STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365661	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heights Rehabilitation and Healthcare Center, The	2801 E Royalton Rd Broadview Heights, OH 44147

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure nursing staff called report and sent associated laboratory reports to the emergency room (ER) when a resident sustained a change in condition and was transferred to the ER. This affected one resident (Resident #120) of six residents reviewed for change in condition. The facility census was 107.Findings include:Resident #120 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia (low oxygen levels in the blood), diabetes, chronic kidney disease, high blood pressure, vascular dementia without behavioral disturbance, prostate cancer, a cerebral aneurysm, a gastrostomy (a surgically placed tube placed into the stomach to allow feeding through a tube), and neuromuscular dysfunction of the bladder. The resident was transferred to the ER on [DATE] and did not return to the facility.Review of the physician's orders revealed Resident #120's head of the bed must be elevated to at least 30 degrees to allow for easier breathing related to his diagnosis of COPD as well as the fact he received a tube feeding for nutrition and elevating the head of the bed assists in preventing aspiration of the tube feeding. Laboratory tests were drawn on 03/17/26 for a complete blood count, a complete metabolic profile, and blood cultures. Resident #120 also received five liters of oxygen via nasal cannula continuously. The resident had an order for an aerosol breathing treatment of Ipratropium-Albuterol 0.5-2.5 milligrams (mg) per three milliliters (ml) every four hours as need for shortness of breath or wheezing. The resident also had several wounds for which he received daily dressing changes.Review of the comprehensive quarterly Minimum Data Set (MDS) 3.0 assessment, dated 01/19/26, revealed Resident #120 was rarely/never understood, was dependent upon staff for all care, exhibited no indicators of pain, and received oxygen continuously.Review of the nursing progress notes revealed the Director of Nursing (DON) completed a Change of Condition template dated 03/15/26 at 5:04 P.M. Resident #120 was congested and had decreased lung sounds upon assessment. The change in condition started on 03/15/26 in the afternoon. The resident's blood pressure was 98/85 (normal blood pressure is less than 120/80), heart rate of 56 (normal is 60 to 100), respirations were 14 (normal is 12 to 20), his temperature was 101.1 degrees Fahrenheit (elevated), and his oxygen level was 100% on supplemental oxygen. The physician was notified on 03/15/26 at 4:00 P.M. and new orders were given to obtain a complete blood count, a basal metabolic panel, a urinalysis, and a chest x-ray. Resident #120's labs were drawn on 03/16/26 at 6:35 A.M. and were reported to the facility on [DATE] at 5:47 P.M. Resident #120's white blood cell count was high at 25.7 with the normal range being 4.5 to 10.8. His hemoglobin was low at 2.76 with the normal range being 14.0 to 18.0 and his hematocrit was low at 25.0 with the normal range 42.0 to 54.0. On 03/17/26 at 2:18 A.M., the laboratory results were reported to Nurse Practitioner (NP) #506 and additional lab work was ordered. On 03/17/26 at 5:51 A.M., Licensed Practical Nurse (LPN) #335 documented Resident #120 was to be transferred to the emergency room (ER). The resident was admitted with admitting diagnoses of septic arthritis in the left hip, osteomyelitis in the sacral wound, aspiration pneumonia, and a urinary tract infection. No documentation was noted regarding LPN #335 calling report to the ER regarding the resident's (continued on next page)

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

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition.Review of the ER medical record dated 03/17/26 revealed at 6:41 A.M. ER Physician (ER MD) #601 documented Resident #120 was sent from the nursing home because of abnormal labs but what labs were abnormal was not provided by the facility. No report from the nursing home was received.Interview with the DON on 06/01/26 at 3:05 P.M. revealed when someone is transferred to the ER due to a change of condition, she would expect the nurse to call report to the ER.Review of the facility's undated Change in a Resident's Condition or Status policy revealed the nurse will notify the physician/nurse practitioner for any significant change in a resident's condition or if there's a need to transfer the resident to the hospital. The nurse will record in the medical record information relative to changes in the resident's condition.Review of the facility's undated Documentation: Charting policy revealed the nurse was to document follow up action to nursing observations.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews, and a review of facility policies, the facility failed to provide required activities of daily living (ADL) care by not removing facial hair for one resident (Resident #29) and by not ensuring showers were provided for another resident (Resident #20). This deficiency affected two residents (Residents #20 and #29) who were dependent on staff for care, out of four residents reviewed for ADL services. The facility census was 107.Findings include: 1. Review of the medical record for Resident #29 revealed an admission date of 04/08/24 with diagnoses including encephalopathy, spastic hemiplegia, type II diabetes mellitus with diabetic neuropathy, dysphagia, major depressive disorder, anxiety, schizoaffective disorder, legal blindness, obstructive sleep apnea, cerebral palsy, essential hypertension, diastolic heart failure, mild intellectual disabilities, and anemia. Review of Resident's #29 annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14/15, indicating the resident was cognitively intact. Review of functional abilities revealed Resident #29 required set-up assistance for eating and oral hygiene and substantial assistance with upper and lower body dressing and putting on footwear. Resident #29 was dependent on staff for toileting, showering/bathing, and personal hygiene which included combing hair, shaving, applying makeup, washing/drying face and hands. Review of Resident's #29 Care Plan dated 05/14/26 revealed the resident had an ADL self-care performance deficit related to anxiety, congestive heart failure (CHF), depression, history of falls, neuropathy, pain, psychoactive drug use, and seizures. Interventions included assisting with ADL (i.e.: dressing, grooming, personal hygiene, locomotion, oral care, etc.) as needed. During an interview and observation on 05/19/26 at 5:20 P.M., Resident #29 had overgrown chin hair on her face. When asked if she would like her chin hair shaved, she said yes. This was verified during an interview at the time of the observation with Registered Nurse (RN) Assistant Director of Nursing (ADON) #419 who said she would get a certified nursing assistant (CNA) to shave the resident. Review of the undated facility policy titled, Activities of Daily Living (ADL) stated residents will be provided with the care, treatment and services as appropriate to maintain or improve their ability to carry out ADL. Residents who were unable to carry out ADL independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 2. Review of Resident #20's medical record revealed an admission date of 09/11/25 with diagnoses including dysphagia (difficulty swallowing), tracheostomy, and gastrostomy (feeding tube). Review of the care plan dated 03/18/26 revealed Resident #20 had ADL deficits. Interventions included assistance with bathing, toileting and transfers via a mechanical lift. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #20 had no cognition score due to resident being rarely understood. Resident #20 was dependent on staff with toileting, bathing and personal hygiene and was incontinent of bowel and bladder. Review of the medical record documentation from April and May 2026 for Resident #20 revealed no (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented evidence of bathing. Observation on 05/17/26 at 11:33 A.M. revealed Resident #20 was in bed, and her hair appeared to be greasy, matted and multiple large areas of crusted white debris. At time of observation, interview with Licensed Practical Nurse (LPN) #390 confirmed Resident #20's appearance and stated she was unsure when she had last received a shower or bed bath. Resident #20 was not able to be interviewed due to cognitive impairment. Observation on 05/26/26 at 2:52 P.M. revealed Resident #20's appearance was same as the previous observation on 05/1726. Interview with CNA #355 at the time of the observation verified Resident #20's appearance. She stated she was unsure when Resident #20 had last received a shower or bed bath. During an interview on 05/27/26 at 8:30 A.M., RN #391 revealed she had assisted staff on the evening of 05/26/26 with giving Resident #20 a shower. Observation of Resident #20 at time of interview revealed Resident #20's hair appeared to be clean, unmatted, and without debris. Review of the undated facility policy titled Activities of Daily Living (ADL), stated appropriate care and services will be provided to residents who are unable to care out ADL independently that included hygiene, bathing, and grooming. This deficiency represents non-compliance investigated under Complaint Numbers 2992281 and 2746797.

