bag with gloved hands, then used the same gloves to pick up and place bread onto resident trays. The same gloved hands then touched her clothes, refrigerator handles, forehead, and dishwasher handles before continuing to handle ready-to-eat bread. Dietary staff #280 touched the floor to pick up dropped bread with gloved hands, then reached inside the puree mixer and touched the inside of the lid with the same gloves. Staff also used gloved hands to write temperatures with a pen and then push green beans on plates with those gloved hands. Multiple times throughout the meal service, Dietary staff #280 removed their gloves, exited the kitchen, returned without washing hands, and immediately put on new gloves before resuming food service. Staff turned on the gas stovetop with gloved hands and then used those same gloves to handle bread and cheese directly with the same gloves after being cooked.Interview on 05/18/26 at 11:59 A.M. with Dietary staff #280 confirmed all of the above hand hygiene concerns.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, review of the infection control and surveillance plan, interview, and review of the facility policy, the facility failed to ensure appropriate infection surveillance. This had the potential to affect all residents. Additionally, the facility failed to ensure Personal Protective Equipment (PPE) was worn during care for a resident on Enhanced Barrier Precautions (EBP). This affected one resident (#9) of one resident reviewed for EBP. The facility identified 12 residents on EBP. The facility census was 55.Findings Include: 1. Review of the infection surveillance and control sheets for 01/2026 through 03/2026 revealed the facility did not track each infections bacteria when indicated. Further review of the infection surveillance and control sheets revealed there was no surveillance for the month of 04/2026. Interview on 05/26/26 at 8:32 A.M. with Assistant Director of Nursing (ADON) #263, also the infection control nurse, confirmed the facility was not tracking the bacteria of infections that were being treated with antibiotics. ADON #263 further confirmed that there was no documentation for the 04/2026 for infection surveillance and control. Review of the undated facility policy titled Antibiotic Stewardship revealed when a culture and sensitivity is ordered, lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued. 2. Review of the medical record for Resident #9 revealed an admission date of 05/27/25. Diagnoses included chronic pancreatitis, gastrostomy status, type two diabetes mellitus, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition. Review of the physician orders dated 08/05/25 revealed an enteral feed order to provide a 90 milliliter (ml) fluid flush every four hours. Review of the plan of care initiated 08/18/25 and revised on 05/01/26 revealed the resident had a gastrostomy feeding tube with an intervention for enhanced barrier precautions. Review of a physician order dated 12/25/25 revealed the resident required enhanced barrier precautions for a gastrostomy tube. Observation on 05/19/26 beginning at 4:02 P.M. of Resident #9 revealed the resident had an enhanced barrier precaution (EBP) sign posted on the room door. The sign stated for staff to wear a gown and gloves during high contact care including device care including feeding tube care. Further observation revealed Licensed Practical Nurse (LPN) #272 administered oral medications for Resident #9. Further observation on 05/19/26 at 4:05 P.M. revealed LPN #272 administered a 90-milliliter enteral flush for Resident #9. LPN #272 wore gloves but was not wearing a gown. Interview on 05/19/26 at 4:10 P.M., LPN #272 verified the resident was on EBP. LPN #272 verified she had not worn a gown while flushing the resident's gastrostomy tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 05/19/26 at 4:17 P.M., the Director of Nursing (DON) verified staff should wear a gown when flushing a resident's feeding tube. Review of the facility policy Enhanced Barrier Precautions, revealed EBP refers to the use of gown and gloves during high contact care activities for residents with known infection or colonization with a resistant organism when contact precautions do not other wise apply, chronic wounds, and indwelling medical devices. High contact care activity would include caring for or using and indwelling medical device.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, and policy review, the facility failed to ensure adequate monitoring for psychotropic medication effectiveness and adverse effects. This affected five (#5, #8, #17, #31, and #59) of five residents reviewed for unnecessary medications. The facility identified 43 residents receiving psychotropic medications. The facility census was 55. Findings include: 1. Review of the medical record for Resident #8 revealed an admission date of 03/30/26. Diagnoses included dementia with behavioral disturbance, psychotic disturbance, atrial fibrillation, altered mental status, and cerebral infarction. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition. Review of the plan of care initiated 03/31/26 and last revised 04/16/26 revealed to monitor and report for adverse effects of antidepressant medication, antianxiety medication and antipsychotic medications. Review of the physician orders dated 03/30/26 revealed the resident had orders for mirtazapine 7.5 milligrams (mg) daily for depression, and olanzapine 5 mg twice daily for psychotic disturbance. Review of a physician order dated 05/08/26 revealed an order for buspirone 10 mg every eight hours for anxiety. Further review of the physician orders revealed no orders for monitoring efficacy and adverse effects of the psychotropic medications. Review of the progress notes, medication administration record, and treatment administration records dated 04/01/26 through 05/18/26 revealed no documentation of monitoring for adverse effects and efficacy of the psychotropic medications. Interview on 05/18/26 at 10:28 A.M., the Director of Nursing (DON) verified there was no documentation of monitoring for adverse effects of the psychotropic medications. Interview on 05/18/26 at 10:28 A.M., the Regional Director of Nursing (RDON) #307 revealed the resident's care plan had an intervention to monitor for adverse effects and the nurse would monitor when administering medications. 2. Review of the medical record for Resident #17, revealed an admission date of 11/22/25. Diagnoses included Alzheimer's disease, nontraumatic subdural hemorrhage, anxiety disorder, major depressive disorder. Review of the quarterly MDS 3.0 assessment dated [DATE] for Resident #17 revealed the resident had severe cognitive impairment. The resident was assessed to require substantial/maximal assistance with toileting, showering, lower body dressing, putting on footwear and personal hygiene. Review of the care plan dated 11/25/25 and revised on 03/28/26 revealed Resident #17 took antianxiety and antidepressant medication related to anxiety, and depression. Interventions included monitoring and reporting to the physician any adverse effects of antianxiety and antidepressant medication use. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician orders for Resident #17 revealed an order for buspirone oral tablet 5 mg at bedtime for anxiety. Further review of the physician's orders revealed an order for Mirtazapine oral tablet 15mg at bedtime for depression. Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) revealed there was no monitoring for side effects of antidepressants, or antianxiety medication. 3. Review of the medical record for Resident #59 revealed an admission on [DATE]. Diagnoses included depression, anxiety, and epilepsy. Review of the admission MDS dated [DATE] revealed Resident #59 had cognitive impairment. Further review of the MDS revealed Resident #59 received antipsychotic, and antidepressant medication. Review of the care plan dated 05/17/26 revealed Resident #59 took psychotropic and antidepressant medications related to depression. Interventions included monitor for and report to physician adverse effects of antipsychotic medication, and antidepressant medication use. Review of the physician's orders for Resident #59 revealed an order for cariprazine oral capsule 3 mg every day for depression. Further review of the physician's orders revealed an order for sertraline 50 mg every day for depression. Additional review of the physician's orders revealed an order for benztropine mesylate oral tablet 0.5mg, one table every day for depression. Review of the MAR and TAR revealed there was no monitoring for side effects of antidepressant, or antipsychotic medication. Interview on 05/19/26 at 11:52 A.M. with the DON revealed the only location to monitor for adverse effects for antipsychotic medications was located in the care plan, however there was no documentation of the monitoring for adverse effects related to antipsychotic medication. 4. Review of the medical record for Resident #05, revealed an admission date of 05/09/25. Diagnoses included: vascular dementia, severe, with other behavioral disturbance, dysphasia, type II diabetes mellitus, major depressive disorder, generalized anxiety disorder, and chronic kidney disease, stage 3B. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #05 had severe cognitive impairment. The resident was assessed to require setup or cleanup assistance for eating and oral hygiene. The resident was dependent for toileting and required partial/moderate assistance for showering/bathing, lower body dressing, putting on/taking off footwear, and personal hygiene. The resident required supervision or touching assistance for upper body dressing. A care plan focus revised on 03/28/26 revealed Resident received psychotropic/antianxiety medications due to anxiety, depression, delusional disorders and insomnia. Further review of the care plan revealed an intervention to monitor for and report to physician adverse effects (drowsiness, dizziness, restlessness, weight gain, dry mouth, constipation, nausea and vomiting, blurred vision, low blood pressure, uncontrolled movements, tics, tremors, seizures, and increased risk for falls) of antipsychotic medication use. Review of physician orders for Resident #05 revealed two orders dated 04/16/26 for Ziprasidone (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hydrochloride (HCl) oral capsule 60 mg, with instructions to give 1 capsule by mouth once daily and Ziprasidone HCl oral capsule 80 mg, with instructions to give 1 capsule by mouth at bedtime for bipolar disorder. Review of the MAR for 05/01/26 thru 05/25/26 for Resident #05 revealed the medication was administered daily as prescribed, however, there was no indication on the MAR that nurses were tracking the resident's response to the medication for effectiveness, adverse effects or side effects. 5. Review of the medical record for Resident #31 revealed an admission date of 01/27/26. Diagnoses included pulmonary embolism, emphysema, chronic obstructive pulmonary disease, and asthma. Review of the quarterly MDS assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. Further review revealed no behaviors were identified. Additional review revealed the resident required extensive to dependent assistance with activities of daily living, utilized a wheelchair, and had shortness of breath with exertion and while lying flat. Review of the care plan initiated 03/19/26 and revised 03/28/26 revealed the resident received psychotropic medications related to antipsychotic, antianxiety, and antidepressant medication use. Further review of the care plan revealed an intervention for staff to monitor for and report adverse effects of antipsychotic medication use including drowsiness, dizziness, restlessness, weight gain, dry mouth, constipation, nausea and vomiting, blurred vision, low blood pressure, uncontrolled movements, tics, tremors, seizures, and increased risk for falls. Review of physician orders revealed an active order dated 04/01/26 for Lurasidone Hydrochloride 20 milligrams by mouth every evening related to bipolar disorder. Review of the MAR from 04/01/26 through 05/19/26 revealed the resident received the antipsychotic medication daily as ordered. Further review revealed no documented monitoring for effectiveness, adverse effects, or side effects related to the antipsychotic medication. Interview on 05/19/26 at 11:52 A.M. with Regional Director of Nursing #307, and Director of Nursing, confirmed the only location for monitoring adverse effects related to antipsychotic medications was located in the care plan. They further confirmed there was no documentation the resident was monitored for adverse effects related to the resident's antipsychotic medication use. Review of the facility policy titled, Documentation: Charting, dated 08/2023, revealed documentation in the clinical record was to include adverse reactions to medications and responses to medications and treatments. Further review revealed charting was to be complete and accurate and include follow-up action to nursing observations. Review of the facility policy Psychotropics, dated 09/2021, revealed the facility would use psychotropic medication appropriately working with the interdisciplinary team to ensure appropriate use, evaluation, and monitoring. Adverse reaction would be monitored according to the resident plan of care.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, interview, and facility policy review, the facility failed to ensure resident medical records were accurate and complete. This affected six (#3, #9, #18, #26, #43, and #49) of 22 sampled residents reviewed for accuracy of the medical record. The facility census was 55. Findings include: 1. Review of the medical record for Resident #9 revealed an admission date of 05/27/25. Diagnoses included chronic pancreatitis, gastrostomy status, type two diabetes mellitus, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition. Review of the care plan for hospice care last revised 12/25/25 revealed for the facility to collaborate with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. Review of the physician orders dated 12/25/25 revealed the resident was admitted to hospice services. Review of the resident's hospice documentation revealed no documentation of hospice care provided since 01/02/26. Interview on 05/18/26 at 2:00 P.M. with the Administrator and Assistant Director of Nursing (ADON) #263 revealed the facility had no recent documentation of hospice care provided for the resident. ADON #263 revealed she was unaware who was designated as the facility hospice coordinator. ADON #263 revealed hospice had not been updating the resident's binder with care documentation. ADON #263 revealed they received hospice documentation quarterly. The Administrator revealed she would review the hospice contract. 2. Review of the medical record for Resident #18 revealed an admission date of 12/04/20. Diagnoses included dementia, Alzheimer's disease, anxiety, peripheral vascular disease, atrial fibrillation, hypertension, and depressive disorder. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident was dependent on staff for activities of daily living. Review of the care plan revised 04/17/25 for the resident's impaired cognitive function revealed the resident had dementia with behaviors and was physically and verbally aggressive during care. Review of the care plan revised 05/19/26 revealed the resident was at risk for impaired skin integrity due to dementia, impaired musculoskeletal status, cardiac status, renal status, and behaviors. Staff were to notify the nurse of any new areas of skin breakdown noted during bathing or daily care including redness, blisters, bruises, or discoloration. Staff were also to notify the physician of new skin breakdown. Review of the weekly skin assessments and review of the nurse's notes dated 04/13/26 through (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/19/26 revealed no documentation of the resident having bruising to the bilateral forearms. Review of the Certified Nursing Assistant (CNA) task charting for monitoring/skin observations dated 04/27/26 through 05/26/26 revealed a new unidentified skin area was observed on 05/12/26. There was no documentation in the nurse's notes on 05/12/26 regarding the unidentified skin area. Review of a nurse's note dated 05/15/26 at 8:20 A.M. revealed the resident had a skin tear on the back of the left hand. There was no documentation regarding bruising to the bilateral lower arms. Review of an incident report dated 05/15/26 at 5:30 A.M. revealed the resident was combative and agitated. The CNA notified the nurse the resident had a skin tear to the back of the left hand as he was attempting to swing his hands and arms on the CNA, he accidently hit his hands/arms on his bedrail. A scant amount of blood was noted. The skin tear to the left hand was well approximated and a new treatment was ordered. Injuries noted post incident included bruising to the right and left forearm. The physician and family were notified. A new intervention included physician ordered protective sleeves to the bilateral arms. Observation on 05/17/26 at 1:59 P.M. revealed Resident #18 had multiple bruised areas on his bilateral lower arms. The resident had no protective sleeves in place. Observation on 05/18/26 at 12:18 P.M. revealed Resident #18 was in the dining room. The resident had no protective sleeves in place. The resident had visible bruising on the bilateral lower arms. Observation on 05/20/26 at 2:08 P.M. with the Director of Nursing (DON) and Regional Director of Nursing (RDON) #307 verified the resident had bruised areas to his bilateral arms. Interview on 05/26/26 at 10:42 A.M., ADON #263 revealed the nursing assistants should have been aware of the residents bruising and reported the areas to the nurse. ADON #263 revealed the nurse should have assessed the bruising and documented the evaluation and skin assessment. Interview on 05/26/26 at 1:19 P.M., RDON #307 revealed the incident report was not part of the resident's medical record. Review of the undated facility policy Change in a Resident's Condition or Status, revealed the nurse would record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. 3. Review of the medical record for Resident #49 revealed an admission date of 11/03/25. Diagnoses included malignant neoplasm of the brain, cerebrovascular disease, depression, and a stage three pressure ulcer of the right ankle. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident was at risk for skin breakdown. Review of the care plan dated 04/15/26 revealed the resident had a pressure area to the right lateral lower leg. Interventions included to provide wound treatments per physician orders. Review of a physician order dated 05/04/26 revealed to cleanse area to the right lateral ankle with wound cleanser. Apply collagen particles and calcium alginate. Cover with bordered dressing daily and as needed for wound management. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the treatment administration record (TAR) dated 04/01/26 through 05/26/26 revealed staff documented the wound treatment was completed on 05/23/26, 05/24/26, and 05/25/26. Observation on 05/26/26 at 10:46 A.M. of wound care for Resident #49 with the Assistant Director of Nursing (ADON) #263 revealed the resident had a wound dressing in place on the right lateral ankle dated 05/22/26. Interview on 05/26/26 at 10:46 A.M., ADON #263 verified the wound dressing was dated 05/22/26 and had not been completed per physician orders. ADON #263 revealed the wound dressing to the right lateral ankle should have been changed daily. Interview on 05/26/26 at 1:23 P.M. with the DON and RDON #307 verified the resident's wound treatments were incorrectly documented by agency staff as completed on 05/23/26, 05/24/26, and 05/25/26. The DON revealed the facility was going to notify the agency staffing providers. 4. Review of the medical record for Resident #03 revealed an original admission date of 07/17/2019 with a discharge to a local hospital on [DATE] and readmission of 12/09/25. Pertinent diagnoses included: Paraplegia, Type 2 diabetes mellitus, schizoaffective disorder, bipolar type; cognitive communication deficit, major depressive disorder, post-traumatic stress disorder (PTSD), generalized anxiety disorder, unspecified intellectual disabilities, chronic kidney disease and dysphagia oropharyngeal phase and dysphasia pharyngoesophageal phase. A diagnosis of acute respiratory failure with hypoxia was added 12/09/25 after Resident #03's hospitalization. Review of Resident #03's progress notes revealed no progress notes were recorded on 12/03/25 regarding Resident #03 eating his stool. Review of a progress note dated 12/04/25 at 3:00 P.M. revealed Resident #03 was sent to the emergency room (ER) due to a sudden drop in his oxygen saturation to 72% on room air from his norm of 95-96% on room air, tachycardia with a pulse of 154 (beats per minute), sweating, and a low grade fever of 99.9 degrees Fahrenheit by temporal route. Resident #03 was reported to have gotten into his colostomy bag 24 hours previously and was observed eating his stool. He experienced nausea and dry heaves over the last 24 hours and would not eat any food. Fluid intake was minimal and only when encouraged. The progress note indicated the signs and symptoms came on rapidly and the nurse noted he was in the room [ROOM NUMBER] minutes prior working with the resident and his roommate, at which time the resident was not showing the above symptoms. 911 called and report was called to the local hospital prior to the arrival of Emergency Medical Services (EMS). No family or guardian was listed to call, but nursing staff did notify his friend per the resident's request. During an interview on 05/19/26 at 6:54 A.M., Licensed Practical Nurse (LPN) #273 reported Resident #03 was very childlike and she had seen him pick at his colostomy bag. She said she also had seen him eat his own scabs four or five times. She said she didn't think she had documented either because it wasn't a big deal. During an interview on 05/19/26 at 7:09 A.M. Certified Nursing Assistant (CNA) #259 said that she had seen resident #03 put ten packets of salt on his food and she thought that was bad for him but when she was dismissed by nurses who said it was just a craving she stopped trying to report it. She said he grabs salt packages and puts it on his dessert every day. During an interview on 05/19/26 at 11:52 A.M. the Director of Nursing (DON) said she would expect (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the 12/03/25 observation of resident eating feces and subsequent change in condition (as referenced in the 12/04/25 progress note) to be documented. During an interview on 05/20/26 at 12:43 P.M., Certified Physician Assistant #300 confirmed she managed Resident #03's psychiatric medications. She said she received her information from record review and the nurses and did not speak with any of the aides. She said she was not aware that there were behaviors that were not documented. 5. Review of the medical record for the Resident #42 revealed an admission date of 09/04/24. Diagnoses included chronic obstructive pulmonary disease, type 2 diabetes mellitus with other specified complication, peripheral vascular disease, and type 2 diabetes mellitus with other skin ulcer. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident had intact cognition. Review of the care plan dated 12/20/24 revealed the resident had impaired cardiovascular status related to peripheral vascular disease. Interventions included apply Kerlix to both lower legs from toes to knee, cover with Ace wraps, and change daily. Review of physician orders identified an order dated 05/09/26 to cleanse both lower legs, apply Xeroform to open areas, then Kerlix and Ace wraps to both lower extremities every morning. Review of the Medication Administration Record (MAR) for May 2026 showed the Kerlix and Ace wrap treatment documented as completed daily through 05/16/26, with 05/17/26 marked as chart code 9 (see nurse's note). Review of the nurses notes dated 05/17/26 at 1:57 P.M. revealed staff documented that they were out of Kerlix and obtained an order for an alternative treatment. Observation on 05/17/26 at 1:15 P.M. revealed the resident's legs were not wrapped. The resident stated he had not had Kerlix since the previous Wednesday 05/13/26 and staff had been out of the supply. Interview on 05/17/26 at 1:33 P.M. the resident's roommate confirmed the resident's legs had not been wrapped and Kerlix had been unavailable. Interview on 05/17/26 at 1:49 P.M. Licensed Practical Nurse (LPN) #247 confirmed Kerlix was out of stock. Interview on 05/17/26 at 2:18 P.M. the Director of Nursing (DON) and Certified Nursing Assistant (CNA) #209 stated Kerlix had been out since Wednesday evening and the new supply would not arrive until 05/20/26. Interview on 05/18/26 at 7:56 A.M. Resident stated he refused the alternative ABD pads because they felt too tight and he would wait for Kerlix to return. Review of documentation dated 05/20/26 at 9:28 A.M. revealed the Administrator stated the facility had no policy on central supply processes. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of the medical record for Resident #26 revealed an admission date of 08/03/23. Diagnoses included Parkinson's disease, infection and inflammatory reaction due to indwelling urethral catheter, obstructive and reflux uropathy, and history of recurrent urinary tract infections. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident had intact cognition. Review of the care plan dated 12/20/24 revealed the resident required a Foley (indwelling urinary) catheter related to urinary retention and obstructive uropathy. Interventions included provide catheter care every shift and as needed, monitor for signs and symptoms of urinary tract infection, and report changes to the physician. Review of physician orders identified an order for Foley catheter care every shift and as needed dated 03/02/25. Review of the Medication Administration Record (MAR) showed Foley catheter care documented as completed on the morning of 05/18/26 by a licensed nurse. Review of the nurses notes revealed the resident had been hospitalized from [DATE] to 03/21/26 for an extended spectrum beta-lactamase (ESBL) urinary tract infection and was currently receiving Hiprex (an antibacterial medication used primarily to prevent recurrent or chronic urinary tract infections. Hiprex is not used to treat active, acute infections but rather as a long-term preventative medication) for urinary tract infection prophylaxis. Interview on 05/18/26 at 2:10 P.M. Licensed Practical Nurse (LPN) #230 stated he signed off on catheter care without verifying it was completed and confirmed this was not proper protocol. Interview on 05/18/26 at 2:36 P.M. Certified Nursing Assistant (CNA) #600 stated catheter care was not provided that morning due to resident refusal during a bed bath. Interview on 05/18/26 at 2:20 P.M. the Director of Nursing (DON) confirmed nurses should be providing catheter care. Review of facility policy titled Documentation: Charting, dated September 2021, revealed the facility's expectation that the clinical record is a legal document that must be accurate and complete. The policy requires staff to record care given including treatments only after it is given and to document follow-up action to nursing observations.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, and policy review, the facility failed to ensure advance directives were consistent throughout the medical record. This affected three (#17, #38, #59) of four residents reviewed for advance directives. The facility census was 55. Findings include: 1. Review of the medical record for Resident #38 revealed an admission date of 02/14/26. Diagnoses included chronic obstructive pulmonary disease, schizoaffective disorder, anorexia nervosa, anxiety, and hypertension. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition.eview of a Do Not Resuscitate (DNR) Comfort Care (CC) form dated 02/12/26 revealed the resident had chosen a DNRCC-Arrest (DNRCC-A) code status (all measures of care provided until the point of cardiac or respiratory arrest.) Review of the care plan initiated 02/15/26 and last revised on 02/25/26 revealed the resident code status was a Do Not Resuscitate Comfort Care - Arrest DNRCC-A. Interventions included involving the physician in advanced directive conversations, periodically review advance directive with the resident and family, and record the resident's advanced directives in the clinical record. Review of a physician order dated 02/27/26 revealed an order for a Do Not Resuscitate (DNR) Comfort Care (CC) code status. Interview on 05/18/26 at 10:20 A.M., the Director of Nursing (DON) verified Resident #38 had a physician order for a Do Not Resuscitate Comfort Care (DNRCC) code status while the signed DNR order revealed the resident's code status was documented as DNRCC-A. 2. Review of the medical record for Resident #17 revealed an admission date of 11/22/25. Diagnoses included: Alzheimer's disease, nontraumatic subdural hemorrhage, anxiety disorder and major depressive disorder. Review of the quarterly MDS 3.0 assessment dated [DATE] for Resident #17 revealed resident had severe cognitive impairment. The resident was assessed to require substantial/maximal assistance with toileting, showering, lower body dressing, putting on footwear and personal hygiene. A care plan focus revised on 12/29/25 revealed Resident #17 had a code status of Do Not Resuscitate Comfort Care-Arrest (DNRCC-A). Interventions included to involve the physician in advanced directives conversations, periodically review advanced directives with resident/family, and recording the resident's advanced directives in the clinical record. Review of the physician order dated 12/05/25 for Resident #17 revealed code status order of DNRCC-Arrest. Review of the documents uploaded to the electronic medical record for Resident #17 revealed a DNRCC order dated 01/13/26. During an interview on 05/18/2026 at 10:26 A.M. the DON verified that the code status type listed on (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plan and the physician order was different than the uploaded document on file and that the order list and care plan should have reflected the updated code status of DNRCC. 