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on closed medical record review, review of emergency medical services (EMS) run report, interview, and facility policy review, the facility failed to timely provide basic life support (BLS) including cardiopulmonary resuscitation (CPR) to Resident #123 (a resident with advance directives for a Full Code status). This resulted in Immediate Jeopardy and Actual Harm with subsequent death on [DATE] at approximately 4:20 A.M. when Resident #123 was found not breathing, not moving, unresponsive, and without vital signs. Prior to initiating CPR, Registered Nurse (RN) #439 requested assistance from RN #301. The two nurses attempted to notify the on call Nurse Practitioner (NP) who did not answer and then notified Assistant Director of Nursing (ADON) #419 that the resident was unresponsive and absent of vital signs. ADON #419 instructed them to begin CPR as the resident was a Full Code. CPR was initiated and EMS were contacted. When EMS arrived at the facility at 4:40 A.M., CPR was not in progress, and the resident was only being ventilated by bag valve mask (BVM). When EMS personnel asked facility staff why CPR was stopped, the (unnamed) facility staff member stated, because you guys walked in and my back hurts. EMS re-initiated CPR and life-sustaining efforts which were unsuccessful. After collaboration with an offsite physician, the resident was pronounced deceased by EMS at 5:04 A.M. This affected one resident (#123) of three residents reviewed for death. The facility census was 107.On [DATE] at 11:02 A.M. the Administrator, Director of Nursing (DON), Chief Nursing Officer (CNO) #507, Co-Owner #508, and Regional Clinical Support (RCS) #509 were notified Immediate Jeopardy began on [DATE] at 4:20 A.M. when facility staff failed to provide timely and adequate basic life saving measures (CPR) to Resident #123 who was found unresponsive, per the resident's advance directive. EMS arrived and re-initiated CPR, which was unsuccessful, and pronounced Resident #123 deceased on [DATE].The Immediate Jeopardy was removed on [DATE] and the deficiency continued at a Severity Level 2 (no harm with the potential for more than minimal harm that is not Immediate Jeopardy) until the deficiency was corrected on [DATE], when the facility implemented the following corrective actions:On [DATE] following the incident, the DON removed RN #439 from the schedule and re-educated the nurse on the facility's CPR policy. RN#439 was reinstated on the evening of [DATE]. On [DATE], the DON educated all facility staff, in all departments, on the facility's CPR policy. The training covered the key topics within the policy including initiating CPR, recognizing a change in condition and responsiveness, verifying code status, initiating a code blue, obtaining the crash cart, directing staff to call 911 (emergency medical services) and continuing CPR until EMS arrived and assumed resuscitation efforts. Staff members who were not working were called and made aware of the outstanding training that was due to be completed on [DATE]. Training was verified by review of the electronic staff training confirmations. On [DATE], CNO #507 completed a root cause analysis (RCA). The root cause was determined to be a breakdown in emergency response execution involving delayed CPR initiation, inconsistent clinical competency under stress, and insufficient team-based emergency response activation, resulting in failure to immediately and continuously provide CPR to a resident with full code status until EMS assumed care. The RCA identified corrective actions needed including re-education, CPR drills on different shifts, an audit of all CPR certifications for licensed nurses, and a QA review of drill outcomes and any emergency response events for tracking and trending. On [DATE], an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held to discuss Resident #123's CPR initiation and to develop an action plan. The ad hoc QAPI meeting identified the need for staff re-training, ongoing audits of nursing staff CPR certifications, ongoing audits for residents who experienced a code blue, and mock CPR drills to provide enhanced training for staff. Those in attendance included Physician #511 (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(identified as the co-Medical Director), the DON, the Administrator, and Administrator in Training (AIT) #303. On the evening of [DATE], the DON completed education with the five nurses (RN #301, Licensed Practical Nurse (LPN) #302, RN #319, RN #410, and RN #439) who were working at the time of Resident #123's code. The five nurses had to verbalize the appropriate steps of initiating CPR, including recognizing a change in condition and responsiveness, verifying code status, initiating a code blue, obtaining the crash cart, directing staff to call 911 (emergency medical services) and continuing CPR until EMS arrived and assumed resuscitation efforts. Interviews with RN #301, RN #319, and RN #439 during the survey confirmed the nurses were re-educated on the evening of [DATE] and were knowledgeable of the facility's CPR policy. There were no concerns identified with the training. On the evening of [DATE], the DON completed an audit of all licensed nurses' CPR certifications. All licensed nursing staff employed by the facility, including 22 RNs and 14 LPNs had current CPR certifications with no concerns identified. Beginning on [DATE], the DON began weekly audits for all residents who experienced a code to ensure staff followed the facility's CPR policy, including immediate initiation of CPR when indicated. This audit was completed weekly by the DON or designee for a duration of four weeks, with the last weekly audit completed on [DATE]. There were no concerns identified with the code audits. The results of the audits will be referred to the facility's quality assurance (QA) committee for tracking, trending and additional recommendations. Beginning on [DATE], the DON began weekly CPR drills on varying shifts to ensure staff demonstrated the ability to initiate CPR timely. This was completed weekly by the DON or designee for a duration of four weeks, with the last weekly audit completed on [DATE]. There were no concerns identified with the CPR drills. The results of the audits will be referred to the facility's quality assurance (QA) committee for tracking, trending and additional recommendations. On [DATE], the facility's QAPI team met and reviewed the results of the timeline, corrective action, and ongoing audits and identified no further action was needed. Present at the QAPI meeting was the Administrator, AIT #303, ADON #375, ADON #388, Physician #512, Admissions #427, Minimum Data Set (MDS) Coordinator #315, MDS #323, Business Office Manager (BOM) #307, BOM #396, Environmental Services (EVS) #346, Transporter #353, Central Supply #367, Human Resources (HR) #340, and Social Services (SS) #348.Findings include:Review of the closed medical record for Resident #123 revealed an original admission date of [DATE] and a readmission date of [DATE]. Diagnoses included end stage renal disease, chronic obstructive pulmonary disease, cirrhosis of the liver and congestive heart failure. Resident #123 expired at the facility on [DATE]. Review of Resident #123's care plan dated [DATE] revealed the resident's advance directive was listed as a Full Code (indication for healthcare providers to attempt all possible life-saving measures in the event of a cardiac or respiratory arrest). Interventions included to involve the physician in advanced directive conversations, periodically review advance directives with the resident/family, and record the resident's advance directives in the clinical record.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #123 had intact cognition. Resident #123 was independent with ambulation, transfers, and bed mobility and was continent of bowel and bladder. Review of the physician orders revealed an order dated [DATE] indicating Resident #123 was a Full Code.Review of a progress note dated [DATE] at 11:05 A.M., authored by SS #348, revealed she had met with Resident #123 to further discuss the resident's plan of care. Resident #123 had declined a hospice referral and stated she wished to remain a Full Code. The interdisciplinary team (IDT) discussed Resident #123's decline and Resident #123 again stated she wished to remain a Full Code with no hospice interventions at that time. The note did not indicate what the resident's decline entailed.Review of progress note dated [DATE] at 5:05 A.M., authored by RN #439, revealed while doing care rounds around 4:20 A.M., an aide noted Resident #123 looked different and did not appear to be breathing. Upon entering Resident #123's room, RN #439 assessed Resident #123 and noted the resident was unresponsive and observed the absence of vital signs, noted the resident's pupils were fixed, dilated, and unresponsive to light, and the resident had a sunken-in appearance. RN #439 noted mottling (patchy, uneven skin (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	discoloration caused by poor blood circulation and decreased oxygen levels; it can be a sign that the body is shutting down) in both of the resident's legs from the feet up to the thighs and noted the resident's skin was patchy red and cool to touch. Resident #123 was noted to have been a Full Code and RN #439 had notified on-call staff (unspecified in the progress note) that CPR was initiated and 911 was called. EMS arrived at 4:40 A.M. and relieved facility staff of performing CPR and continued with CPR until 5:04 A.M. when Resident #123 was pronounced deceased .Review of a linked progress note dated [DATE] at 6:45 A.M. (linked to the prior progress note timed [DATE] at 5:05 A.M.), authored by RN #439, revealed CPR was initiated at 4:30 A.M., with 30 chest compressions and two rescue breaths administered by facility nurses. 911 was called at 4:32 A.M. and CPR continued until EMS arrived and relieved facility staff.Review of an EMS run report dated [DATE] revealed a call was received at 4:34 A.M. and EMS personnel arrived at the patient at 4:40 A.M. The EMS narrative stated upon arrival Resident #123 was found lying supine (on her back) in bed and was unresponsive. CPR was not being administered upon EMS arrival but Resident #123 was being ventilated via bag valve mask (BVM) (device used for manual ventilation). When EMS personnel asked why CPR had stopped the staff member (name not specified) stated because you guys walked in and my back hurts. EMS immediately began manual compressions and after two minutes of CPR a pulse check was conducted and reflected asystole (a state of total cardiac arrest characterized by the complete absence of electrical and mechanical activity in the heart). CPR and life-sustaining interventions were resumed using a [NAME] device (mechanical device used for chest compressions). The EMS personnel's assessment indicated Resident #123 was cyanotic and cool to touch but noted the residents' left and right eyes were both PERRL (indicating pupils were equal, round, and reactive to light). Staff informed EMS during the resuscitative efforts that Resident #123 was last seen well approximately two hours prior. After approximately 23 minutes of resuscitative measures, EMS contacted an offsite collaborating physician and pronounced Resident #123 deceased at 5:04 A.M.Telephone interview on [DATE] at 2:48 P.M. with RN #439 revealed she arrived at the facility at approximately 11:00 P.M. on [DATE] and worked until approximately 7:00 A.M. on [DATE]. RN #439 stated she performed walking rounds at approximately 12:00 A.M. and visualized Resident #123 from the doorway. RN #439 stated she did not enter Resident #123's room but noted the resident appeared to be sleeping at that time. RN #439 stated Resident #123 was continent of bowel and bladder, and she had not provided Resident #123 with any care or medications during her shift. RN #439 stated at approximately 4:20 A.M. she was alerted by a staff member (she could not recall who) that Resident #123 didn't look right. RN #439 stated she immediately entered the resident's and observed Resident #123 in bed and it appeared the resident was not breathing. The resident's pupils were fixed and dilated, and she was stiff and cold. RN #439 stated Resident #123 appeared to have been gone for a while. RN #439 stated she found another RN to come and see the resident and both nurses entered Resident #123's room. RN #439 stated she asked RN #301 if she should begin CPR and RN #439 stated she believed performing CPR at that time would be abuse of a corpse. RN #439 stated she called the on-call NP (she could not recall whom) with no answer and she then called ADON #419 who advised Resident #123 was a Full Code, instructed them to begin CPR, and to call 911. RN #439 stated after speaking with ADON #419, she then initiated a code blue (a common phrase for a critical, life-threatening medical emergency within a hospital system) and chest compressions were started. RN #439 stated CPR was performed until EMS arrived approximately twenty minutes later when EMS assumed care of Resident #123.Telephone interview on [DATE] at 9:54 A.M. with Paramedic #513 revealed he had responded to the facility on [DATE] and upon arrival he observed staff not actively performing CPR on Resident #123. Paramedic #513 stated when the (unnamed in the report) staff member was asked why CPR was not in progress, the staff member stated what the report stated, because you guys walked in and my back hurts. Paramedic #513 stated EMS assumed Resident #123's care and were unable to revive her. Paramedic #513 stated an offsite collaborating physician at a local hospital was contacted and updated and Resident #123 was pronounced deceased at the (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility.Interview on [DATE] at 9:27 A.M. with Certified Nursing Assistant (CNA) #431 revealed she cared for Resident #123 during the day of [DATE] and stated the resident did not look well. CNA #431 stated during her shift, Resident #123 did not eat or drink as much as she usually did and stated she informed the nurse (couldn't recall the nurse's name). When CNA #431 arrived for her next shift a few days later, she was informed Resident #123 had passed away. Interview on [DATE] at 11:09 A.M. with ADON #375 revealed she had a conversation with Resident #123 the morning of [DATE] to discuss her code status. During the conversation Resident #123 opted to remain a Full Code and declined hospice services. ADON #375 stated the morning of [DATE], Resident #123 didn't look like herself. ADON #375 stated Resident #123 appeared to be paler and more lethargic at the time of their discussion.Interview on [DATE] at 12:28 P.M. with the DON revealed she had been made aware Resident #123 had passed on [DATE] by ADON #419. At the time of the interview, the DON stated she had not been made aware of any issues or concerns with the nursing staff's response to Resident #123's change in condition or the CPR that was provided to the resident.Interview on [DATE] at 11:55 A.M. with ADON #419 revealed she received a call from RN #439 at approximately 4:30 A.M. and was informed Resident #123 was unresponsive. ADON #419 stated she was aware Resident #123 was a Full Code and instructed RN #439 to begin CPR and to call a code blue and EMS. ADON #419 stated she was not aware CPR had not been started prior to receiving the phone call. ADON #419 verified CPR should have been initiated immediately due to Resident #123 having an advance directive of Full Code status. Telephone interview on [DATE] at 4:41 P.M. with RN #301 revealed she was present on [DATE] when RN #439 approached her and stated she thought Resident #123 had passed away. RN #301 stated she had been working on the downstairs unit and upon being approached immediately went to Resident #123's room on the upstairs unit with RN #439. RN #301 stated upon entering Resident #123's room, the resident appeared to be lifeless, not breathing, her eyes and mouth were closed, and she appeared dusky. RN #301 stated she checked for a pulse and Resident #123 was cold and stiff and without a pulse. RN #301 stated she believed Resident #123 was on hospice and told RN #439 to contact hospice to inform of her passing. RN #301 further stated she checked Resident #123's medical records and then saw Resident #123 was a Full Code. RN #301 revealed RN #439 had stated, she's already gone, however RN #301 stated CPR was to still be done. RN #301 stated RN #439 then proceeded to place calls to the on-call NP as well as ADON #419. RN #301 stated upon speaking with ADON #419, RN #439 had been instructed to initiate a code blue and to begin CPR. RN #301 stated approximately four rounds of CPR had been performed prior to EMS arrival and stated once EMS arrived, they had taken over Resident #123's care. RN #301 stated the code had not been ran correctly as she believed Resident #123 was under hospice care and therefore did not initiate CPR immediately. Interview on [DATE] at 11:41 A.M. with RCS #509, the DON, and the Administrator, confirmed the facility leadership were aware there had been a delay in initiating CPR for Resident #123 on [DATE]. RCS #509 provided the facility's corrective action plan they had begun developing and implementing on [DATE]. RCS #509 indicated upon staff identification of a resident without vital signs, it is the facility's policy and the expectation for CPR to be initiated immediately.Interview on [DATE] at 12:28 P.M. with the DON revealed the DON was shown the EMS report indicating a facility staff nurse was noted to not be performing CPR on Resident #123 upon EMS personnel's arrival at the facility on [DATE] because the staff member's back hurt. The DON read the report and declined to further acknowledge or converse about the details contained within the EMS report.Review of facility policy titled Cardiopulmonary Resuscitation (CPR) revised [DATE] revealed CPR should be initiated immediately when cardiac or respiratory arrest occurs. Once CPR is initiated it will be discontinued only by physician order and/or arrival of rescue personnel.This deficiency represents non-compliance investigated under Complaint Number 2746747.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews, and facility policy review, the facility failed to ensure wound care orders were updated and treatments had been administered per physician orders for three residents. This affected two residents (#73 and #105) of three reviewed for wound care and one resident (#35) out of three residents reviewed for tube feeding. Additionally, the facility failed to ensure timely and appropriate incontinence care had been completed. This affected one resident (#12) of three observed for incontinence care. The facility also failed to ensure appropriate and timely care provided for a change in condition for one resident (#120) of six residents reviewed for change of condition. The facility census was 107.Findings Include: 1. Record review for Resident #105 revealed resident was admitted on [DATE] with diagnosis that included: cerebral infraction, pyogenic arthritis, type two diabetes, insomnia, essential hypertension, hyperlipidemia, end stage renal disease, carpal tunnel syndrome and generalized anxiety disorder. Review of Care Plan dated 05/15/26 revealed the resident had aggressive behaviors towards staff, verbally aggressive towards others, combative with care, would yell at staff in dialysis, scream and kick at staff and would put on the call-light requesting help and then was combative and resistant to assistance. Resident had behaviors related to refusing wound care, refusing leg wraps, refusing dressing changes and refusing to elevate her legs. Resident had impaired skin as evidenced by vascular wounds. Review of Resident #105's wound care note dated 04/29/26 authored by Wound Nurse Practitioner (WNP) #503 revealed the resident was being seen for a follow up visit for wound care. Resident was evaluated for venous ulcers to bilateral lower extremities. Resident had 10 wounds receiving wound care. Resident was ordered compressions with instructions to lightly wrap bilateral lower extremities with all cotton elastic (ACE) wrap every morning (QAM), remove at bedtime (HS), and to wrap from base of toes to below knee if patient allows. Review of WNP #503 notes from 05/06/26, 05/13/26 and 05/20/26 revealed the same orders for the compressions. Review of physician order dated 05/20/26 revealed orders to lightly wrap bilateral lower extremities (BLE) with ACE wrap QAM, remove at HS, wrap from base of toes to below knee if patient allows. There was no documented evidence of an order for the ACE wraps prior to 05/20/26. Observation on 05/17/26 at 2:56 P.M. of Resident #105 in her room wiping her legs with a tissue and no ACE wraps were present. Interview on 05/20/26 at 5:01 P.M. with WNP #503 revealed she first ordered the ACE wraps on 05/06/26. Interview on 05/21/26 at 12:47 P.M. with Licensed Practical Nurse (LPN) Assistant Director of Nursing (ADON) #375 confirmed the order for the ACE wrap was not added until yesterday and that treatment was originally ordered by WNP #503 in a note on 04/29/26. 2. Review of Resident #73's medical records revealed an admission date of 04/21/26. Diagnoses included left femur fracture, muscle weakness, difficulty walking and need for personal care assistance. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #73's admission assessment dated [DATE] revealed a 2 centimeter (cm) by 3 cm skin tear to the left arm. Review of the care plan dated 04/22/26 revealed Resident #73 was at risk for impaired circulatory status. Interventions included administer treatments as ordered. Resident #73 was also at risk for impaired skin integrity. Interventions included complete skin checks every 7 to 10 days and as needed and administer treatments as ordered. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #73 had impaired cognition and required moderate assistance with activities of daily living (ADL) care. Review of Resident #73's physician orders revealed orders dated 04/22/26 to cleanse the left upper extremity skin tear with normal saline, pat dry, apply calcium alginate (absorbent wound dressing) and cover with a silicone foam dressing every day shift and as needed. The order was discontinued on 05/11/26. Review of Medication Administration Record (MAR) and Treatment Administration Record (TAR) for May 2026 revealed the treatment was documented as completed on 05/09/26 and 05/10/26. Observation on 05/17/26 at 10:02 A.M. revealed Resident #73 was seated in a chair in her room with a silicone foam bandage to her left elbow with a date of 05/09/26. Resident #73 was not interviewable. Interview on 05/17/26 at 11:33 A.M. with LPN #390 confirmed Resident #73's dressing date and she stated she was unsure of the orders for her dressing changes. 3. Resident #120 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia (low oxygen levels in the blood), diabetes, chronic kidney disease, high blood pressure, vascular dementia without behavioral disturbance, prostate cancer, a cerebral aneurysm, a gastrostomy tube (a surgically placed tube placed into the stomach to allow feeding through a tube), and neuromuscular dysfunction of the bladder. The resident was transferred to the emergency room (ER) on 03/22/26 and did not return to the facility. Review of the care plans for Resident #120 revealed a care plan was initiated on 10/29/25 for impaired respiratory status related to COPD, respiratory failure and sleep apnea. The intervention to assist the resident with breathing was to elevate the head of the bed for comfort and to avoid shortness of breath when lying flat. Review of the physician's orders revealed Resident #120's had an order for a breathing treatment of Ipratropium-Albuterol 0.5-2.5 milligrams (mg) per three milliliters (ml) via inhalation treatment every four hours as need for shortness of breath or wheezing. Review of the comprehensive quarterly Minimum Data Set (MDS) 3.0 assessment, dated 01/19/26, revealed Resident #120 was rarely/never understood, was dependent upon staff for all care, exhibited no indicators of pain, and received oxygen continuously. Review of the nursing progress notes revealed Resident #120 was readmitted to the facility on [DATE] with wounds to his sacrum, both heels, and left anterior forearm. The resident also had a peripheral intravenous (IV) line inserted through which he was receiving an IV antibiotic for a urinary (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tract infection. On 03/22/26 at 5:00 P.M. Registered Nurse (RN) #350 completed a Change in Condition template indicating Resident #120 was tachypneic (fast respirations) and tachycardic (fast heart rate) starting on 03/22/26 at night. RN #350 assessed the resident's vital signs. His blood pressure was 114/66 (normal was typically noted around 120/80), a heart rate of 136 beats per minute (bpm) (normal ranged from around 60 to 100 bpm), a respiratory rate of 28 breaths per minute (normal ranges from around 12 to 20 breaths per minute), and a temperature of 97.4 degrees Fahrenheit. His oxygen level was 94% on room air (normal ranges from around 93% to 100%). His blood sugar was 229 milligrams per deciliter (mg/dL). Upon entering the resident's room RN #350 noted Resident #120 was breathing fast and heard crackles (an abnormal, clicking, bubbling, or popping sounds heard during breathing typically indicating the presence of fluid, mucus, or pus in the airways) in the base of his lungs. RN #350 contacted Nurse Practitioner (NP) #506 who said to transfer the resident to the ER for evaluation. No further information was documented on what occurred after transfer. Review of the Emergency Medical Service (EMS) run report for Resident #120, dated 03/22/26, revealed EMS dispatch received a call from the facility on 03/22/26 at 5:15 P.M. and EMS was en route to the facility at 5:17 P.M. and arrived on scene at 5:20 P.M. The chief complaint provided by the facility was the resident was tachycardic and they felt he was septic. At 5:21 P.M. Paramedic #600 assessed Resident #120's breathing. The resident's rate of respirations were normal, his respirations were unlabored and his lung sounds were clear bilaterally. His blood pressure was within the normal range of 116/61, his heart rate was rate was 98 bpm, and his oxygen level was 98%. Review of the narrative report revealed the squad was dispatched for a male with a high heart rate. RN #350 told EMS the resident was recently in the hospital for sepsis due to a large sacral wound on the resident's back side. The resident still had a few days of his antibiotic left but did not seem to be responding as fast as the facility believed he should. The resident had audible gargling sounds while breathing and was lying flat in bed. EMS transferred the resident to the stretcher and raised the head of the stretcher in order to facilitate the resident's breathing and placed him on two liters of oxygen via nasal cannula. The gargling sounds decreased and by the time they reached the ER the gargling sounds had stopped. Review of the March 2026 Medication Administration Record (MAR) for Resident #120 revealed the resident's order for a breathing treatment of Ipratropium-Albuterol 0.5-2.5 mg per three ml via inhalation treatment every four hours as need for shortness of breath or wheezing was not administered on 03/22/26 or at any time in March 2026. Interview with the Director of Nursing (DON) on 05/20/26 at 2:30 P.M. confirmed Resident #120 had not been given the as needed breathing treatment per orders for shortness of breath prior to being transferred to the hospital on [DATE]. 4. Review of Resident #12's medical records revealed a readmission date of 03/09/25. Diagnoses included dementia, anxiety and wandering. Review of Minimum Data Set (MDS) assessment dated [DATE] reveled Resident #12 had impaired cognition. Resident #12 was dependent with toileting, bathing and personal hygiene and was incontinent of bowel and bladder. Review of care plan dated 04/30/26 revealed Resident #12 was incontinent of bowel and bladder. Interventions included provide pericare after each incontinence episode. Observation of incontinence care on 05/26/26 at 9:27 A.M. with Certified Nursing Assistant (CNA) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#431 revealed Resident #12 was wearing a pull up incontinence brief with a second incontinence brief over top. Further observation revealed Resident #12 was saturated with urine that had soaked through both incontinence briefs, his mattress pad and on to his mattress, along with a strong odor of stale urine being detected. Interview with CNA #431 at time of observation revealed she was not the assigned CNA for Resident #12, and stated there was another aide who had arrived late and likely had not provided Resident #12 with care yet. CNA #431 stated residents should not be wearing more than one incontinence product and confirmed the stale urine odor and Resident #12 having been saturated with urine. CNA #431 stated she was unaware when Resident #12 had last been provided with incontinence care. Resident #12 was not interviewable. 5. Review of Resident #35's medical records revealed an admission date of 03/16/26. Diagnoses included stroke, dysphagia (difficulty swallowing) and gastrostomy (feeding tube). Review of care plan dated 03/13/26 revealed Resident #35 was at risk for altered nutritional status related to a feeding tube. Interventions included treatment to tube site as physician ordered, monitor and report signs of pain or tenderness at tube site to provider and check tube placement as indicated. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed no cognition score due to Resident #35 was rarely understood. Resident #35 was dependent with toileting, bathing and personal hygiene and was incontinent of bowel and bladder. Review of physician orders for May 2026 revealed to cleanse Resident #35's PEG tube site with normal saline every day shift. Review of Treatment Administrator Record (TAR) for May 2026 revealed no documentation of the PEG tube site having been cleaned with normal saline on 05/06/26, 05/07/26, 05/16/26 and 05/17/26. Observation and interview on 05/17/26 at 2:14 P.M. with Licensed Practical Nurse (LPN) #390 revealed Resident #35's PEG tube site had a gauze dressing around it that was undated, had a large amount of dried dark debris and a foul pungent odor. LPN #390 stated she had not cleansed the site today and was unsure when it had last been done. Interview with Resident #35's wife at time of observation revealed she had to ask staff numerous times to cleanse his PEG tube site and it had rarely been cleaned. Interview and observation on 05/20/26 at 1:36 P.M. with Resident #35's wife revealed his PEG tube site had not been cleaned and the dressing had not been changed. At the time of the interview Resident #35's wife had lifted his shirt and a gauze dressing was observed with a date 05/17/26 and the dressing was soiled with dark colored debris and the area continued to have a foul pungent odor. Observation and interview on 05/20/26 at 2:00 P.M. of Resident #35's PEG tube site with Registered Nurse (RN) #391 confirmed the soiled dressing, foul odor and dressing dated 05/17/26. RN #391 stated the dressing changes were supposed to have been done on night shift and she was unaware the dressing had not been done. RN #391 further stated she would inform the physician of the foul odor for Resident #35's PEG tube site. Review of change in condition progress note dated 05/20/26 timed 2:25 P.M. authored by RN #391 revealed Resident #35 had brownish red drainage coming from his PEG tube site. Nurse Practitioner (NP) #506 had been made aware and had given orders for lab work and to start Doxycycline (antibiotic) 100 milligrams (mg) twice a day for seven days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficiency represents noncompliance investigated under Complaint Numbers 2980251, 2795193, and 2746747.

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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 record review, observations, interviews, and facility policy review, the facility failed to ensure wound care treatments for a pressure ulcer were administered per physician orders. This affected one resident (#100) of five reviewed for pressure ulcers. The facility census was 107. Findings Include:Record review for Resident #100 revealed an admission date of 12/18/18 with diagnosis that included Alzheimer's disease, type two diabetes, repeated falls, dementia, anxiety disorder, major depressive disorder, hyperlipidemia, disorientation, delusional disorder, essential hypertension and hypothyroidism.Review of the Skin Inspection assessment dated [DATE] revealed Resident #100 did not have any new skin issues. Review of the Wound Evaluation assessment authored by ADON #375 and dated 05/16/26 revealed the resident had a new pressure deep tissue injury (DTI) wound on her left heel that was 5.5 centimeters (cm) in length and 6 cm in width. Review of Resident #100's wound care note dated 05/20/26 authored by Wound Nurse Practitioner #503 revealed the wound size was 9 cm in length and 7.6 cm in width.Review of Resident #100 wound care note dated 05/27/26 authored by WNP #503 revealed the wound size was 9.5 cm in length and 6.2 cm in width. The wound status was listed as improved/healing deep purple non-blanchable discoloration noted, less purple discoloration, more epithelial today. Large intact blister without open areas or skin breakdown. Presentation consistent with a DTI. Plan is to pad and protect, and apply skin prep.Review of the most recent wound care orders dated 05/27/26 revealed the resident was ordered to cleanse left heel with normal saline (NS), pat dry, apply skin prep, cover with abdominal (ABD) gauze pads and loosely wrap with kerlix every dayshift and as needed (PRN). Review of Resident #100's wound care note dated 05/27/26 authored by WNP #503 revealed in addition to the above orders, that resident was to wear offloading boots.Observation and interview on 06/01/26 at 3:03 P.M. with ADON #375 revealed Resident #100 was sitting in a wheelchair in the dining room. ADON #375 brought the resident to her room to complete wound care. Resident #100 was observed with offloading boots on that were not properly attached to the residents' left heel. ADON #375 removed the residents bandage dated 05/31/26 which revealed kerlix was wrapped around residents left foot but there was no ABD bandage applied underneath the kerlix as ordered. Interview with ADON #375 at the time of the observation, confirmed the observations.Review of the undated facility policy titled, Pressure Ulcers/Skin Breakdown-Clinical Policy revealed the following under treatment/management: 1. The physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents if indicated for type of skin alteration.This deficiency represents noncompliance investigated under Complaint Numbers 2980251.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure Resident #24 and Resident #121 was free from significant medication error. This affected two residents (#24 and #121) of three reviewed for medications as physician ordered. The facility census was 107. Findings include: 1. Review of Resident #24's medical records revealed an admission date of 07/08/21. Diagnoses included high blood pressure and multiple sclerosis. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 had impaired cognition. Resident #24 was dependent with toileting, bathing and personal hygiene and incontinent of bowel and bladder. Review of care plan dated 04/24/26 revealed Resident #24 had impaired cardiovascular status related to hypertension (high blood pressure). Interventions included medications per physicians orders, monitor and report to physician signs/symptoms of hypertension that include headache, lethargy or confusion and monitor vital signs as needed. Review of change in condition progress note dated 03/25/26 timed 1:37 P.M. authored by Assistant Director of Nursing (ADON) #375 revealed Resident #96 had complaints of a headache and abnormal vital signs were taken and resident appeared more confused. Resident #96's blood pressure was recorded at 200/105 (normal range is 120/80). Change in condition further included Resident #96 had been given Tylenol for her complaints of a headache, blood pressure was obtained three times in different positions on different arms and all were within the same range, and resident appeared more confused than baseline. Hospice and Resident #96's representative was notified. Review of progress note dated 03/25/26 timed 4:06 P.M. authored by ADON #375 revealed hospice had given orders for Losartan (blood pressure medication) 50 milligrams (mg) every day. Upon reassessment Resident #24's blood pressure was 188/90. Review of Medication Administration Record (MAR) for March 2026 revealed Resident #24 had received Losartan on the morning of 03/26/26. Interview on 05/26/26 at 11:09 A.M. with ADON #375 revealed she had been made aware of Resident #24's elevated blood pressure reading on 03/25/26 and stated she had contacted hospice and had received the orders to administer Losartan. ADON #375 further confirmed Resident #24 had complaints of a headache and was more confused than her normal and stated the Losartan had not been administered until the following morning. ADON #375 stated the Losartan should have been administered on 03/24/26 when Resident #24 had been exhibiting the symptoms of high blood pressure. 2. Resident #121 was admitted to the facility on [DATE] and was transferred to the hospital on [DATE] and did not return to the facility. Admitting diagnoses included acute and chronic respiratory failure, morbid obesity, a peritoneal abscess, diverticulitis of the large intestine with perforation and an abscess with bleeding, high blood pressure, chronic kidney disease, hypothyroidism, lymphedema, and a colostomy (a surgically inserted opening to the bowels to allow for stool to drain from the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	body). Review of the physician's orders for Resident #121 revealed an order dated 01/22/25 for the resident to receive the antibiotic Daptomycin 1 gram (gm) intravenously (IV) every 24 hours for an elevated white blood cell count. Review of the Medication Administration Record (MAR) for January and February 2025 revealed the resident did not receive the medication on 01/30/25, 01/31/25, 02/09/25, and 02/10/25. The MAR indicated to see the nursing progress notes for a reason. Review of the nursing progress notes for January and February 2025 revealed no information as to why the resident did not receive her Daptomycin. Review of the physician's orders for Resident #121 revealed an order dated 01/22/25 for Meropenem (an antibiotic)1 gm IV every eight hours for an elevated white blood cell count. Review of the MAR for January and February 2025 revealed the resident did not receive the medication on 02/18/26 at 6:00 A.M. Review of the nursing progress notes for February 2025 revealed no information as to why the resident did not receive her Meropenem. Review of the physician's orders for Resident #121 revealed an order dated 01/22/25 for Mycamine (an antifungal medication) 100 mg IV every 24 hours for an elevated white blood cell count. Review of the MAR for January and February 2025 revealed the resident did not receive the medication on 02/09/25, 02/14/25, and 02/15/25. Review of the nursing progress notes for January and February 2025 revealed no information as to why the resident did not receive her Mycamine. Review of the Medicare 5 Day comprehensive Minimum Data Set (MDS) 3.0, dated 01/29/25, revealed Resident #121 was cognitively intact, was dependent for toileting, was admitted with a pressure ulcer, had surgical wounds, as well as moisture associated skin damage, and received IV medications, as well as occupational and physical therapy. Interview with the Director of Nursing (DON) on 06/02/26 at 10:08 A.M. revealed she did not know why Resident #121 did not receive her IV antibiotics and antifungal medication during the resident's stay. This deficiency represents non-compliance investigated under Complaint 2746747 and 2992281.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure medications were not left unattended at the bedside. This affected one Resident (#1), of three observed for unattended medications. The facility census was 107. Findings include:Review of Resident #1's medical records revealed an admission date of 03/04/26. Diagnoses included diabetes, chronic pain, depression, anxiety and hypertension (high blood pressure).Review of Resident #1's Minimum Data Set (MDS) assessment dated [DATE] revealed no cognition score due to Resident #1 was rarely understood. Resident #1 was dependent with toileting, bathing and personal hygiene and was non-ambulatory.Observation on 05/17/26 at 8:24 A.M. revealed a medication cup on Resident #1's bedside that contained two white tablets and one capsule. Resident #1 was sleeping during observation.Interview on 05/17/26 at 8:31 A.M. with Registered Nurse (RN) #369 confirmed the medication cup in Resident #1's room however she was unable to identify the medications inside the cup. RN #369 stated she had not administered Resident #1's medication yet and stated they may have been left from the evening shift. Interview with Resident #1 at time of observation revealed he was unaware the medication cup was on his bedside table and was unable to state when the medications may have been left. RN #369 proceeded to remove the cup of medications and stated medications were not to be left unattended in residents rooms and stated medications should be monitored to ensure residents consumed them.This deficiency represents non-compliance investigated under Complaint Number 2992281.