3. Review of the medical record for Resident #59 revealed an admission date of 05/14/26. Diagnoses included unspecified fracture of upper end of left humerus, acute respiratory failure, chronic obstructive pulmonary disease, atherosclerotic heart disease, dementia, depression and anxiety. Review of the 5 day Medicare MDS 3.0 assessment dated [DATE] for Resident #59 revealed the resident had severe cognitive impairment. The resident was assessed to require setup or cleanup assistance for eating and partial/moderate assistance for oral hygiene, toileting, showering, upper and lower body dressing, putting on/taking off footwear. Initial review of the electronic medical record for Resident #59 revealed no indication of code status. A care plan focus initiated on 05/17/26 indicated Resident #59 was full code. Review of the physician order dated 05/17/26 for Resident #59 revealed code status of DNRCC-A. During an interview on 05/18/2026 at 5:08 P.M., the DON confirmed that Resident #59 was DNRCC-A the previous day and was the result of the order being entered in without a signed paper, they changed code status to full code. She said they tell people at admission that they need to have a completed and signed form, otherwise the resident is switched to a full code until the paperwork can be completed by the physician. During an interview on 05/18/26 at 5:35 P.M., the resident representative for Resident #59 said her brother had a DNR order. She did not remember whether it was DNRCC or a DNRCC-A. She said the facility asked and she had told them he had DNR. Review of uploaded documents for Resident #59 revealed a DNRCC-A order signed on 05/19/26. Review of the undated facility policy titled, Do not Resuscitate Order revealed do not resuscitate orders must be signed by the resident's attending physician on the physician's order sheet maintained in the resident's medical record. Review of the facility policy Advance Directives, dated 09/01/21 revealed during the care planning process, the facility would identify, clarify, and review with the resident or legal representative whether they desired to make any changes related to Advance Directives. Further review of the policy revealed nay decision making would be documented in the resident's medical record and communicated to the interdisciplinary team.

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and review of the facility policy, the facility failed to ensure proper assessment and notification to the physician after moving a resident to the secured memory care unit. This affected one (#59) of three residents reviewed for dementia care. The facility census was 55.Findings include:Review of the medical record for Resident #59 revealed an admission on [DATE]. Diagnoses included depression, anxiety, and epilepsy.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 had cognitive impairment. The resident was assessed to require setup or cleanup assistance for eating and partial to moderate assistance for oral hygiene, toileting, showering, upper and lower body dressing, putting on and taking off footwear.Review of the care plan dated 05/21/26 revealed Resident #59 resided on the secured memory care unit for a therapeutic environment related to dementia and had exit seeking behavior. Interventions included to encourage the resident to avoid secured doorways to avoid injury when staff and visitors are entering and exiting the unit and to periodically reevaluate the residents' need for the secured unit.Review of Resident #59's progress notes revealed no documentation pertaining to a room change, or notes of exit seeking behavior.Review of the admission Evaluation dated 05/14/26 revealed Resident #59 had a history of wandering but did not have exit seeking behavior. Resident #59 had not attempted to elope from either the secured unit or the facility.Review of the medical record for resident #59 revealed a census change from the skilled unit to the secured memory care unit on 05/15/26. No further documentation or assessments were noted about a move to the secured memory care unit. Review of the Elopement Evaluation dated 05/17/26 revealed Resident #59 did not wander within the facility or have a history of wandering. Further review revealed no exit seeking behavior or attempts of actual elopement were noted.Interview on 05/18/26 at 5:35 P.M. with Resident #59's sister and Power of Attorney (POA) revealed Resident #59 came to the facility for rehabilitation after falling at an assisted living facility. Resident #59's sister was surprised that Resident #59 needed to be moved to the secured memory care unit and she was unaware of a dementia diagnoses. Resident #59's sister stated the resident was moved to the secured memory care unit soon after admission, but she was unsure of the exact date.Interview on 05/26/26 at 1:58 P.M. with Regional Director of Nursing (RDON) #307 revealed Resident #59 was moved to the secured memory care unit on 05/15/26 after showing exit seeking behaviors of going to the front doors. Resident #59 never exited the facility, but staff were concerned of possible attempts to elope. RDON #307 further confirmed that there were no assessments completed, and that the physician was not contacted related to moving Resident #59 into the secured memory care unit.Review of the facility policy titled Memory Care Unit Policy, dated 09/2024 revealed residents exhibiting behavioral changes or acute decline will be promptly assessed and interventions implemented as indicated.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based in record review, staff interview, and review of facility policy the facility failed to ensure a bed hold notice and a notice of transfer were given to resident or the resident representative upon discharge to the hospital. This affected one (#56) of one resident reviewed for hospitalization. The facility census was 55. Findings include: Review of the medical record for Resident #56 revealed an admission date of 04/10/26 and a discharge date of 04/22/26. Diagnoses included sepsis due to unspecified organism, cystitis without hematuria, morbid obesity due to excess calories, type II diabetes mellitus with ketoacidosis without coma, unspecified protein-calorie malnutrition, and generalized muscle weakness.Review of nursing documentation dated 04/22/26 at 11:30 A.M. revealed the resident experienced a significant change in condition and was found unresponsive with a snoring sound and no verbal response. Further review revealed emergency medical services were called, oxygen therapy was initiated, and the resident was transferred to the hospital. Review of electronic medical record documentation dated 04/23/26 at 12:04 A.M., 04/23/26 at 9:10 P.M., and 04/24/26 at 8:17 A.M. revealed the resident was documented as being at the hospital.Review of the clinical record revealed no documentation a bed hold notice, or a notice of transfer was provided to the resident or the resident representative.Interview on 05/18/26 at 10:12 A.M. with Social Worker #269, revealed the facility provided Ombudsman notification, but there was no documentation that a notice of transfer or bed hold notice was provided to the resident or the resident representative.Review of the facility policy titled, Transfer or Discharge Notice, dated September 2021, revealed the facility was required to provide a resident and/or resident representative with a 30-day written notice of an impending transfer or discharge. The policy further required that written notice includes the reason for transfer or discharge, effective date, location of transfer, appeal rights, bed hold policy information, Ombudsman contact information, and other required state agency contact information. The policy additionally required that a copy of the notice be sent to the Office of the State Long-Term Care Ombudsman and documented in the resident's medical record.Review of the facility policy titled, Bed-Holds and Returns, dated September 2021, revealed residents and resident representatives were to be informed prior to transfer of the bed hold policy. The policy further stated that the facility would provide written information explaining bed hold rights, including Medicaid bed hold limitations, private pay bed hold requirements, and conditions for return to the facility following hospitalization or therapeutic leave.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to notify the state mental health authority for Resident #03 when he was readmitted to the facility with new diagnosis of acute respiratory failure with hypoxia and sepsis after a hospitalization following an incident in which he ingested his own feces and for Resident #16 after a significant change in condition which resulted in a new diagnosed mental health condition. This affected two residents (#03 and #16) of two residents reviewed for preadmission screening and resident review (PASRR). The facility census was 55.Findings include:1. Review of the medical record for Resident #03 revealed an original admission date of 07/17/2019 with a discharge to a local hospital on [DATE] and readmission of 12/09/25. Pertinent diagnoses included paraplegia, type II diabetes mellitus, schizoaffective disorder, bipolar type; cognitive communication deficit, major depressive disorder, post-traumatic stress disorder (PTSD), generalized anxiety disorder, unspecified intellectual disabilities, chronic kidney disease and dysphagia oropharyngeal phase and dysphasia pharyngoesophageal phase. A diagnosis of acute respiratory failure with hypoxia was added 12/09/25 after Resident #03's hospitalization.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #03 revealed Resident #03 was cognitively intact. Resident #03 was assessed to be dependent for toileting and required substantial/maximal assistance for showering/bathing, lower body dressing, including putting on footwear. Resident #03 required supervision or touching assistance for personal hygiene, set up or clean-up for oral hygiene. Active diagnoses included paraplegia, anxiety disorder, depression, bipolar, schizophrenia, post-traumatic stress disorder (PTSD).Review of the medical record for Resident #03 revealed a hospital exemption document dated 07/15/19 and no Preadmission Screening and Resident Review (PASRR) documentation in the record.During an interview on 05/18/26 at 1:02 P.M., Social Services Director #269 said she also could not find a historical PASRR for Resident #03.Review of the medical record for Resident #03 revealed a PASRR was completed and submitted by Social Services Director #269 on 05/18/26. Review of the Preadmission Screening and Resident Review Result Notice dated 05/18/26 for Resident #03 revealed to be considered for admission or to continue to reside in a Medicaid certified nursing facility a resident must be screened for indications of serious mental illness and developmental disability. A resident review is required for nursing facility residents upon a significant change in condition. The results indicated that Resident #03 was selected for a level II evaluation to determine if the facility had the appropriate access to services to provide sufficient psychosocial care to the resident.2. Review of the medical record for Resident #16 revealed an admission date of 09/13/19. Diagnoses included bipolar disorder current episode depressed moderate, severe vascular dementia with behavioral disturbance, epilepsy not intractable without status epilepticus.Review of the quarterly Minimum Data Set, dated [DATE] revealed a Brief Interview for Mental Status score of 00 indicating severe cognitive impairment, a mood score of 12 and diagnoses that included bipolar disorder, depression, anxiety, and non-Alzheimer's dementia.Review of documentation dated 05/17/26 at 12:05 P.M. revealed the resident had a newly identified diagnosis of bipolar disorder with an onset date of 01/14/26 and no PASRR was completed to reflect the updated mental health diagnosis.Review of documentation dated 05/18/26 at 3:55 P.M. revealed Social Worker #269, stated the facility previously did not have access to PASRR documentation following corporate acquisition and therefore the newly diagnosed bipolar disorder was not captured on an updated PASRR. Further review revealed a PASRR was completed on 05/18/26 after the deficiency was identified.Review of documentation dated 05/20/26 at 9:28 A.M. revealed the Administrator stated the facility had no policy on PASRR processes.

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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 observation, review of the medical record, staff interview, and policy review, the facility failed to timely assess, monitor, and treat a change in skin condition. Additionally, the facility failed to ensure a skin wound treatment was completed per physician orders. This affected two (#18, #42) of two residents reviewed for non-pressure related skin conditions. The facility census was 55.Findings include: 1. Review of the medical record for Resident #18 revealed an admission date of 12/04/20. Diagnoses included dementia, Alzheimer's disease, anxiety, peripheral vascular disease, atrial fibrillation, hypertension, and depressive disorder. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. The resident was dependent on staff for activities of daily living. Review of the care plan revised 04/17/25 for the resident's impaired cognitive function revealed the resident had dementia with behaviors and was physically and verbally aggressive during care. Review of the care plan revised 05/19/26 revealed the resident was at risk for impaired skin integrity due to dementia, impaired musculoskeletal status, cardiac status, renal status, and behaviors. The resident was noted with a skin tear to the left second finger and back of the left hand. Interventions included assisting the resident with repositioning as needed, completing skin inspections every seven to ten days and as needed, and protective sleeves to the bilateral arms. Staff were to notify the nurse of any new areas of skin breakdown noted during bathing or daily care including redness, blisters, bruises, or discoloration. Staff were also to notify the physician of new skin breakdown. Review of the physician orders through 05/19/26 revealed no orders to monitor bruising. There were no physician orders for the protective sleeves to the bilateral arms. Review of the weekly skin assessments revealed the resident had not had a weekly skin assessment completed since 04/13/26 which noted no new observed skin areas. Review of the nurse's notes dated 04/13/26 through 05/19/26 revealed no documentation of any bruising. Review of the Treatment Administration Record (TAR) dated 04/13/26 through 05/19/26 revealed no documentation to monitor bruising. Also, there was no documentation the protective sleeves were being applied. Review of the Certified Nursing Assistant (CNA) task charting for monitoring/skin observations dated 04/27/26 through 05/26/26 revealed a new unidentified skin area was observed on 05/12/26. There was no documentation in the nurse's notes on 05/12/26 regarding the unidentified skin area. Review of a nurse's note dated 05/15/26 at 8:20 A.M. revealed the resident had a skin tear on the back of the left hand. There was no documentation regarding bruising to the bilateral lower arms. Review of an incident report dated 05/15/26 at 5:30 A.M. revealed the resident was combative and agitated. The CNA notified the nurse that the resident had a skin tear to the back of the left hand as he was attempting to swing his hands and arms on the CNA, he accidentally hit his hands/arms on his bedrail. A scant amount of blood was noted. Skin tear to the left hand was well approximated and a new treatment was ordered. Injuries noted post incident included bruising to the right and left forearm. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician and family were notified. A new intervention included physician ordered protective sleeves to the bilateral arms. Observation on 05/17/26 at 1:59 P.M. revealed Resident #18 had multiple bruised areas on his bilateral lower arms. The resident had no protective sleeves in place. Observation on 05/18/26 at 12:18 P.M. revealed Resident #18 was in the dining room. The resident had no protective sleeves in place. The resident had visible bruising on the bilateral lower arms. Observation on 05/20/26 at 2:08 P.M. with the Director of Nursing (DON) and Regional Director of Nursing (RDON) #307 revealed the resident had bruised areas to his bilateral arms. Subsequent interview with RDON #307 revealed there should be something in place for monitoring the bruising. Further interview with the DON revealed the resident had protective sleeves and was not sure why they were not in place. RDON #307 revealed the nursing assistants should document when the protective sleeves were in place. Interview on 05/26/26 at 10:42 A.M., the Assistant Director of Nursing (ADON) #263 revealed the nursing assistants should have been aware of the residents' bruising and reported the areas to the nurse. ADON #263 revealed the nurse should have assessed the bruising and documented the evaluation and skin assessment. ADON #263 revealed a head-to-toe skin assessment should be completed weekly. Interview on 05/26/26 at 1:19 P.M., the DON and RDON #307 verified the resident had not had a weekly skin assessment completed since 04/13/26. The DON and RDON #307 verified skin assessment should be completed weekly. RDON #307 revealed the facility had no policy regarding weekly skin assessments. RDON #307 verified the incident report was not part of the resident's medical record. Review of the undated facility policy Change in a Resident's Condition or Status, revealed the nurse would record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Review of the undated facility policy Documentation: Charting, revealed documentation would include care given including treatments and anything abnormal or out of the ordinary. 2. Review of the medical record for Resident #42 revealed an admission date of 09/04/24. Diagnoses included type II diabetes mellitus, transient cerebral ischemic attack, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, difficulty in walking, muscle weakness, need for assistance with personal care, peripheral vascular disease, hyperlipidemia, cellulitis of part of limb, and acute kidney failure. Review of the quarterly MDS dated [DATE] revealed a Brief Interview for Mental Status score of 15 indicating intact cognition. Further review revealed the resident required assistance with multiple activities of daily living and utilized a wheelchair for mobility. Additional review revealed skin impairments requiring pressure reducing devices and nonsurgical dressings. Review of the care plan initiated 12/20/24 and revised 04/19/26 revealed the resident required bilateral lower extremity wound care including gauze wrap from toes to knee and elastic (ACE) wraps applied daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician orders revealed an active order dated 05/17/26 at 7:00 A.M. for cleansing bilateral lower extremities, applying Xeroform (a sterile, non-adhering occlusive gauze dressing impregnated with petrolatum) to open areas, covering with rolled gauze (Kerlix), and wrapping with ACE bandages from toes to knee. Further review revealed an additional order dated 05/17/26 at 7:00 A.M., after surveyor intervention, allowing the use of abdominal (ABD) pads or light gauze over Xeroform with ACE wraps if Kerlix was not available and monitoring circulation and skin integrity every shift. Review revealed a prior wound care order was discontinued on 05/18/26. Review of Medication Administration Record (MAR) and treatment documentation revealed the ordered bilateral lower extremity wound care was documented as administered through 05/16/26. Further review revealed no completed documentation on 05/17/26 and an entry indicating a nursing note without corresponding documentation. Review of nursing documentation dated 05/17/26 at 1:15 P.M. revealed staff reported Kerlix was not available in the facility and the resident's legs were not wrapped. Further review revealed the resident stated supplies had not been available since the prior week and replacement supplies were not expected until 05/20/26. Interview on 05/17/26 at 1:33 P.M. with Administrator confirmed Resident #42's legs were not wrapped per physician orders. Interview on 05/17/26 at 1:49 P.M. with Licensed Practical Nurse (LPN) #247 confirmed Kerlix was out of stock within the facility since 05/13/26. Interview on 05/17/26 at 2:18 P.M. with DON confirmed Kerlix had been unavailable since approximately the prior week and replacement supply was not expected until 05/20/26. Interview on 05/18/26 at 7:56 A.M. with resident #42 confirmed refusal of ABD pad application and reported he would not allow leg wrapping until Kerlix supplies were available due to the ABD pads feeling tight on his legs. Interview on 05/18/26 at 9:21 A.M. with DON indicated the resident's wound care supplies were typically provided after his wound care appointment but there was no documentation or evidence confirming supply delivery following the last dressing change appointment on 05/13/26. Additionally, she confirmation that ABD pads were being used as an alternative due to Kerlix unavailability. Interview on 05/20/26 at 9:28 A.M. with the Administrator revealed the facility had no policy on central supply processes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, staff interview, and policy review, the facility failed to ensure pressure ulcer wound treatments were completed per physician orders. This affected one (#49) of one resident reviewed for pressure ulcers. The facility identified four residents with pressure ulcers. The facility census was 55. Findings include:Review of the medical record for Resident #49 revealed an admission date of 11/03/25. Diagnoses included malignant neoplasm of the brain, cerebrovascular disease, depression, and a stage three pressure ulcer of the right ankle.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident was at risk for skin breakdown.Review of the care plan dated 04/15/26 revealed the resident had a pressure area to the right lateral lower leg. Interventions included pressure reducing boots to bilateral feet as tolerated, elevate heels, low air loss mattress, and assist with turning and repositioning as needed. Also to provide wound treatments per physician orders. Review of a physician order dated 05/04/26 revealed to cleanse area to the right lateral ankle with wound cleanser. Apply collagen particles and calcium alginate. Cover with bordered dressing daily and as needed for wound management. Review of a wound nurse practitioner progress note dated 05/21/26 revealed the resident had a chronic stage three pressure ulcer to the right lateral ankle measuring one centimeter (cm) in length, one cm in width, with a depth of 0.3 cm with 100 percent granulation tissue. A new treatment recommendation was ordered to cleanse the wound with wound cleanser/normal saline, apply collagen with silver, normal saline moistened to base of the wound, secure with bordered dressing, change daily and as needed.Review of the Treatment Administration Record (TAR) dated 04/01/26 through 05/26/26 revealed there was no documentation the wound treatment to the right lateral ankle had been completed on 04/22/26, 04/24/26, 04/27/26, 04/28/26, and 05/16/26. Further review of the TAR revealed staff falsely documented the wound treatment was completed on 05/23/26, 05/24/26, and 05/25/26. Observation on 05/26/26 at 10:46 A.M. of wound care for Resident #49 with the Assistant Director of Nursing (ADON) #263 revealed the resident had a wound dressing in place on the right lateral ankle dated 05/22/26. Further observation revealed ADON #263 removed the dressing covering the right ankle revealing there was no calcium alginate in place under the wound dressing. The resident had a stage three pressure ulcer approximately one centimeter in length, one cm in width, with minimal depth. There was no wound odor and no signs of infection. There was a small amount of dried yellow exudate on the wound dressing. ADON #263 applied collagen particles to the wound base, applied calcium alginate, and covered with a bordered dressing. Interview on 05/26/26 at 10:46 A.M., ADON #263 verified the wound dressing was dated 05/22/26 and had not been completed per physician orders. ADON #263 revealed the wound dressing to the right lateral ankle should have been changed daily. Follow up interview with ADON #263 verified the facility had not implemented the new order for wound care treatment recommended by the wound care provider on 05/21/26. Interview on 05/26/26 at 1:23 P.M. with the Director of Nursing (DON) and Regional Director of Nursing (RDON) #307 verified there was no documentation wound treatments were completed on 04/22/26, 04/24/26, 04/27/26, 04/28/26, and 05/16/26. Further interview with the DON and RDON #307 verified the resident's wound treatments were incorrectly documented by agency staff as completed on 05/23/26, 05/24/26, and 05/25/26. The DON revealed the facility was going to notify the agency staffing providers. Review of the facility policy Wound Care, dated 09/2021, revealed wound treatments would be administered as ordered by the physician.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview, staff interview, and facility policy review, the facility failed to ensure residents were was free from accident hazards. This affected one (#31) of three residents reviewed for accidents. The facility census was 55. Findings include:Review of the medical record for Resident #31 revealed an admission date of 01/27/26. Diagnoses included pulmonary embolism, emphysema, chronic obstructive pulmonary disease, and asthma.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 revealing the resident had intact cognition. Additionally, the resident was dependent for bed mobility, transfers, and activities of daily living.Review of the fall risk assessment dated [DATE] revealed the resident was at high risk for falls.Review of the plan of care dated 05/15/26 revealed the resident was at risk for falls due to generalized weakness, history of falls, decreased strength and endurance, and need for assistance with activities of daily living. Interventions included educate the resident and family to call for assistance before transferring, food and fluids within reach, implement preventative fall interventions and devices, maintain call light within reach and educate the resident to use the call light, maintain needed items within reach, monitor for changes in mobility, non-skid footwear, physical therapy and occupational therapy evaluations, and low bed.Review of the fall investigation dated 05/15/26 revealed the resident was found on the floor on her left side with a knot noted to the left side of her head. The resident stated her legs slid out of the bed first which pulled her body out. The contributing factor identified was the bed left up too high by staff after a transfer. At the time of the fall the resident was dependent for bed mobility and transfers. Two staff members had assisted the resident into bed prior to the fall yet the bed was not lowered. The resident was on anticoagulant medication and was sent to the emergency department for evaluation. A previous positioning fall occurred on 01/28/26 from the recliner. The care plan was updated after the fall to include the low bed intervention. The facility investigated the fall and determined changes were required to ensure consistent implementation of existing interventions.Review of a nursing note dated 05/17/26 at 7:39 P.M. revealed the resident was status post fall out of bed. The resident was moving extremities as per baseline with stable vital signs and no acute pain complaints.Interview on 05/19/26 at 2:14 P.M. the Certified Nursing Assistant (CNA) #259 stated the resident could not move her own feet without assistance, her feet were hanging off the side of the bed, she was yelling for help prior to the fall, and the bed was raised up high prior to the fall.Interview on 05/19/26 at 2:30 P.M. Resident #31 stated she was unable to reach the call light due to upper extremity impairment and had to yell for help. She also confirmed that two staff assisted her into bed prior to the fall.Interview on 05/19/26 at 2:37 P.M. CNA #244 stated protocol for dependent residents is to lower the bed when placing them in bed.Interview on 05/19/26 the Director of Nursing (DON) and Regional DON 307 confirmed the contributing factor noted on the fall investigation was the bed being up too high.Review of facility policy titled Falls, dated September 2021, revealed the facility's expectation to identify appropriate interventions based on the resident's specific risks, implement additional or different interventions if falling recurs, monitor subsequent falls, and ensure interventions such as low bed positioning are consistently applied to prevent falls and minimize injury.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, interview, and policy review, the facility failed to ensure interventions were implemented for significant weight loss, failed to monitor fluid restrictions, and failed to provide nutritional supplements per physician orders. This affected three (#1, #38, #27) of three residents reviewed for nutrition. The facility identified three residents with significant weight loss, two residents with fluid restrictions, and five residents receiving nutritional supplements. The facility census was 55. Findings include: 1. Review of the medical record for Resident #1 revealed an admission date of 04/27/26. Diagnoses included trigeminal neuralgia, atrial fibrillation, heart failure, pneumonitis, and pleural effusion.