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy the facility failed to ensure labs were completed as ordered. This affected one resident (Resident #29) of five residents reviewed for lab services. The facility census was 107.Findings include:Review of Resident #29 medical record revealed resident was admitted on [DATE] with diagnosis that included: encephalopathy, spastic hemiplegia, type 2 diabetes mellitus with diabetic neuropathy, dysphagia, major depressive disorder, anxiety, schizoaffective disorder, legal blindness, obstructive sleep apnea, cerebral palsy, essential hypertension, diastolic heart failure, mild intellectual disabilities and anemia. Review of Resident #29's physician orders revealed the resident had an order dated 12/18/24 for HgA1C labs every 3 months (December, March, June, September). There was no evidence of Resident #29's HgA1C for March 2026.Interview on 05/19/26 at 3:30 P.M. with Resident #29 during the Resident Council meeting revealed the resident was ordered labs quarterly to check her HgA1C. She said she had not had lab work completed recently. Interview on 05/19/26 at 5:23 P.M with Registered Nurse (RN) Assistant Director of Nursing (ADON) #419 confirmed Resident #29's A1C levels were not checked quarterly as ordered. Review of medical record revealed original order for lab work was discontinued on 05/19/26 and reordered on 05/19/26.This deficiency represents non-compliance investigated under Complaint Number 2746797.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on record review, observation, and interview, the facility failed to serve meals to meet the nutritional needs of residents requiring double portions at meals. This affected all 24 residents (#1, #5, #7, #8, #14, #18, #28, #37, #38, #46, #47, #50, #56, #63, #69, #74, #84, #89, #90, #94, #95, #106, #108, and #119) identified by the facility as requiring double portions at lunch meals. The facility census was 107. Findings include: 1. Review of the medical record for Resident #1 revealed an admission date of 03/04/26 with diagnoses including type two diabetes mellitus, anemia in chronic kidney disease, hypertension, and anxiety. Review of the dietary assessment note dated 05/06/26 at 4:27 P.M. revealed Resident #1 received a regular diet with regular texture and double entree portions. Review of the nutritional care plan, revised 05/14/26, revealed Resident #1 was at risk for altered nutritional status related to diabetes mellitus, hypertension, hyperlipidemia, anxiety, depression, gastroesophageal reflux disease, anemia, altered nutrition related labs, history of significant weight loss, and refusing supplements. Interventions included provide meals and snacks based on resident preferences and physician orders initiated 12/05/22. 2. Review of the medical record for Resident #5 revealed an admission date of 04/10/25 with diagnoses including end stage renal disease, hypertension, atrial fibrillation, sacral spina bifida, and cerebral palsy. Review of the physician's orders for Resident #5 identified orders for a renal diet with double portions effective 03/13/26. Review of the dietary assessment note dated 05/14/26 at 3:53 P.M. revealed Resident #5 went to dialysis on Mondays, Wednesdays, and Fridays and received a renal diet with regular texture and double portions. The note indicated Resident #5 refused the addition of oral nutrition supplements. Review of the nutritional care plan, revised 05/14/26, revealed Resident #5 was at risk for altered nutritional status related to respiratory failure, atrial fibrillation, heart failure, cerebral palsy, end stage renal disease, dialysis dependent, morbid obesity, increased nutrient needs, and refusal of nutritional supplements. Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 04/15/25. 3. Review of the medical record for Resident #7 revealed an admission date of 09/16/19 with diagnoses including type two diabetes mellitus, cerebral infarction, iron deficiency anemia, and anxiety. Review of the physician's orders for Resident #7 identified orders for a consistent carbohydrate diet with double protein portions effective 12/05/25. Review of the nutritional care plan, revised 03/13/26, revealed Resident #7 was at risk for altered nutritional status related to hemiplegia and hemiparesis, type two diabetes mellitus, morbid obesity, bipolar, schizophrenia, lupus, hypertension, vitamin D deficiency, abnormal labs, increased nutrient needs, and history of significant weight loss. Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 03/07/22. Review of the dietary assessment note dated 04/21/26 at 3:09 P.M. revealed Resident #7 received a consistent carbohydrate diet with double portions of protein. 4. Review of the medical record for Resident #8 revealed an admission date of 02/11/26 with diagnoses including type two diabetes mellitus, dementia, major depressive disorder, anxiety, and hypertension. Review of the nutritional care plan, revised 02/18/26, revealed Resident #8 was at risk for altered nutritional status related to diabetes mellitus, anxiety, depression, dementia, obesity, therapeutic diet needs, and double portions per request. Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 02/18/26. Review of the physician's orders for Resident #8 identified orders for a consistent carbohydrate diet with double entree portions effective 02/19/26. Review of the dietary assessment note dated 05/14/26 at 3:18 P.M. revealed Resident #8 received a regular diet with double portions per request. 5. Review of the medical record for Resident #14 revealed an admission date of 12/09/16 with diagnoses including type two diabetes mellitus, morbid obesity, iron deficiency anemia, vitamin D deficiency, anxiety, and hypertension. Review of the physician's orders for Resident #14 identified orders for regular diet with double entree portions effective 09/15/25. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the nutritional care plan, revised 01/07/26, revealed Resident #14 was at risk for altered nutritional status related to depression, type two diabetes mellitus, vitamin D deficiency, hyperlipidemia, anemia, anxiety, gastroesophageal reflux disease, history of significant weight changes, morbid obesity, and hospice care. Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 10/03/23. Review of the dietary assessment note dated 04/08/26 at 3:59 P.M. revealed Resident #14 received a regular diet with double entree portions. 6. Review of the medical record for Resident #18 revealed an admission date of 03/18/22 with diagnoses including chronic obstructive pulmonary disease, morbid obesity, major depressive disorder, hyperlipidemia, anxiety, spinal stenosis, and gastroesophageal reflux disease. Review of the physician's orders for Resident #18 identified orders for a no added salt diet with double entree portions effective 08/05/25. Review of the nutritional care plan, revised 05/03/23, revealed Resident #18 was at risk for altered nutritional status related to spinal stenosis, depression, anxiety, hypertension, congestive heart failure, and gastroesophageal reflux disease. Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 03/22/22. Review of the dietary assessment note dated 05/05/26 at 4:02 P.M. revealed Resident #18 received a no added salt diet with double portions. 7. Review of the medical record for Resident #28 revealed an admission date of 04/02/26 with diagnoses including severe protein calorie malnutrition, respiratory failure, dysphagia, hypertension, and tracheostomy status. Review of the physician's orders for Resident #28 identified orders for a regular diet with double portions effective 04/28/26. Review of the nutritional care plan, revised 05/18/26, revealed Resident #28 was at risk for altered nutritional status related to respiratory failure, dysphagia, hypertension, severe protein calorie malnutrition, underweight status, and requesting double portions at meals. Interventions included provide diet as ordered initiated 04/24/26. Review of the dietary assessment note dated 05/19/26 at 7:26 A.M. revealed weight gain was desirable for Resident #28 due to underweight status and his current diet order was appropriate for meeting nutritional needs. 8. Review of the medical record for Resident #37 revealed an admission date of 11/22/23 with diagnoses including type two diabetes mellitus, morbid obesity, anemia, major depressive disorder, and anxiety. Review of the physician's orders for Resident #37 identified orders for a regular diet with double entree portions effective 02/02/24. Review of the nutritional care plan, revised 01/28/26, revealed Resident #37 was at risk for altered nutritional status related to type two diabetes mellitus, depression, gastroesophageal reflux disease, morbid obesity, history of significant weight changes, and selective eating habits. Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 11/27/23. Review of the dietary assessment note dated 04/28/26 at 6:06 P.M. revealed Resident #37 received a regular diet with regular texture and double entree portions. 9. Review of the medical record for Resident #38 revealed an admission date of 01/11/24 with diagnoses including type two diabetes mellitus, major depressive disorder, adult failure to thrive, hypertension, gastroesophageal reflux disease, and morbid obesity. Review of the physician's orders for Resident #38 identified orders for a consistent carbohydrate diet with double entree portions effective 01/10/24. Review of the nutritional care plan, revised 01/14/26, revealed Resident #38 was at risk for altered nutritional status related to depression, adult failure to thrive, hypertension, gastroesophageal reflux disease, morbid obesity, altered nutrition related lab values, history of weight loss, and increased nutrient needs. Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 01/15/24. Review of the dietary assessment note dated 04/14/26 at 3:50 P.M. revealed Resident #38 received a consistent carbohydrate diet with double portions. 10. Review of the medical record for Resident #46 revealed an admission date of 07/16/25 with diagnoses including type two diabetes mellitus, end stage renal disease, morbid obesity, cancer, major depressive disorder, hypertension, and gastroesophageal reflux disease. Review of the nutritional care plan, revised 08/13/25, revealed Resident #46 was at risk for altered nutritional status related to type two diabetes mellitus, end stage renal disease on hemodialysis, (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cancer, major depression, hypertension, gastroesophageal reflux disease, and history of weight loss. Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 07/22/25. Review of the physician's orders for Resident #46 identified orders for renal consistent carbohydrate diet with double portions of protein and vegetables effective 12/09/25. Review of the dietary assessment note dated 04/21/26 at 10:53 A.M. revealed Resident #46 was on a renal consistent carbohydrate diet with double portions of protein and vegetables. 11. Review of the medical record for Resident #47 revealed an admission date of 11/22/23 with diagnoses including type two diabetes mellitus, dementia, anxiety, morbid obesity, major depressive disorder, gastroesophageal reflux disease, and hypertension. Review of the physician's orders for Resident #47 identified orders for consistent carbohydrate diet with double protein portions effective 02/03/25. Review of the nutritional care plan, revised 02/11/26, revealed Resident #47 was at risk for altered nutritional status related to type two diabetes mellitus, hyperkalemia, lymphedema, morbid obesity, depression, gastroesophageal reflux disease, hypertension, and history of significant weight changes. Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 11/27/23. Review of the dietary assessment note dated 03/18/26 at 8:33 A.M. revealed Resident #47 received a consistent carbohydrate diet with double protein portions. 12. Review of the medical record for Resident #50 revealed an admission date of 02/18/26 with diagnoses including chronic obstructive pulmonary disease, obesity, chronic respiratory failure, hyperlipidemia, atrial fibrillation, end stage renal disease, dependence on renal dialysis, and type two diabetes mellitus. Review of the physician's orders for Resident #50 identified orders for renal consistent carbohydrate diet with double protein portions effective 04/27/26. Review of the nutritional care plan, revised 04/28/26, revealed Resident #50 was at risk for altered nutritional status related to respiratory failure, obesity, hyperlipidemia, atrial fibrillation, end stage renal disease on hemodialysis, type two diabetes mellitus, gastroesophageal reflux disease, and increased nutrient needs. Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 02/24/26. Review of the dietary assessment note dated 05/25/26 at 10:45 A.M. revealed Resident #50 was on a renal consistent carbohydrate diet with double protein portions. 13. Review of the medical record for Resident #56 revealed an admission date of 01/22/24 with diagnoses including vitamin D deficiency, major depressive disorder, hypertension, cardiomegaly, gastroesophageal reflux disease, and schizophrenia. Review of the physician's orders for Resident #56 identified orders for regular diet with double entree portions effective 01/22/24. Review of the nutritional care plan, revised 10/29/25, revealed Resident #56 was at risk for altered nutritional status related to vitamin D deficiency, depression, hypertension, cardiomegaly, gastroesophageal reflux disease, schizophrenia, and history of significant weight changes. Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 01/28/24. Review of the dietary assessment note dated 04/22/26 at 1:46 P.M. revealed Resident #56 received a regular diet with double entree portions. 14. Review of the medical record for Resident #63 revealed an admission date of 02/17/25 with diagnoses including chronic kidney disease, severe protein calorie malnutrition, dependence on renal dialysis, crohn's disease, major depressive disorder, and dysphagia. Review of the physician's orders for Resident #63 identified orders for a no added salt diet with double entree portions effective 12/02/25. Review of the dietary assessment note dated 03/04/26 at 8:06 A.M. revealed Resident #63 was reliant on dialysis and received a no added salt diet with double entree portions. Review of the nutritional care plan, revised 03/04/26, revealed Resident #63 was at risk for altered nutritional status related to severe protein calorie malnutrition, crohn's disease, chronic kidney disease, underweight status, history of total parenteral nutrition use, history of significant weight loss, and refusing renal diet restrictions. Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 02/18/25. 15. Review of the medical record for Resident #69 revealed an admission date of 01/08/24 with diagnoses including protein calorie malnutrition, chronic obstructive pulmonary disease, type two diabetes (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mellitus, iron deficiency anemia, vitamin D deficiency, major depressive disorder, and hypertension. Review of the physician's orders for Resident #69 identified orders for regular diet with double entree portions effective 11/08/25. Review of the nutritional care plan, revised 01/14/26, revealed Resident #69 was at risk for altered nutritional status related to protein calorie malnutrition, chronic obstructive pulmonary disease, type two diabetes mellitus, iron deficiency anemia, vitamin D deficiency, depression, hypertension, and history of weight loss. Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 01/09/24. Review of the dietary assessment note dated 04/13/26 at 6:07 P.M. revealed Resident #69 received a regular diet with double entree portions. 16. Review of the medical record for Resident #74 revealed an admission date of 10/07/25 with diagnoses including alcohol dependence, major depressive disorder, gastroesophageal reflux disease, and hypertension. Review of the physician's orders for Resident #74 identified orders for a regular diet with double entree portions effective 10/07/25. Review of the nutritional care plan, revised 02/24/26, revealed Resident #74 was at risk for altered nutritional status related to multiple amputations, depression, gastroesophageal reflux disease, hypertension, alcohol use, and history of weight changes. Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 10/13/25. 17. Review of the medical record for Resident #84 revealed an admission date of 07/24/18 with diagnoses including morbid obesity, schizophrenia, gastroesophageal reflux disease, dementia, major depressive disorder, hypertension, and dysphagia. Review of the physician's orders for Resident #84 identified orders for regular diet with double entree portions effective 08/05/24. Review of the dietary assessment note dated 04/13/26 at 7:13 P.M. revealed Resident #84 received a regular diet with double entree portions. Review of the nutritional care plan, revised 05/18/26, revealed Resident #84 was at risk for altered nutritional status related to schizophrenia, hyperlipidemia, depression, dysphagia, dementia, hypertension, morbid obesity, and significant weight loss. Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 09/08/25. 18. Review of the medical record for Resident #89 revealed an admission date of 01/17/14 with diagnoses including dementia, vitamin D deficiency, chronic obstructive pulmonary disease, schizophrenia, major depressive disorder, hypertension, gastroesophageal reflux disease, and cognitive communication deficit. Review of the physician's orders for Resident #89 identified orders for regular diet with double entree portions effective 01/17/24. Review of the nutritional care plan, revised 10/22/25, revealed Resident #89 was at risk for altered nutritional status related to dementia, chronic obstructive pulmonary disease, depression, schizophrenia, hypertension, vitamin D deficiency, gastroesophageal reflux disease, and obesity. Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 01/22/24. 19. Review of the medical record for Resident #90 revealed an admission date of 04/05/24 with diagnoses including dementia, hypothyroidism, obesity, hyperlipidemia, and altered mental status. Review of the physician's orders for Resident #90 identified orders for regular diet with double entree portions effective 01/22/25. Review of the nutritional care plan, revised 01/14/26, revealed Resident #90 was at risk for altered nutritional status related to hypothyroidism, hyperlipidemia, dementia, altered mental status, obesity, and history of significant weight changes. Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 04/11/24. Review of the dietary assessment note dated 04/13/26 at 3:03 P.M. revealed Resident #90 received a regular diet with double portions. 20. Review of the medical record for Resident #94 revealed an admission date of 02/19/26 with diagnoses including anemia, alcohol abuse, cocaine abuse, rhabdomyolysis, and chronic kidney disease. Review of the physician's orders for Resident #94 identified an order for regular diet with double entree portions effective 02/19/26. Review of the dietary assessment note dated 05/20/26 at 10:59 A.M. revealed Resident #94 received a regular diet with double entree portions. Review of the nutritional care plan, revised 05/20/26, revealed Resident #94 was at risk for altered nutritional status related to chronic kidney disease, anemia, alcohol and drug abuse, and rhabdomyolysis. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 02/24/26. 21. Review of the medical record for Resident #95 revealed an admission date of 08/06/21 with diagnoses including hyperlipidemia, atrial fibrillation, gastroesophageal reflux disease, major depressive disorder, anemia, vitamin D deficiency, hypertension, and peripheral vascular disease. Review of the physician's orders for Resident #95 identified orders for a regular diet with double entree effective 08/06/21. Review of the nutritional care plan, revised 01/07/26, revealed Resident #95 was at risk for altered nutritional status related to atherosclerosis, anxiety, depression, vitamin D deficiency, peripheral vascular disease, anemia, hypertension, and history of significant weight changes. Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 03/17/22. Review of the dietary assessment note dated 04/08/26 at 4:16 P.M. revealed Resident #95 received a regular diet with double entree portions. 22. Review of the medical record for Resident #106 revealed an admission date of 11/24/21 with diagnoses including parkinson's disease, protein calorie malnutrition, vitamin B12 deficiency anemia, vitamin D deficiency, major depression disorder, and hypertension. Review of the physician's orders for Resident #106 identified orders for a regular diet with double entree portions effective 06/25/23. Review of the nutritional care plan, revised 04/01/26, revealed Resident #106 was at risk for altered nutritional status related to protein calorie malnutrition, parkinson's disease, hyponatremia, hypotension, appetite stimulant use, and history of significant weight changes. Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 11/30/21. Review of the dietary assessment note dated 04/01/26 at 3:52 P.M. revealed Resident #106 received a regular diet with double entree portions. The note indicated Resident #106 had non-significant weight loss at 90 days and 180 days and continued on an appetite stimulant and oral nutritional supplements. 23. Review of the medical record for Resident #108 revealed an admission date of 02/05/26 with diagnoses including end stage renal disease, dependence on renal dialysis, hemiplegia and hemiparesis following cerebral infarction, congestive heart failure, hypotension, and major depressive disorder. Review of the physician's orders for Resident #108 identified orders for a regular diet with double protein portions effective 05/05/26. Review of the dietary assessment note dated 05/13/26 at 4:44 P.M. revealed Resident #108 received a regular diet with double protein portions added since last nutritional review. Review of the nutritional care plan, revised 05/13/26, revealed Resident #108 was at risk for altered nutritional status related to end stage renal disease, cerebral infarction with hemiplegia, congestive heart failure, hyperlipidemia, overweight status, dialysis reliant, and abnormal labs. Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 02/09/26. 