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident was independent with eating meals. Review of hospital documentation dated 04/24/26 revealed Resident #1 weighed 130 pounds prior to discharge to the facility. Review of the physician orders dated 04/27/26 revealed to obtain weight upon admission and every week for three weeks. Further review of the medical record and physician orders through 05/17/26 revealed no orders or interventions for significant weight loss. Review of the resident's weight record revealed the resident weighed 130 pounds on 04/27/26. On 04/28/26 the resident's weight was documented twice at 130 pounds. On 05/01/26 the resident's weight was documented as 180 pounds and the weight was struck out and noted as incorrect documentation. Review of the care plan dated 04/29/26 revealed the resident was at risk for altered nutritional status related to pneumonitis and altered texture diet. Interventions included monitoring changes in meal intake percentages and periodically obtaining resident's weight and reporting significant weight changes to the registered dietician, physician, and family.Review of a dietary assessment progress note dated 04/29/26 revealed the resident was at moderate nutritional risk related to an altered diet texture. The resident's current body weight was 130 pounds. The resident's current weight goal was weight maintenance. The resident had a pureed textured diet with 50 percent to 75 percent meal intakes noted as less than optimal but adequate to meet estimated needs. The dietician noted for the resident to have weekly weights for four weeks. Meal intakes, laboratory results, and skin status would be monitored with follow up quarterly and as needed for significant changes. Review of a care conference progress note dated 05/06/26 at 1:16 P.M. revealed one topic area discussed during the care conference was nutrition. The resident had lost over 20 pounds since being in the hospital and felt weak. The resident was on a regular diet with regular texture with 75 percent to 100 percent intake for meals. The resident's current body weight was 107.4 pounds. The resident reported she used to be on a pureed diet and had not wanted to eat that. The resident was now on a regular diet and eating well and starting to regain strength.Review of the nurse's notes dated 04/27/26 through 05/17/26 revealed no documentation the physician or registered dietitian had been notified of the resident's weight loss. Interview on 05/17/26 at 12:42 P.M. Resident #1 revealed she had concerns with her weight loss. Resident #1 revealed she was on a pureed diet but now was on a regular diet. The resident revealed she had difficulty eating due to her surgery for trigeminal neuralgia. Interview on 05/18/26 at 11:36 A.M., Licensed Practical Nurse (LPN) #522 revealed the last documented weight for Resident #1 was 130 pounds on 04/28/26. LPN #522 revealed the resident should have been weighed weekly. LPN #522 then requested the nursing assistants to weigh the resident.Observation on 05/18/26 at 11:40 A.M. of Resident #1 with Certified Nursing Assistant (CNA) #259 and CNA #218 revealed the resident weighed 109 pounds indicating a 16 percent weight loss since admission. While being weighed, Resident #1 stated she had been weighing herself on the same scale. CNA #259 revealed the nurses provided a list of residents who needed completed weights. Interview on 05/18/26 at 11:44 A.M., the Director of Nursing (DON) revealed there was no documentation of the resident's weight since 04/28/26 while reviewing the resident's weights in the electronic medical record. Review of the resident's weight documentation on 05/18/26 revealed two (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	additional weights had just been added in the electronic medical record. For 05/04/26 a weight of 109 pounds was added and for 05/11/26 a weight of 109 pounds was added noting a 16.2 percent weight loss since admission. Also, on 05/18/26 the facility stuck out the resident's weight of 130 pounds for 04/27/26 and noted incorrect documentation. Interview on 05/19/26 at 2:41 P.M., Registered Dietitian (RD) #304 revealed he had not been notified of the resident's weight loss until 05/18/26. RD #304 revealed he discussed the resident's weight with the DON and they believed the resident's hospital weight and admission weight completed at the facility were incorrect. RD #304 revealed on 05/18/26 he recommended a nutritional supplement for the resident. Interview on 05/19/26 at 3:20 P.M., the DON revealed if a resident has a significant weight loss then a risk meeting would be held, the dietitian, family, and physician would be notified. The DON revealed no notifications were made to the physician and dietician because they had not believed the resident had a true weight loss. The DON revealed the resident's weight had been written on paper and had not been entered into the electronic medical record. Follow up interview with the DON revealed if an incorrect weight was documented then the resident should have been reweighed the same day.Interview on 05/20/26 at 8:02 A.M., Licensed Social Worker (LSW) #269 revealed a care conference for Resident #1 was held on 05/06/26. LSW #269 revealed the resident had not attended the meeting. LSW #269 revealed present at the meeting was herself and two of the resident's family members. LSW #269 revealed the resident's family reported the resident had felt weak because she had not really eaten but was better since returning to normal food. The resident's family reported that the resident weighed 107 pounds. LSW #269 revealed the resident's family wanted her stronger so she could go home. LSW #269 revealed she had not notified anyone about the resident's 107-pound weight reported by the family because she had not known what the resident's starting weight was. LSW #269 revealed she had not provided nursing with any concern forms from the care conference meeting. Review of the facility policy Weight Assessment and Interventions, dated 09/2021 revealed the multidisciplinary team would strive to prevent, monitor, and intervene for undesirable weight loss for residents. The nursing staff would measure resident weights on admission and at least monthly unless ordered by the physician. A weight loss of greater than five percent in one month would be considered significant unplanned and undesired weight loss and interventions would be based on careful consideration of the resident choice and preferences. 2. Review of the medical record for Resident #38 revealed an admission date of 02/14/26. Diagnoses included chronic obstructive pulmonary disease, schizoaffective disorder, anorexia nervosa, anxiety, and hypertension.Review of the admission MDS assessment dated [DATE] revealed the resident had intact cognition.Review of the care plan dated 02/20/26 and last revised 05/13/26 revealed the resident was at risk for altered nutritional status due to significant weight loss and a mechanically altered diet. One intervention noted providing meals/snacks/fluids based on resident food preferences and physician orders. Also to provide nutritional supplements as ordered by the physician. Review of a physician order dated 03/02/26 revealed the resident had a regular diet with mechanical soft texture, and thin liquid consistency. The resident also had a physician order dated 03/02/26 for a magic cup three times a day for a nutritional supplement.Review of the resident's meal ticket for 05/18/26 revealed the resident had a mechanical soft diet with an added grilled cheese at each meal. There was no documentation on the meal ticket regarding additional nutritional supplements. Observation on 05/18/26 at 12:22 P.M. revealed Resident #38 received his meal tray for lunch. Further observation of the meal tray revealed that the resident had no nutritional supplement on his meal tray. Interview on 05/18/26 at 12:22 P.M., Certified Nursing Assistant (CNA) #218 verified Resident #38 was on a mechanical soft diet. CNA #218 verified Resident #38 had not received a nutritional treat on his meal tray. CNA #218 also verified Resident #38's meal ticket had not listed the magic cup for a nutritional treat. Interview on 05/18/26 at 12:25 P.M., Dietary Manager (DM) #284 verified if the nutritional supplement was not listed on the meal ticket then the resident was not receiving the supplement. DM #284 stated the dietitian must not have notified her about the nutritional supplement. Further interview on 05/20/26 at 1:41 P.M., DM #284 revealed the dietary (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	manager had sent an electronic communication for the resident to receive magic cups. DM #284 revealed she had missed the email. DM #284 revealed the resident would not have received the magic cup unless the nurse went to the dietary department to ask for the magic cup. Review of the facility policy Therapeutic Diets dated 09/01/21 revealed mechanically altered diets, as well as diet modified for medical or nutritional needs would be considered therapeutic diets. Further review of the policy revealed the food service manager would establish and use a tray identification system to ensure each resident received their diet as ordered.3. Review of the medical record for Resident #27 revealed an admission date of 01/10/25. Diagnoses included type two diabetes mellitus, chronic obstructive pulmonary disease, end stage renal failure, chronic kidney disease, vascular dementia, hypertension, atrial fibrillation, and dependence on renal dialysis. Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. Review of the care plan dated 02/07/25 revealed the resident had end stage renal disease and was receiving dialysis services. Review of the nutrition care plan last revised 02/27/26 revealed the resident was on 1800 milliliter (ml) fluid restriction (dietary provides 240 ml at breakfast and lunch, 360 ml dinner; nursing provided 600 ml 7:00 P.M. to 7:00 A.M. and 360 ml from 7 A.M. to 7:00 P.M.Review of a physician order dated 02/26/26 revealed the resident received dialysis services three times per week. Review of a physician order dated 02/27/26 revealed the resident was ordered a 1500 milliliter (ml) fluid restriction (420 ml from nursing and 1080 ml from dietary with 380 ml of fluids provided at breakfast, 240 ml at lunch, and 120 ml at dinner). Review of the treatment administration record from 04/01/26 through 05/19/26 revealed the nurses had placed a check mark each shift for the residents' 1500 ml fluid restrictions. There was no documentation of the fluid amount the resident had received. Review of the nursing notes dated 04/01/26 through 05/19/26 revealed no documentation the resident had refused to follow the physician ordered fluid restriction. Observation on 05/17/26 at 11:30 A.M. revealed a large water cup on the resident's bedside table. The cup was half full of water. Observation on 05/18/26 at 2:31 P.M. revealed there was a large water cup in the resident's room on the bedside table. The cup was approximately half full. Interview on 05/18/26 at 2:31 P.M., Resident #27 revealed staff filled the water cup when it was empty. Resident #27 was unaware of how much fluid he was allowed each day. Resident #27 revealed he tried not to drink many fluids. Interview on 05/18/26 at 2:33 P.M., LPN #230 revealed Resident #27 was on fluid restrictions. LPN #230 revealed he gave the resident about 120 ml of fluids with his medications. LPN #230 verified the large cup on the resident's bedside table was half full of water. Interview on 05/18/26 at 2:43 P.M., CNA #218 revealed Resident #27 was on fluid restrictions, so she only filled the resident's water cup half full of water and the other half with ice. Observation on 05/18/26 at 3:17 P.M., with the Assistant Director of Nursing (ADON) #263 revealed ADON #263 measured how much water the resident's water cup would hold when full. Further observation revealed the resident's cup held 580 ml of water. Observation on 05/19/26 at 10:50 A.M. of Resident #27 revealed LPN #522 provided the resident with his morning medications. LPN #522 provided the resident with a water cup with 200 ml of water to take the medications. Further observation revealed the resident drank 60 ml of water with the medications. LPN #522 then took the remaining water out of the room. Continued observation revealed LPN #522 had not documented the amount of fluid given to the resident. Concurrent interview with LPN #522 verified the resident was on fluid restrictions and she had provided the resident with 200 ml of water. LPN #522 revealed the nurses were not required to document the amount of water the resident consumed. Interview on 05/19/26 at 11:33 A.M., the DON verified the monitoring of the resident's fluid restriction was not adequate. The DON revealed the nursing staff should be documenting the amount of fluids the resident had received. The DON verified the resident's physician order for a 1500 ml fluid restriction was not consistent with the 1800 ml fluid restriction noted in the resident's care plan. The DON revealed only the nurses should be providing the resident with fluids not the CNAs. The DON revealed the resident should not have a water pitcher in his room. Review of the facility policy Hydration, dated 09/2021, revealed no guidelines no guidelines for fluid restrictions.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, staff interview, and policy review, the facility failed to ensure placement of a gastrostomy tube prior to administering a gastrostomy tube flush. This affected one (#9) of one resident reviewed for tube feeding. The facility identified one resident with a feeding tube. The facility census was 55. Findings include:Review of the medical record for Resident #9 revealed an admission date of 05/27/25. Diagnoses included chronic pancreatitis, gastrostomy status, type two diabetes mellitus, and hypertension.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition.Review of the care plan initiated 08/18/25 and revised on 05/01/26 revealed the resident had a gastrostomy feeding tube with interventions to provide enteral nutrition per physician orders, flush feeding tube per physician orders, and check for tube placement and residual as indicated. Review of a physician order dated 05/28/25 revealed to check tube placement every shift prior to feeding, flushing, and administering medication. Review of the physician orders dated 08/05/25 revealed an enteral feed order to provide a 90 milliliter (ml) fluid flush every four hours. Observation on 05/19/26 at 4:05 P.M. revealed Licensed Practical Nurse (LPN) #272 administered a 90 milliliter (ml) enteral flush for Resident #9. LPN #272 had not checked for tube placement prior to flushing the feeding tube. Interview on 05/19/26 at 4:05 P.M., LPN #272 verified she had not checked for placement prior to flushing the feeding tube. Interview on 05/19/26 at 4:17 P.M., the Director of Nursing (DON) verified the nurse should have checked for placement prior to flushing the feeding tube. Review of the facility policy Gastrostomy Tube/Jejunostomy Tube Care, dated 09/2021, revealed to follow treatments as ordered by a physician. To confirm placement of tube in stomach, attach syringe to end of tube and place stethoscope over left quadrant of resident's abdomen. Instill 20 ml of air into the tube and listen for swooshing sound in stomach. Aspirate stomach contents by attaching syringe to end of tube and gently pulling back on plunger.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, resident interview, staff interview, and review of facility policy, the facility failed to ensure residents received the necessary respiratory care and services to meet their needs. This affected one (#29) out of two residents reviewed for respiratory care. The facility census was 55.Findings include:Review of the medical record for the Resident #29 revealed an admission date of 09/24/24. Diagnoses included chronic obstructive pulmonary disease, severe protein-calorie malnutrition, chronic atrial fibrillation, and chronic combined systolic and diastolic heart failure.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident had intact cognition. Additionally, the resident experienced shortness of breath with exertion, at rest, and while lying flat.Review of the plan of care dated 01/05/25 and revised 04/27/25 revealed the resident had impaired respiratory status related to chronic obstructive pulmonary disease and shortness of breath. Interventions included oxygen as ordered by physician, change oxygen tubing per policy, and elevate the head of bed as needed for comfort and breathing.Review of physician orders for 02/08/26 identified an order for oxygen at 2 liters per nasal cannula continuously every shift and to change oxygen tubing and set up weekly at bedtime every Sunday related to chronic obstructive pulmonary disease.Interview with Resident #29 on 05/17/2026 at 1:21 P.M. revealed he gets nose bleeds from dryness due to not having a humidifier bottle connected to his oxygen. The resident also stated they do not change his oxygen tubing, he thinks it has been over a year since the tubing was changed. Observation at the time of the interview revealed no date on the oxygen tubing. Resident #29 also stated the filter on the concentrator was fuzzy and that he could smell whatever was growing on the filter. Observation of the filter revealed it appeared to be covered in dust.Interview on 05/17/26 at 1:33 P.M. the Resident #29's roommate, Resident #42 confirmed all of the above concerns voiced by Resident #29 being shared with facility staff, including the dusty filter and the lack of a humidifier bottle.Interview on 05/17/26 at 1:43 P.M. Licensed Practical Nurse (LPN) #247 stated humidifier bottles are only used when oxygen is continuous. LPN #247 confirmed the resident's oxygen was ordered as continuous.Interview on 05/19/26 at 11:25 A.M. the Director of Nursing (DON) stated all residents on continuous oxygen should have humidifier bottles.Review of facility policy titled Oxygen Administration, dated September 2021, revealed the facility's expectation to administer oxygen therapy safely and noted that bacterial contamination associated with certain nebulizers and humidifiers may occur.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, and policy review, the facility failed to ensure ongoing communication with the dialysis services provider. This affected one (#27) of one resident reviewed for dialysis services. The facility identified two residents as receiving dialysis services. The facility census was 55. Findings include:Review of the medical record for Resident #27 revealed an admission date of 01/10/25. Diagnoses included type two diabetes mellitus, chronic obstructive pulmonary disease, end stage renal failure, chronic kidney disease, vascular dementia, hypertension, atrial fibrillation, and dependence on renal dialysis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Review of the care plan dated 02/07/25 revealed the resident had end stage renal disease and was receiving dialysis services. An intervention dated 02/27/26 revealed for staff to coordinate resident's care in collaboration with the dialysis center. Review of a physician order dated 02/26/26 revealed the resident received dialysis services three times per week. Review of the medical record revealed no dialysis communication forms were found in the medical record from 01/01/26 through 05/26/26. Review of a blank dialysis communication report form used by the facility revealed the nurse would record the residents vital signs, weight, glucose level, cognition status, COVID-19 status, pain medications administered, and any changes in condition since the last dialysis day prior to sending the resident to dialysis. The dialysis center would return the form with the resident's post dialysis weight, vital signs, treatment duration, kilograms of fluid removed, medications administered, condition or events during/post dialysis, and any special instructions. Interview on 05/18/26 at 2:33 P.M., Licensed Practical Nurse (LPN) #230 revealed a packet including a dialysis communication form was prepared by the night shift staff. LPN #230 revealed the form was sent with the resident and returned after dialysis and placed in a file. LPN #230 reviewed the electronic medical record and revealed there were no dialysis communication forms scanned into the medical record since 01/01/26. Interview on 05/19/26 at 11:28 A.M., the Director of Nursing (DON) revealed the dialysis communication forms should be in a binder or folder at the nurse's station. The DON revealed she was unable to find the communication forms at the nurses station. Interview on 05/20/26 at 9:30 A.M., the DON revealed a communication form was sent with residents to dialysis for Resident #27 with the transport driver and the forms were returned to the facility by the transport driver. The DON revealed she was unable to find any dialysis communication sheets for Resident #27 or the binder they were kept in. The DON revealed they had received two reports from dialysis dated 05/15/26 and 05/18/26. The DON also provided a copy of blank dialysis communication form. Follow-up interview on 05/26/26 at 4:00 P.M., the DON verified shewas still not able to locate the resident's dialysis binder with the dialysis communication forms for surveyor review. Review of the facility policy Hemodialysis dated 09/2021, revealed staff would coordinate with the dialysis center. There were no guidelines regarding the use of dialysis communication forms.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure that residents with post-traumatic stress disorder (PTSD) received necessary care and services to meet the resident's psychosocial needs. This affected two (#31 and #03) of two residents reviewed for trauma informed care. The facility census was 55.Findings include: 1. Review of the medical record for Resident #31 revealed an admission date of 01/27/26. Diagnoses included pulmonary embolism without acute cor pulmonale, chronic obstructive pulmonary disease, asthma, and post-traumatic stress disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident had intact cognition and that the resident had a diagnoses that included post-traumatic stress disorder. Review of the plan of care dated 03/19/26 and revised 05/18/26 revealed the resident had an impaired psychiatric and mood status related to anxiety, bipolar disorder, and post-traumatic stress disorder. Interventions included behavioral health consults as needed, monitor for signs of mood changes or distress, provide a calm safe environment, encourage expressions of feelings, and refer to social worker as needed. There was no documentation of identified PTSD triggers in the care plan. Review of the nurses notes revealed a PTSD assessment was not completed until 05/19/26 but still had no written triggers documented. Interview on 05/18/26 at 4:00 P.M. the Director of Social Services #269 confirmed that no trauma informed care assessment related to the resident's PTSD triggers had been completed. Director of Social Services #269 stated that moving forward she will complete assessments to capture triggers. 2. Review of the medical record for Resident #03 revealed an original admission date of 07/17/2019 with a discharge to a local hospital on [DATE] and a readmission date of 12/09/25. Pertinent diagnoses included paraplegia, type II diabetes mellitus, schizoaffective disorder, bipolar type; cognitive communication deficit, major depressive disorder, PTSD, generalized anxiety disorder, unspecified intellectual disabilities, chronic kidney disease and dysphagia oropharyngeal phase and dysphasia pharyngoesophageal phase. A diagnosis of acute respiratory failure with hypoxia was added 12/09/25 after Resident #03's hospitalization. Review of the quarterly MDS 3.0 assessment dated [DATE] for Resident #3 revealed Resident #3 was cognitively intact. Resident #03 was assessed to be dependent for toileting and required substantial/maximal assistance for showering/bathing, lower body dressing, putting on footwear, required supervision or touching assistance for personal hygiene, set up or clean-up for oral hygiene and active diagnoses included paraplegia, anxiety disorder, depression, bipolar, schizophrenia, PTSD. A care plan focus revised on 03/11/25 revealed Resident #03 was at risk for alteration in psychosocial wellbeing due to diagnosis of depression, diagnosis of intellectual/developmental disability. Interventions included: administer medications per physician order. Monitor for effectiveness and side effects, encourage resident to ask questions when concerned with their medical condition to reduce anxiety, give non-judgmental support, monitor for psycho-social changes, observe and report any changes in mental status caused by situational stressors. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An additional care plan focus revised on 01/24/26 revealed Resident #03 had an impaired psychiatric/mood status due to anxiety, bipolar disorder, depression, mood disorder and PTSD, anxiety, schizoaffective disorder no family support as evidenced by tearful. Interventions included: assist resident to cope by discussing possible solutions to conflict, behavioral health consults as needed (psycho-geriatric team, psychiatrist etc), encourage ongoing family involvement, encourage participation from resident to make own decision, encourage resident to reminisce and review life to identify past coping skills and personal strengths, monitor mood, monitor sleep pattern changes, provide quality listening time and encourage expressions of feelings, refer to social worker as needed if resident communicates need to speak with someone. Further review of the care plan for Resident #03 revealed no mention of specific triggers related to resident's trauma history. During an interview on 05/18/26 at 1:02 P.M., Director of Social Services #269 confirmed there was no mention in the care plan of Resident #03's trauma history or triggers. She also confirmed she did not know the resident's triggers and did not have trauma assessment. During an interview on 05/19/26 at 6:54 A.M., Licensed Practical Nurse (LPN) #273 said Resident #03 was very childlike and she had seen him pick at his colostomy bag. She said she also had seen him eat his own scabs four or five times. She said she didn't think she had documented either because it wasn't a big deal. She said she didn't know what triggered his behaviors. During an interview on 05/20/26 at 10:35 A.M. Certified Nursing Assistant (CNA) #228 said Resident #03 cried frequently. She said he cried whenever he was told what to do. She said she did not know his triggers. During an interview on 05/20/26 at 12:43 P.M., Certified Physician Assistant (CPA) #300 confirmed she managed Resident #03's psychiatric medications. She confirmed she was not a therapist and she confirmed she did not suggest interventions to staff regarding Resident #03 ingesting his feces. She said she only knew of the couple of documented instances of Resident #03 eating his feces. She said she received her information from record review and the nurses and did not speak with any of the aides. She said she was not aware that there were behaviors that were not documented. She said had she known that his behavior of eating his feces and copious amounts of salt was more chronic she would have listed pica (consumption of non-food items) or copraphogia (consumption of feces) as a diagnosis. CPA #300 said the resident would benefit from talk therapy and that if she had known about the ongoing behaviors, she would have explored more with the resident as to what was going on. CPA #300 also stated she did not know his triggers or trauma history. Review of facility policy titled Behavioral Assessment, Intervention and Monitoring, dated September 2021, revealed the facility's expectation that as part of the comprehensive assessment, staff will evaluate the resident's typical or past responses to stress, fatigue, fear, anxiety, frustration and other triggers. The policy requires the interdisciplinary team to thoroughly evaluate behavioral symptoms, incorporate findings into the care plan, and monitor residents with impaired cognition and behavior.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, review of hospital records and policy review, the facility failed to facilitate guardianship and appropriate behavioral health services to meet the complex psychosocial needs of a resident with schizoaffective disorder, post-traumatic stress disorder (PTSD), depression, anxiety, and an intellectual disability, which resulted in Resident #03 continuing with behaviors that were detrimental to his psychosocial and physical well-being. This affected one resident (#03) of two residents reviewed for behaviors. The facility census was 55. Findings include:Review of the medical record for Resident #03 revealed an original admission date of 07/17/19 with a discharge to a local hospital on [DATE] and readmission of 12/09/25. Pertinent diagnoses included: Paraplegia, Type 2 diabetes mellitus, schizoaffective disorder, bipolar type; cognitive communication deficit, major depressive disorder, post-traumatic stress disorder (PTSD), generalized anxiety disorder, unspecified intellectual disabilities, chronic kidney disease and dysphagia oropharyngeal phase and dysphasia pharyngoesophageal phase. A diagnosis of acute respiratory failure with hypoxia was added 12/09/25 after Resident #03's hospitalization. A care plan focus revised on 12/12/24 revealed Resident #03 had an alteration in elimination due to need for ostomy. Interventions included: empty colostomy bag as needed, treatment to stoma site as ordered, monitor stoma site for complications when colostomy appliance is changed. Further review of the care plan revealed no mention of Resident #03 opening colostomy bag himself, there were no interventions regarding attempting to prevent Resident #03 from eating his feces and no interventions regarding what to do if Resident #03 was observed or suspected of eating his feces.A care plan focus revised on 03/11/25 revealed Resident #03 was at risk for alteration in psychosocial wellbeing due to diagnosis of depression, diagnosis of intellectual/developmental disability. Interventions included: administer medications per physician order. Monitor for effectiveness and side effects, encourage resident to ask questions when concerned with their medical condition to reduce anxiety, give non-judgmental support, monitor for psycho-social changes, observe and report any changes in mental status caused by situational stressors.An additional care plan focus revised on 01/24/26 revealed Resident #03 had an impaired psychiatric/mood status due to anxiety, bipolar disorder, depression, mood disorder and post-traumatic stress disorder (PTSD), anxiety, schizoaffective disorder no family support as evidenced by tearful. Interventions included: assist resident to cope by discussing possible solutions to conflict, behavioral health consults as needed (psycho-geriatric team, psychiatrist, etc.), encourage on-going