24. Review of the medical record for Resident #119 revealed an admission date of 05/16/26 with diagnoses including type two diabetes mellitus, morbid obesity, chronic obstructive pulmonary disease, respiratory failure, dependence on ventilator, major depressive disorder, hypertension, gastroesophageal reflux disease, chronic kidney disease, and long term use of insulin. Review of the physician's orders for Resident #119 identified orders for a consistent carbohydrate diet with double entree portions effective 05/15/26. Review of the nutritional care plan, revised 05/18/26, revealed Resident #119 was at risk for altered nutritional status related to chronic obstructive pulmonary disease, morbid obesity, type two diabetes mellitus, depressive disorder, hyperlipidemia, hypertension, gastroesophageal reflux disease, tachycardia, and insomnia. Interventions included provide meals and snacks based on resident food preferences and physician orders initiated 05/18/26. Review of the dietary assessment note dated 05/18/26 at 10:20 A.M. revealed Resident #119 received a consistent carbohydrate diet. The note indicated double entree portions would be added to meals. On 5/19/26 at 12:16 P.M., an observation of the lunch meal tray line revealed [NAME] #405 used a #16 scoop to serve cheese raviolis and [NAME] #405 counted to ensure residents received 10 raviolis. Further observation of the trayline revealed residents with orders for double portions were served 15 raviolis. On 05/19/26 at 12:16 P.M., interview at the time of observation with [NAME] #405 said the production sheet indicated a #16 scoop was to be used to (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to accurately document the care for facility residents. This affected five residents (Residents #4, #87, #113, #120, and #121) of nine closed records reviewed and 34 open records reviewed. The facility census was 107. Findings include: 1. Resident #4 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis after a stroke affecting the right dominant side, diabetes, a gastrostomy (a surgical incision to the stomach used to provide nutrition to the resident), atrial fibrillation, diabetes, high blood pressure, neuromuscular dysfunction of the bladder, and convulsions. The resident was transferred to the emergency room (ER) on [DATE] and did not return. Review of the quarterly comprehensive Minimum Data Set (MDS) 3.0 assessment, dated [DATE], revealed Resident #4 was rarely/never understood, was dependent on staff for all care, and has a feeding tube. Review of the nursing progress notes revealed on [DATE] at 5:49 A.M. Registered Nurse (RN) #301 documented she assessed Resident #4 around 5:00 A.M. and found the resident's eyes were fixed to the right and her arm was stiff. The resident's blood pressure was 149/99 (normal range 120/80), her heart rate was 135, her respirations were 22, and her oxygen saturation level was 94% on room air (normal is 93% to 100% on room air). The resident did not respond to stimuli. Emergency Medical Services (EMS) were called and the resident was transferred to a local ER. The emergency contact and the nurse practitioner were notified. No further information was documented regarding what happened to the resident after transfer. Interview with the Director of Nursing (DON) on [DATE] at 3:05 P.M. revealed the expectation was for nurses to document whether the resident was admitted to the hospital, transferred elsewhere, or discharged back to the facility, confirming Resident #4's medical record did not contain complete record of what happened to the resident after the hospital transfer. Review of the facility's undated Documentation: Charting policy revealed the clinical record is a legal document and may be used as evidence in law courts. It is essential the record be accurate, legible, and complete. The medical record should have documentation regarding admission, transfer, and discharge as well as any follow up actions to nursing observations. 2. Resident #87 was admitted to the facility on [DATE] with diagnoses including postsurgical malabsorption, chronic kidney disease, major depressive disorder, history of malignant neoplasm of the thyroid, gastric reflux, and hypothyroidism. Review of the quarterly comprehensive Minimum Data Set (MDS) 3.0 assessment, dated [DATE], revealed Resident #87 was cognitively intact, was able to provide his own personal care needs, and has had a significant weight gain over the previous six months. Review of the physician's orders for Resident #87 revealed an order dated [DATE] for Total Parental Nutrition (TPN—an intravenous infusion providing nutrition to keep the body nourished and allow the digestive system to rest) to infuse through a central venous catheter (CVC) to infuse 2280 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	milliliters (ml) over 12 hours at 165 ml per hour. A registered nurse (RN) was to draw labs from the right CVC prior to administering the TPN on Monday and Thursday evenings. Review of the Medication Administration Record (MAR) for April, May, and [DATE] for Resident #87, revealed numerous dates of the resident's TPN infusion being marked as other/see progress notes. The dates marked as this were [DATE], [DATE], [DATE], [DATE] through [DATE], [DATE] through [DATE], [DATE] through [DATE], [DATE], [DATE] through [DATE], [DATE], [DATE], [DATE] through [DATE], [DATE] through [DATE], and[DATE] through [DATE]. Review of the nursing progress notes from [DATE] through [DATE] revealed Licensed Practical Nurse (LPN) #412 documented Resident #87's TPN infusion was administered by whoever the RN scheduled to work that night was. The RN who hung the TPN infusion did not sign off that they started the infusion. Interview with the DON on [DATE] at 2:27 P.M. revealed LPN # 412 was not able to hang the TPN infusion as it must be administered by an RN. LPN #412 marked the MAR as see progress notes and documented the RN was who started the infusion. When asked why the RN who started the infusion did not sign off the infusion was started, the DON replied she did not know but it should be documented by the RN who administered it. Review of the facility's undated Documentation: Charting policy revealed the clinical record is a legal document and may be used as evidence in law courts. It is essential the record be accurate, legible, and complete. The documentation should record care given including, but not limited to, medications and treatments. 3. Resident #120 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia (low oxygen levels in the blood), diabetes, chronic kidney disease, high blood pressure, vascular dementia without behavioral disturbance, prostate cancer, a cerebral aneurysm, a gastrostomy (a surgically placed tube placed into the stomach to allow feeding through a tube), and neuromuscular dysfunction of the bladder. The resident was transferred to the ER on [DATE] and did not return to the facility. Review of the physician's orders revealed Resident #120's head of the bed must be elevated to at least 30 degrees to allow for easier breathing related to his diagnosis of COPD as well as the fact he received a tube feeding for nutrition and elevating the head of the bed assists in preventing aspiration of the tube feeding. Labs were drawn on [DATE] for a blood count, a complete metabolic profile, and blood cultures. Resident #120 also received five liters of oxygen via nasal cannula continuously. The resident also had an order a breathing treatment of Ipratropium-Albuterol 0.5-2.5 milligrams (mg) per three milliliters (ml) via inhalation treatment every four hours as need for shortness of breath or wheezing. The resident also had several wounds for which he received daily dressing changes. Review of the comprehensive quarterly Minimum Data Set (MDS) 3.0 assessment, dated [DATE], revealed Resident #120 was rarely/never understood, was dependent upon staff for all care, exhibited no indicators of pain, and received oxygen continuously. Review of the nursing progress notes revealed Resident #120 was readmitted to the facility on [DATE] with wounds to his sacrum, both heels, and left anterior forearm. The resident also had a peripheral intravenous (IV) line inserted through which he was receiving an IV antibiotic for a urinary tract infection. On [DATE] at 5:00 P.M. Registered Nurse (RN) #350 completed a Change in Condition (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	template indicating Resident #120 was tachypneic (fast respirations) and tachycardic (fast heart rate) starting on [DATE] at night. RN #350 assessed the resident's vital signs. His blood pressure was 114/66 (normal range), a heart rate of 136, a respiratory rate of 28, and a temperature of 97.4 degrees Fahrenheit. His oxygen level was 94% on room air. His blood sugar was 229 which was high. Upon entering the resident's room RN #350 noted Resident #120 was breathing fast and heard crackles (an abnormal, clicking, bubbling, or popping sounds heard during breathing typically indicating the presence of fluid, mucus, or pus in the airways) in the base of his lungs. RN #350 contacted Nurse Practitioner (NP) #506 who said to transfer the resident to the ER for evaluation. No further information was documented on what occurred after transfer. Interview with the DON on [DATE] at 3:05 P.M. revealed the expectation was for nurses to document whether the resident was admitted to the hospital, transferred elsewhere, or discharged back to the facility, confirming Resident #120's record lacked evidence of what transpired after hospital transfer. Review of the facility's undated Documentation: Charting policy revealed the clinical record is a legal document and may be used as evidence in law courts. It is essential the record be accurate, legible, and complete. The medical record should have documentation regarding admission, transfer, and discharge as well as any follow up actions to nursing observations. 4. Resident #121 was admitted to the facility on [DATE] and was transferred to the hospital on [DATE] and did not return to the facility. Admitting diagnoses included acute and chronic respiratory failure, morbid obesity, a peritoneal abscess, diverticulitis of the large intestine with perforation and an abscess with bleeding, high blood pressure, chronic kidney disease, hypothyroidism, lymphedema, and a colostomy (a surgically inserted opening to the bowels to allow for stool to drain from the body). Review of the Medicare 5 Day comprehensive Minimum Data Set (MDS) 3.0, dated [DATE], revealed Resident #121 was cognitively intact, was dependent for toileting, was admitted with a pressure ulcer, had surgical wounds, as well as moisture associated skin damage, and received IV medications, as well as occupational and physical therapy. Review of the nursing progress notes revealed on [DATE] Resident #121 on [DATE] at 2:00 P.M. revealed a change in condition occurred. The resident had low blood pressure and developed chills while in physical therapy. Her blood pressure was 76/50 (normal is 120/80). The resident requested to be transferred to the emergency room (ER) and was transferred as requested. No further information is documented in the chart regarding what happened to the resident after the request for a transfer to the ER was approved. Interview with the DON on [DATE] at 3:05 P.M. revealed the expectation was for nurses to document whether the resident was admitted to the hospital, transferred elsewhere, or discharged back to the facility, confirming Resident #121's record lacked evidence of what transpired after hospital transfer. Review of the facility's undated Documentation: Charting policy revealed the clinical record is a legal document and may be used as evidence in law courts. It is essential the record be accurate, legible, and complete. The medical record should have documentation regarding admission, transfer, and discharge as well as any follow up actions to nursing observations. 5. Review of the medical record for Resident #113 revealed an admission date of [DATE] with diagnoses including chronic respiratory failure, dependence on ventilator, type two diabetes mellitus, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dependence on renal dialysis, hypertension, and history of venous thrombosis and embolism. Review of the respiratory therapy progress note dated [DATE] at 1:55 P.M. revealed respiratory therapy responded to Resident #113's vent alarm and found the resident bucking the vent, suctioning produced nothing, the resident had no pulse, and her skin was cold and clammy. Cardiopulmonary resuscitation (CPR) was started within a few minutes while Resident #113 was on a body board flat on her bed. Emergency medical services (EMS) were called, Resident #113's pulse returned, and the resident was transported to the hospital. Review of the nursing progress note dated [DATE] at 3:24 P.M. indicated Resident #113 had a change in condition in the afternoon identified by respiratory therapy, the resident was unresponsive with no pulse, and CPR was initiated. The resident's pulse returned and EMS transported Resident #113 to the hospital. The vital signs recorded regarding the change in condition were as follows: pulse was 98 on [DATE] at 1:26 A.M., oxygen saturation was 98% on [DATE] at 1:26 A.M., blood pressure was 106/59 on [DATE] at 1:29 A.M., respirations were 18 on [DATE] at 1:29 A.M., temperature was 97.6 degrees on [DATE] at 1:29 A.M., and there were no vital signs in the nurse's note documented as obtained in the afternoon when the change in condition occurred. The note indicated Resident #113's daughter was notified of the change in condition on [DATE] at 1:55 A.M. The note also indicated Nurse Practitioner (NP) #506 was notified of the change in condition on [DATE] at 2:00 A.M. On [DATE] at 11:20 A.M., an interview with DON confirmed Resident #113 coded on [DATE] and there were discrepancies in the notes regarding the time of the incident and notifications. On [DATE] at 11:58 A.M., an interview with DON confirmed the nurse inaccurately documented the times for the change in condition and notification times for Resident #113's code blue, stating the documented notifications and vital signs should have been recorded for P.M. and not A.M. This deficiency represents non-compliance investigated under Complaint Number 2746747.