family involvement, encourage participation from resident to make own decision, encourage resident to reminisce and review life to identify past coping skills and personal strengths, monitor mood, monitor sleep pattern changes, provide quality listening time and encourage expressions of feelings, refer to social worker as needed if resident communicates need to speak with someone.Review of the progress note dated 10/13/25 at 8:29 A.M. for Resident #03 revealed the nurse noted when she was doing dressing change, she witnessed Resident #03 eating bowel movements (BM) from a leaking colostomy bag. When the nurse attempted to educate resident to not eat his bowel movements, resident started yelling and hitting nurse. Nurse removed herself from the room and notified the physician. Review of a provider progress note dated 10/15/25 at 12:59 A.M. revealed Resident #03 had been reportedly removing his colostomy intermittently and ingesting stool. The note indicated the resident denied the behavior, but the staff had seen it multiple times. The note indicated the resident was tearful when discussing the issue. The note said the resident's behavior of ingesting stool was consistent with pica (an eating disorder characterized by a compulsive, persistent craving and/or consumption of non-food items) and that the plan was to educate the resident on the risks and dangers of ingesting non-food substances. The note indicated the resident would be monitored for any changes in status.Review of physician progress note dated 11/19/26 at (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	00:59 A.M. revealed Resident #03 was noted to have schizoaffective disorder, bipolar type, and moderate congenital intellectual delay, and was being evaluated for decision-making capacity and guardianship needs prior to surgery. The note indicated Resident #03 was scheduled for an upcoming surgery but was unable to provide informed consent due to impaired decision-making capacity. His psychiatric condition continued to affect his judgment and comprehension. The note also stated that Resident #03 had a moderate congenital intellectual delay that further limited his understanding. He reported attending regular classes in school and did not recall being told he had special needs or receiving any specific diagnosis related to his cognitive delay. He denied any prior discussions about guardianship and was uncertain whether he was ever supposed to have one. The note indicated Resident #03 was alert and cooperative but demonstrated limited understanding and was a poor historian. The physician noted Resident #03's condition affected his decision-making capacity, particularly in the context of consenting to upcoming surgery and recommended social services to expedite the guardianship process to ensure the resident had appropriate support for medical decision-making.Further review of the medical record for Resident #03 revealed no follow-up documentation related to the guardianship recommendation.Review of a progress note dated 12/01/25 at 11:37 A.M. revealed Certified Nursing Assistant (CNA) reported to the nurse that Resident #03 was in dining room putting five to six salt packets in his pudding. The CNA tried to explain to the resident that was a lot of salt and the resident began getting frustrated and crying. The CNA reported that the resident slammed his meal tray on the table and left the dining room. No further behaviors were noted.Review of Resident #03's progress notes revealed no progress notes were recorded on 12/03/25 regarding Resident #03 eating his stool.Review of a progress note dated 12/04/25 at 3:00 P.M. revealed Resident #03 was sent to the emergency room (ER) due to a sudden drop in his oxygen saturation to 72% on room air from his norm of 95-96% on room air, tachycardia with a pulse of 154 (beats per minute), sweating, and a low grade fever of 99.9 degrees Fahrenheit by temporal route. Resident #03 was reported to have gotten into his colostomy bag 24 hours previously and was observed eating his stool. He experienced nausea and dry heaves over the last 24 hours and would not eat any food. Fluid intake was minimal and only when encouraged. The progress note indicated the signs and symptoms came on rapidly and the nurse noted he was in the room [ROOM NUMBER] minutes prior working with the resident and his roommate, at which time the resident was not showing the above symptoms. 911 called and report was called to the local hospital prior to the arrival of Emergency Medical Services (EMS). No family or guardian was listed to call, but nursing staff did notify his friend per the resident's request.Review of psychiatry progress note dated 12/05/25 at 12:59 A.M. for date of service 12/04/25 revealed two weeks previously, Resident #03's Buspirone (an oral antianxiety medication) dose was reduced from 10 milligrams (mg) twice daily to 7.5 mg twice daily. He was also taking Wellbutrin XL (an oral antidepressant medication) 300 mg daily. The note indicated [on 12/04/25] the patient reported ongoing vomiting and nausea. He also denied depression, anxiety, suicidal ideation, and hallucinations. Staff reported that emesis began today. Yesterday [12/03/25], the patient was observed eating feces from his colostomy bag. Four days ago, he became frustrated and tearful after being educated about adding several salt packets to his pudding, then left the dining room area. No other behaviors were noted in the chart review. Further chart review indicated a diagnosis of schizoaffective disorder, bipolar type, since 2017 from an outside hospital. No further psychiatric history was available. Given recent gradual dose reduction (GDR) and behaviors after medication changes, a decision was made to increase Buspirone to prior dosing. Due to recent medical history findings, further medication adjustments may be necessary if symptoms and behaviors continue. Follow up scheduled for next visit to assess medication changes. Review of emergency room note dated 12/04/25 at 2:44 P.M. revealed Resident #03 presented to the emergency department due to nausea and vomiting and was hypoxic (low oxygen levels) and tachypneic (elevated and abnormally rapid, shallow breathing) and labored breathing in moderate respiratory distress. His oxygen saturation remained hypoxic in the 80's on four (4) liters of (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supplemental oxygen.Review of the hospital History and Physical dated 12/05/26 at 11:15 A.M. revealed Resident #03 had left lung pneumonia, likely aspiration, and acute respiratory failure with hypoxia associated with pneumonia.Review of the chest abdomen and pelvis computed tomography (CT) scan dated 12/05/25 at 8:18 P.M. revealed an impression of extensive multifocal bilateral airspace disease consistent with pneumonia. Given the appearance and distribution, aspiration should be considered etiology.Review of the progress note for Resident #03 dated 12/09/26 at 10:50 P.M. revealed resident returned from the hospital with a diagnosis of pneumonia.Review of a progress note dated 01/30/26 at 8:00 A.M. for Resident #03 revealed floor staff brought to nursing attention that Resident #03 had been eating out of his colostomy again. The resident did have what appeared to be dried stool on his hands and around his mouth. Nothing was noted in the resident's oral cavity. There was no odor noted by the nurse. Nursing reminded the resident it was not safe to put BM in his mouth nor ingest it and stressed how he could get sick. The resident began crying. Nursing tried to reassure the resident, but he continued to cry.Review of progress note dated 01/30/26 at 1:39 P.M. for Resident #03 revealed the certified nurse practitioner (CNP) was updated on resident having possibly consumed feces from his ostomy this morning. No new orders received.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #03 revealed Resident #03 was cognitively intact on the Brief Interview for Mental Status (BIMS) scale. Resident #03 was assessed to be independent for eating, dependent for toileting and required substantial/maximal assistance for showering/bathing, lower body dressing, and putting on footwear. Resident #03 required supervision or touching assistance for personal hygiene, set up or clean-up for oral hygiene. Active diagnoses included paraplegia, anxiety disorder, depression, bipolar, schizophrenia, and PTSD. Observation and interviews on 05/17/2026 at 10:23 A.M. of Resident #03 sitting in wheelchair facing the wall. Resident #03 said he had lived at facility three years. He denied any concerns with his care. Resident #02, roommate to Resident #03, said that Resident #03 had the mentality (cognition) of a five-year-old.During an interview on 05/18/26 at 1:02 P.M., Director of Social Services #269 confirmed there was no mention in the care plan of Resident #03's trauma history or triggers and there was no evidence a Pre-admission Screening and Resident Review had been filed notifying the local Area Agency on Aging regarding Resident #03's intellectual disability, schizoaffective disorder, Post-Traumatic Stress Disorder and new diagnosis of acute respiratory illness with hypoxia. Director of Social Services #269 additionally confirmed she did not know the resident's triggers.During an interview on 05/18/26 at 2:46 P.M., the Administrator confirmed there was no mention in the care plan of Resident #03 eating feces and therefore no suggested interventions for response when this behavior occurred.During an interview on 05/18/26 at 2:48 P.M., Director of Social Services #269 confirmed she had not followed up on the physician's request for guardianship. She said she felt that a guardian would take away the resident's right to make decisions.During an interview on 05/19/26 at 6:54 A.M., Licensed Practical Nurse (LPN) #273 reported Resident #03 was very childlike and she had seen him pick at his colostomy bag. She said she also had seen him eat his own scabs four or five times. She said she didn't think she had documented either because it wasn't a big deal. She said she didn't know what triggered his behaviors.During an interview on 05:19/26 at 7:09 A.M. CNA #259 said she had seen Resident #03 playing with his colostomy bag and also eating his own feces. She said she has had to clean his mouth out after he ate feces and it was so much that it made her have to leave the room to throw up herself. She said he was very childlike and whenever anyone would tell him not to pick at his [colostomy] bag or eat his feces, he would burst into tears. She stated she had also seen him eat ten salt packets. She said she had brought up the salt packets to the nurses, but they didn't seem to be concerned so she stopped telling them. She said Resident #03 had the mind of a child. She said she saw him on 12/04/25 when he went to the hospital and he was grayish in color and was vomiting. CAN #259 reported he really didn't like going to the hospital and he cried anytime he had to go. She said he typically wouldn't tell you if something was wrong or he was in pain even if you could see that he was hurting.During an interview on 05/19/26 at 12:08 P.M. Physician #301 (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted that an individual who ate feces could pick up a parasite. He noted stool consists of a ton of bacteria and there was a potential for hepatitis (an inflammation of the liver, certain types can be caused by ingesting fecal matter).During an interview on 05/20/26 at 12:19 P.M. CNA #239 reported she had seen Resident #03 eat his feces multiple times. She said when she was providing care for him, if the bag was leaking, he would touch it and lick it. CNA #239 reported when he's told not to do it, he got embarrassed. CNA #239 reported he had habit of hiding food in his room that could spoil. CNA #239 reported she found a pork chop once. CNA #239 reported she has seen him put seven or eight salt packets on his food. She stated the friend that he had listed on his chart visited maybe once a year. She admitted she didn't always update the nurses on what she observed because the facility used agency nurses whom she felt didn't care.During an interview on 05/20/26 at 9:18 A.M. Registered Nurse (RN) #299 said had not personally witnessed Resident #03 eating stool, however, he had seen the aftereffects of stool under the nails and nausea. He said that he believed the change in condition on 12/04/26 was a direct result of Resident #03 eating the stool because it was such a drastic and quick change. He said the first thing he noticed was how pale Resident #03 looked. RN #299 said he didn't think Resident #03 understood what he was doing and the impact of eating stool, because Resident #03 was terrified whenever he had to go to the hospital. During an interview on 05/20/26 at 10:35 A.M. CNA #228 said Resident #03 cried frequently. She said he cried whenever he was told what to do. She said she did not know his triggers.During an interview on 05/20/26 at 11:52 A.M. Resident #02, the roommate of Resident #03, said that Resident #03 cried frequently but he wasn't sure why and that Resident #03 never would tell him. He confirmed he had seen the resident's colostomy bag leak on occasion.During an interview on 05/20/26 at 12:43 P.M., Certified Physician Assistant #300 confirmed she managed Resident #03's psychiatric medications. She confirmed she was not a therapist, and she confirmed she did not suggest interventions to staff regarding Resident #03 ingesting his feces. She said she only knew of the couple of documented instances of Resident #03 eating his feces. She said she received her information from record review and the nurses and did not speak with any of the aides. She said she was not aware that there were behaviors that were not documented. She said had she known that his behaviors of eating his feces and using copious amounts of salt were more chronic, she would have listed pica or coprophagia (the medical and behavioral term for the consumption of feces) as a diagnosis. She stated he would benefit from talk therapy and that if she had known about the ongoing behaviors, she would have explored more with him what was going on. She said she did not know his triggers or trauma history. Certified Physician Assistant #300 stated he always did well on the Brief Interview for Mental Status (BIMS) exam [measuring cognitive ability] however, on other tests he would score lower. Certified Physician Assistant #300 reported that he would also benefit from guardianship given his risk behaviors contradict his strong aversion to going to the hospital. During an interview on 05/20/26 at 1:47 P.M. the Director of Nursing (DON) confirmed there were no documentation of behaviors in the Kardex in October or December for Resident #03.During an interview on 05/20/2026 at 2:42 PM, CNA #268 said that she hadn't witnessed Resident #03 eating his feces but had heard about it. She said the resident's brother used to live at the facility as well and would make fun of him for his colostomy bag. She had seen Resident #03 dump five to six packets of salt on his food. She said if staff would say something to him about it, he would burst out and act like he was crying. During an interview on 05/26/26 at 6:05 A.M. CNA #274 confirmed she had seen Resident #03 pick at his colostomy bag until it opened and he recently did that two days in a row.During an interview on 05/26/26 at 8:16 A.M. the DON reported she could not find any documented evidence that the physician was notified on 12/03/25 regarding the resident eating his feces. She stated she would expect the physician to be notified and that if she was on the floor, she definitely would notify the physician. She stated she could not remember the last time that the resident's friend (listed as the resident's first contact in his medical record) came in to see him.During an interview on 05/26/26 at 8:23 A.M., Director of Social Services #269 confirmed she did not have a social work license and did not provide counseling to (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #03. She reported they generally only notify Resident #03's friend if Resident #03 explicitly requests the friend to be notified. Director of Social Services #269 reported the friend had not been to care conference in a while.During an interview on 05/26/26 at 8:58 A.M., LPN #296 confirmed she had witnessed Resident #03 eating his feces. She said when she told him not to do it, he was very aggressive and she had to leave the room. She said when she had told other people about it, they told her that it wasn't uncommon for him. She expressed belief that he understood that he wasn't supposed to do it, but she didn't think he understood that it was harmful to his health. During an interview on 05/26/26 at 12:53 P.M., Physician #295 said he could not find any record that he was notified on 12/03/25 regarding the resident eating feces. Physician #295 reported he wasn't sure whether there was anything that could be done to stop Resident #03 from eating his feces. He said the care plans are done by nursing so he wouldn't be involved. He said he would expect that they [staff] clean the room and the resident. Physician #295 reported he had not been informed that the guardianship process did not go forward. He said that if Resident #03 didn't understand the implications of his decisions, then that would indicate guardianship might be beneficial. Physician #295 reported he planned to do another capacity evaluation and stated a guardian would also be able to advocate for a counselor as well if that was something Resident #03 wanted. Physician #295 stated we have to do what we can for [Resident #03] to have a good quality of life.Review of the facility policy titled, Behavioral Assessment, Intervention and Monitoring, dated September 2021 revealed as part of the comprehensive assessment, staff will evaluate, based on input from the resident, family and caregivers, review of the medical record and general observations: the resident's typical or past responses to stress, fatigue, fear, anxiety, frustration and other triggers. The interdisciplinary team will thoroughly evaluate new or changing behavioral symptoms to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition. The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the residents and others from harm.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, staff interview, and policy review, the facility failed to ensure medications were administered per physician orders resulting in a medication error rate exceeding five percent. 26 opportunities were observed with three medication errors, resulting in a medication error rate of 11 percent. This affected two (#27 and #52) of six residents observed for medication administration. The facility census was 55. Findings include: 1. Review of the medical record for Resident #52 revealed an admission date of 11/04/24. Diagnoses included paranoid schizophrenia, vascular dementia with behavioral disturbance, bipolar disorder, dysphagia, anxiety, and hypertension.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Review of a physician order dated 11/04/25 revealed an order for Robitussin Cough plus Chest Congestion DM (dextromethorphan) oral liquid 20 milligrams (mg)/200 mg per 20 milliliters (ml), give 10 ml by mouth every 8 hours as needed for cough. The cough syrup contained 20 milligrams of dextromethorphan (cough suppressant) and 200 milligrams of guaifenesin (expectorant) per 20 ml. Observation on 05/19/26 at 10:19 A.M. of medication administration with Licensed Practical Nurse (LPN) #522 revealed the Robitussin Cough plus Chest Congestion DM medication was not in the medication cart. LPN #522 then checked the medication room and three medication carts for the ordered medication and was not able to find the medication. Further observation revealed LPN #522 then found another cough medication in the medication cart and proceeded to administer 10 milliliters of dextromethorphan Polistirex equivalent to Dextromethorphan Hydrobromide 30 mg/5ml (a cough suppressant). The cough syrup administered contained no guaifenesin, a cough expectorant. Interview on 05/19/26 at 11:07 A.M., LPN #522 verified the incorrect medication and incorrect dose of medication were administered to Resident #52. Interview on 05/20/25 at 10:49 A.M., the Director of Nursing (DON) verified the ordered cough medication was not the same as the cough medication administered by LPN #522. The DON further revealed LPN #522 had not reported the medication error. 2. Review of the medical record for Resident #27 revealed an admission date of 01/10/25. Diagnoses included type two diabetes mellitus, chronic obstructive pulmonary disease, end stage renal failure, chronic kidney disease, vascular dementia, hypertension, atrial fibrillation, and dependence on renal dialysis. Review of the quarterly MDS assessment dated [DATE] revealed the resident had intact cognition. Review of a physician order dated 02/19/26 revealed an order for Divalproex Sodium oral tablet delayed release 250 mg, one tablet by mouth two times daily for a mood disorder. The medication was scheduled for 8:00 A.M. and 8:00 P.M. Further review of the physician orders revealed an order dated 03/02/26 for Sevelamer oral tablet 800 mg, give one tablet before meals for end stage renal disease. The medication was scheduled for administration at 7:00 A.M., 12:00 P.M., and 5:00 P.M.Observation on 05/19/26 at 10:24 A.M. of medication administration with LPN #522 revealed the Sevelamer 800 mg was scheduled for administration at 7:00 A.M. and the Divalproex sodium 250 mg was scheduled for administration at 8:00 A.M. LPN #522 never administered the two medications. Interview on 05/19/26 at 10:24 A.M. LPN #522 reveled she was not able to administer the Sevelamer and Divalproex Sodium on time and it was too late to administer the medications now as Resident #27 would be scheduled to receive another dose soon. Review of the medication administration record (MAR) dated 05/19/26 for Resident #27 revealed LPN #522 initially documented the resident had refused the omitted doses of Sevelamer and Divalproex Sodium. Further interview on 05/19/26 at 4:11 P.M., LPN #522 revealed she had not meant to document the resident had refused the medication and revealed she would correct the documentation in the MAR. LPN #522 revealed she had been running rampant today. Review of the MAR dated 05/19/26 for Resident #27 revealed LPN #522 corrected the documentation after surveyor intervention to note the resident had not received the medications and the physician was then contacted. Interview on 05/20/26 at 10:49 A.M., the DON verified LPN #522 had not reported (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the omitted medications for Resident #27 until after surveyor intervention.Review of the undated facility policy Administering Medications, revealed medications would be administered in a safe and timely manner, and as prescribed. Medications would be administered within one hour of their prescribed time. The individual administering the medication would verify the right resident, right medication, right dosage, right time, and right route before administering the medication. For medications withheld, refused, or given at a time other than the scheduled time, the nurse would use the appropriate code for documentation. Review of the facility policy Medication Errors, dated 09/2021, revealed medication errors include the wrong medication, wrong time, wrong dose, wrong route or form, wrong resident, and omission. Medication errors would be reported to the physician and Director of Nursing. Residents with medication errors would be monitored closely.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, staff interview, and policy review, the facility failed to ensure a mechanical soft diet was provided per physician orders. This affected one resident (#38) of two residents reviewed for food. The facility census was 55. Findings include: Review of the medical record for Resident #38 revealed an admission date of 02/14/26. Diagnoses included chronic obstructive pulmonary disease, schizoaffective disorder, anorexia nervosa, anxiety, and hypertension.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition.Review of the care plan dated 02/20/26 and last revised 05/13/26 revealed the resident was at risk for altered nutritional status due to significant weight loss and a mechanically altered diet. One intervention noted providing meals/snacks/fluids based on resident food preferences and physician orders.Review of a physician order dated 03/02/26 revealed the resident was ordered a regular diet with mechanical soft texture and thin liquid consistency.Review of the facility menu for 05/18/26 revealed cube steak for a mechanical soft diet should be ground and served with gravy. Review of the resident's meal ticket for 05/18/26 revealed the resident had a mechanical soft diet with an added grilled cheese at each meal. Observation on 05/18/26 at 12:22 P.M. revealed Resident #38 received his meal tray for lunch. Further observation of the meal tray revealed the resident had received a whole (not ground) cube steak.Interview on 05/18/26 at 12:22 P.M., Certified Nursing Assistant (CNA) #218 verified Resident #38 was on a mechanical soft diet. CNA #218 verified the resident had received a whole cube steak which was not appropriate for a mechanical soft diet. Interview on 05/18/26 at 12:25 P.M., Dietary Manager (DM) #284 verified the resident's cube steak should have been ground up and not served whole. DM #284 further revealed the dietary staff should have checked the meal ticket before sending the tray on the hall cart. Review of the facility policy Therapeutic Diets dated 09/01/21 revealed mechanically altered diets, as well as diet modified for medical or nutritional needs would be considered therapeutic diets. Further review of the policy revealed the food service manager would establish and use a tray identification system to ensure each resident received their diet as ordered.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and review of the facility policy, the facility failed to ensure residents received the coronavirus (Covid-19) vaccination upon consent. This affected one (#22) of five residents reviewed for vaccinations. The facility census was 55.Findings Include: Review of the medical record for Resident #22 revealed an admission on [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), chronic bronchitis, and peripheral vascular disease (PVD). Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #22 had impaired cognition. Further review of the MDS revealed Resident #22 was not up to date on the Covid-19 vaccination. Review of the care plan dated 06/25/25 revealed Resident #22 had impaired respiratory status related to COPD, and pulmonary disease. Interventions included labs and diagnostics testing as ordered, and treatments as ordered by physician. Review of the Vaccine Informed Consent Form dated 10/31/25 revealed the facility offered the Covid-19 vaccination, and Resident #22 accepted to receive.Review of Resident #22's immunizations revealed there was no Covid-19 immunization administered. Review of the physician's orders for Resident #22 revealed no orders for the Covid-19 vaccination. Interview with Assistant Director of Nursing (ADON) #263 on 05/26/26 at 10:50 A.M. revealed Resident #22 signed to receive the Covid-19 vaccination however the vaccine never arrived from pharmacy. ADON #263 confirmed that it should have been followed up by ADON #263. ADON #263 further stated that a physician's order should have been obtained for the vaccination. Review of the facility policy titled Covid Vaccine-Residents dated 10/2023 revealed the Covid vaccine shall be offered to residents in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination unless is medically contraindicated.

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F 0606 Level of Harm - Potential for minimal harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on personnel file review, staff interview, and facility policy, the facility failed to ensure newly hired employees were screened through the abuse registry upon hire to identify potential findings related to abuse, neglect, exploitation, or misappropriation of property for seven of seven newly hired employees reviewed. This had the potential to affect all residents residing in the facility. The facility census was 55.Findings include:1. Review of the employee record for Administrator revealed a date of hire of 07/28/25. Further review revealed there was no abuse registry check completed upon hire.2. Review of the employee record for Director of Nursing (DON) revealed a date of hire of 12/23/25. Further review revealed there was no abuse registry check completed upon hire.3. Review of the employee record for Business Office Manager/Human Resources #500 revealed a date of hire of 11/12/25. Further review revealed there was no abuse registry check completed upon hire.4. Review of the employee record for Activities Director #248 revealed a date of hire of 05/19/25. Further review revealed there was no abuse registry check completed upon hire.5. Review of the employee record for Licensed Practical Nurse (LPN) #258 revealed a date of hire of 04/09/26. Further review revealed there was no abuse registry check completed upon hire.6. Review of the employee record for Med Tech #238 revealed a date of hire of 04/29/26. Further review revealed there was no abuse registry check completed upon hire.7. Review of the employee record for Med Tech #266 revealed a date of hire of 04/23/26. Further review revealed there was no abuse registry check completed upon hire.Interview on 05/19/26 at 1:20 P.M. with Business Office Manager/Human Resources #500, revealed the facility was not completing abuse registry checks for employees hired at the facility.Interview on 05/19/26 at 1:59 P.M. with Administrator revealed corporate staff provided monthly Microsoft excel reports indicating no Office of Inspector General matches were identified. Further interview revealed the facility did not maintain individual abuse registry checks for newly hired employees but only a filled out excel sheet.Interview on 05/19/26 at 3:46 P.M. with Administrator then confirmed the facility had not been completing Office of Inspector General abuse registry checks for newly hired staff to ensure there were no previous abuse concerns prior to employment.