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews, review of facility policy, and review of the Center for Disease Control and Prevention (CDC) guidelines for transmission-based precautions, the facility failed to follow infection control standards during wound care, which affected one resident (#9) out of five reviewed for pressure ulcers. In addition, the facility failed to ensure staff wore appropriate personal protective equipment (PPE) while providing care to residents on contact isolation, which affected one resident (#81) out of four identified by the facility as having orders for contact isolation. The facility census was 107. Findings include: 1. Review of the medical record for Resident #81 revealed an admission date of 10/06/25 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, systemic lupus, aphasia, locked-in syndrome, gastrostomy status, and extended spectrum beta lactamase (ESBL) resistance. Review of the physician's orders for Resident #81 identified orders for contact precautions related to multi-drug resistant organism (MDRO) effective 03/29/26. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #81 had severely impaired cognitive skills for daily decision making and required dependence on staff for activities of daily living (ADLs). Review of the ADL care plan, revised 05/06/26, revealed Resident #81 had an ADL self-care deficit related to generalized weakness, impaired mobility, locked-in syndrome, and cerebrovascular accident. Interventions included assist with ADLs as needed initiated 10/07/25, report changes in ADL abilities to the nurse, physician, or therapy initiated 10/07/25, and two person assistance with bed mobility initiated 02/24/26. Review of the infection care plan, revised 05/17/26, revealed Resident #81 had the potential for infection related to a history of ESBL. Interventions included contact isolation precautions initiated 03/11/26, multi-drug resistant organism (MDRO) initiated 03/11/26, and to monitor and report to the physician any worsening signs or symptoms of MDRO infection initiated 03/11/26. Review of the medication administration record (MAR) for May 2026 revealed contact precautions were marked as administered every shift. On 05/17/26 at 10:53 A.M., an observation of Resident #81's room revealed a yellow sign on the door indicating to see the nurse before entering the room and there was a bin of personal protective equipment (PPE) outside the room. On 05/17/26 at 2:40 P.M., an observation of Resident #81's room revealed Registered Nurse (RN) #416 entered Resident #81's room without donning a gown or gloves prior to entering the room. Once in the room, RN #416 applied gloves to her hands and hooked up Resident #81's enteral feeding tube. After hooking up the enteral feeding tube, RN #416 took the gloves off and exited the room without performing hand hygiene. On 05/17/26 at 2:42 P.M., an interview with RN #416 confirmed the observation, stating she thought Resident #81 was only on enhanced barrier precautions for foley catheter care and it was not required for any other care. RN #416 said she did not know Resident #81 was ordered contact isolation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/26/26 at 12:03 P.M., an observation of Resident #81's room revealed Certified Nursing Assistant (CNA) #327 entered Resident #81's room to answer the call light without applying PPE. CNA #327 repositioned Resident #81 in her chair and then entered the in-room bathroom to wash her hands. At 12:04 P.M., CNA #426 entered Resident #81's room without applying PPE and asked CNA #327 what the resident needed. While talking with CNA #327, CNA #426 adjusted the positioning of Resident #81's touch pad call light on her lap. On 05/26/26 at 12:04 P.M., a combined interview with CNA #327 and CNA #426 verified the observation, claiming Resident #81's contact isolation was removed. Neither CNA #327 or CNA #426 was able to state what the yellow sign on the door was for. At 12:05 P.M., CNA #327 asked Licensed Practical Nurse (LPN) #335 if Resident #81 was still on contact isolation and LPN #335 replied no and said it was discontinued. On 05/26/26 at 12:07 P.M., an interview with Assistant Director of Nursing (ADON) #375 verified Resident #81 still had active physician's orders for contact isolation related to MDRO. Review of the facility's policy titled Isolation - Initiating Transmission-Based Precaution, not dated, indicated transmission-based precautions (TBP) would be initiated when there was reason to believe a resident had a communicable infectious disease and types of TBP included contact precautions, droplet precautions, and airborne precautions. The policy indicated TBP would remain in effect until the attending physician or infection preventionist discontinued them, which would only occur after pertinent criteria for discontinuation was met. Review of the Center for Disease Control and Prevention (CDC) guidelines for transmission-based precautions, dated 04/03/24, revealed contact precautions would be used for patients with known or suspected infections that represent an increased risk for contact transmission. The guidelines indicated personal protective equipment would be used, including gloves and gown, for all interactions that may involve contact with the patient or the patient's environment. 2. Review of Resident #9's medical records revealed an admission date of 12/17/25 and a readmission date of 05/09/26. Diagnoses included difficulty walking, muscle weakness, dysphagia (difficulty swallowing) and need for personal care assistance. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 had no cognition score due to resident was rarely understood. Resident #9 was dependent with toileting, bathing, personal hygiene and transfers and was incontinent of bowel and bladder. Review of Resident #9's skin assessment dated [DATE] revealed an unstageable pressure ulcer to the right heel. Review of physician orders for May 2026 revealed to cleanse Resident #9's right heel with normal saline, apply calcium alginate (absorbent wound dressing), Medihoney (wound care ointment), cover with an absorbent dressing, and wrap with kerlix (gauze roll) every dayshift and as needed. Observation of wound care on 05/18/26 at 2:19 P.M. with Registered Nurse (RN) #350 revealed she had gathered Resident #9's wound care supplies and had placed them on the residents bed. RN #350 had obtained a pair of non wound care scissors from her pocket and had proceeded to remove Resident #9's kerlix dressing and had not disinfected the scissors prior to cutting the bandage. RN #350 had removed Resident #9's dressing and had cleansed the wound with normal saline and had (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then proceeded to place the calcium alginate on Resident #9's wound. RN #350 had then placed the absorbent dressing on Resident #9's right heel and wrapped the area in the kerlix. RN #350 did not change her gloves or perform hand hygiene after cleansing the wound and applying the new dressing. Interview with RN #350 after completion of wound care on 05/18/26 at 2:56 P.M. confirmed the observations and RN #350 stated she should have disinfected the scissors prior to removing the bandage, should not have placed the wound care supplies on the residents bed and should have removed her gloves and performed hand hygiene after cleaning the wound and before applying a new dressing. This deficiency represents non-compliance investigated under Complaint 2992281.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review, interview, and review of facility policy for influenza vaccine, the facility failed to administer the influenza vaccine to Resident #3 after consent was given. This affected one resident (#3) out of five reviewed for immunizations. The facility census was 107. Findings include: Review of the medical record for Resident #3 revealed an admission date of 12/29/25 with diagnoses including chronic obstructive pulmonary disease, morbid obesity, anxiety, and tracheostomy status. Review of Resident #3's Vaccine Informed Consent Form (CRNF) - V 3, dated 12/31/25, revealed Resident #3 consented to receive the influenza vaccine. Review of the immunizations section of Resident #3's electronic medical record revealed No data available. On 06/02/26 at 1:06 P.M., an interview with Director of Nursing (DON) confirmed Resident #3 consented to receive the influenza vaccine on 12/31/25. DON said vaccines were documented in the immunizations section of the electronic medical record and verified Resident #3's immunization section indicated there was no data available. On 06/02/26 at 1:29 P.M., an interview with DON confirmed Resident #3 did not receive the influenza vaccination after providing consent. Review of the facility policy titled Influenza Vaccine - Residents, not dated, indicated residents who had no contraindications to the vaccine would be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. The policy indicated between October and March of each year, the influenza vaccine would be offered to residents unless the vaccine was medically contraindicated. The date of the vaccination, lot number, person administering the vaccine, and the site of vaccination would be documented in the medical record. Administration of the influenza vaccine would be made in accordance with current Center for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain resident bathing facilities in proper functioning order. This had the potential to affect all 107 residents in the facility. Findings include: 1. On 05/17/26 at 3:20 P.M., an observation of the shower room by room [ROOM NUMBER] revealed a sign on the door indicating the shower room was closed until further notice and there was no date on the sign. On 05/17/26 at 3:20 P.M., an interview with Licensed Practical Nurse (LPN) #388 confirmed that shower room was out of order and had been for as long as she had been working at the facility, which she stated was about one year. On 05/20/26 at 11:10 A.M., an observation of the shower room by room [ROOM NUMBER] revealed a walk-in tub in the middle of the shower room. An interview at the time of observation with Regional Maintenance Director #503 stated it needed repairs and they were not going to fix it because the census was low. On 05/20/26 at 12:13 P.M., an interview with Director of Nursing (DON) stated the shower room had been out of order since she began working at the facility over one year ago. DON confirmed that shower room was the only shower room in the facility with a tub. On 05/20/26 at 12:19 P.M., an interview with DON said that shower room had been non-functional since the current owner took over the facility. On 05/20/26 at 1:57 P.M., an interview with Administrator confirmed the shower room had been out of order for a while. On 05/26/26 at 11:31 A.M., an interview with Assistant Director of Nursing (ADON) #375 stated she had worked at the facility for 10 years and the shower room containing the tub had been out of order the entire time. ADON #375 said in the 10 years she had been there, she only saw that tub used one time to bathe a dying resident whose last request was to receive a tub bath. 2. On 05/17/26 at 3:32 P.M., an observation of the shower room by room [ROOM NUMBER] revealed displaced tiles at the bottom of the shower and a hole that went all the way into the wall at the bottom of the wall below the shower head. On 05/17/26 at 3:32 P.M., an interview with LPN #390 verified the displaced tiles and hole in the wall in the shower by room [ROOM NUMBER]. This deficiency represents non-compliance investigated under Complaint Number 2746747.