STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365699	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Club Retirement Ctr IV	55801 Conno-Mara Drive Bellaire, OH 43906

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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 - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, review of hospice notes, review of photos, review of pharmacy records, policy review, and interviews, the facility failed to ensure Resident #40 received adequate and necessary care and services for end-of-life care. This affected one resident (#40) of three residents reviewed for quality care and services.Actual harm was identified on 11/26/25 involving Resident #40, who was admitted to the facility for end of life care and hospice services. The facility failed to ensure the resident received comprehensive assessments and adequate monitoring of his condition, including evaluation and management of ongoing pain and anxiety associated with his terminal illnesses. The facility did not implement or administer the ordered treatments and medications necessary to promote comfort and symptom relief. As a result, the resident experienced continued anxiety and unrelieved pain, necessitating transfer to an inpatient hospice facility on 11/27/25. The resident expired on 11/28/25.Findings include:Closed medical record review revealed Resident #40 was admitted to the facility from an inpatient hospice facility on 11/26/25 at 10:21 A.M. with diagnoses including pancreatic cancer, secondary malignant neoplasm of liver and intrahepatic bile duct, history of skin cancer, hypertension, diabetes, depression, and urinary tract infection. The resident was receiving hospice services at the time of admission. The resident was discharged from the facility on 11/27/25 at 2:15 P.M. back to the inpatient hospice facility.Review of Resident #40's hospice packet (location prior to his admission to the long-term care facility) revealed a code status form dated 10/29/25 that identified the resident's code status was Do Not Resuscitate (DNR) Comfort Care.Review of Resident #40's hospice transfer information dated 11/21/25 (prior to the resident's admission to the long-term care facility on 11/26/25) revealed the resident's primary diagnosis was malignant neoplasm of pancreas and he was not a candidate for chemotherapy due to worsening liver function. The resident was hopeful for treatment and was noted to be tearful, felt depressed, and was losing the desire to live due to his prognosis, pain, and symptoms. He had grimacing and stated the pain was seven (7) out of ten (10) in his abdomen. The pain was severely impacting his daily life by his inability to perform activities of daily living. He was struggling with insomnia due to the pain. He had developed a Stage II pressure ulcer to his coccyx. The resident was hoping for his pain to be a zero (0). The resident was totally bed bound, unable to do any activity, and required total care. The resident's level of consciousness was full or drowsy sometimes confused. The (resident's) wife's biggest concern was the resident being comfortable. The resident's active medications included (but were not limited to): acetaminophen 650 mg every twelve hours for pain, aspirin 81 (nonsteroidal anti-inflammatory) milligrams (mg) daily, mirtazapine (depression) 15 mg at bedtime, oxycodone (narcotic pain medication) 5 mg every six hours as needed for pain , morphine 15 mg 0.5 tablet by mouth sublingual every four hours as needed for pain or shortness of breath, and senna 8.6 mg 1-2 tabs daily as needed for constipation. The resident had urinary foley catheter that may be irrigated with normal saline as needed and changed every thirty days and as needed.Review of hospice attending physician form dated 11/25/25 revealed the patient representative changed attending physician from the facility's hospice provider to the facility's long-term care facility's provider. Review of hospice facility assessment dated [DATE] (the day prior to the resident's admission to the (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	long-term care facility) revealed the resident had facial grimacing, rapid respirations, thrashing, labored breathing, hyperventilation, fists clenched, rigid, knees pulled up, pulling or pushing away, and striking. He was alert, agitated, restless, confused, and disoriented. His urine had a strong smell and a foley catheter was inserted with 550 milliliters (ml) return, he required aspiration precautions and had wounds. He was totally dependent on staff and was a fall risk. Review of hospice facility medication administration records dated 11/25/25 and 11/26/25 revealed on 11/25/25 the resident received Ativan and Morphine four times and one dose of MS Contin for pain, anxiety, and restlessness. On 11/26/25 (prior to admission to the long-term care facility) the resident received a dose of Roxanol (highly concentrated morphine sulfate oral solution used to treat moderate-to-severe chronic or acute pain, particularly in hospice settings) at 1:53 A.M., Ativan and Morphine at 4:47 A.M., and Roxanol and Ativan at 9:08 A.M. The resident was ordered Roxanol 20 mg every eight hours, Ativan 0.5 mg every four hours as needed, Morphine 10 mg every two hours as needed, and MS Contin 15 mg twice daily.Review of the hospice facility progress note dated 11/26/25 at 9:00 A.M., revealed the resident was unable to respond to questions. The foley catheter was patent. The resident was medicated with scheduled Roxanol 20 mg and Ativan 0.5 mg related to restlessness, facial grimacing and moaning out. The assessment indicated the resident did not have three days or less life expectancy. Report was called to the skilled facility and spoke to Licensed Practical Nurse (LPN) #200. Faxed all paperwork to number given. The resident left the hospice facility at 9:30 A.M. Spoke to LPN #200 and updated her that the Roxanol script was signed by the doctor and should be available from the facility's pharmacy. The Ativan script was electronic (e)-scribed. The resident's diet was nothing by mouth and he had no intake the last two days. Review of Resident #40's census report revealed the resident was admitted to the long-term care facility on 11/26/25 at 10:21 A.M. Review of Resident #40's nursing admission checklist dated 11/26/25 revealed the code status was blank, the consents were blank, orders were put in and verified by physician were blank, the diet was blank, nursing assessments were open but not completed, and progress note was placed in the computer. The form was not signed by the nurse. Review of Resident #40's plan of care revealed no evidence an acute plan of care was initiated for the resident. Review of Resident #40's assessment dated [DATE] revealed the following assessments were not completed (blank): admission, bowel and bladder, Braden (pressure ulcer), fall, oral, tuberculosis assessment, vitals and pain evaluation, and abnormal involuntary movement scale (AIMS), and elopement. The only comprehensive assessment completed was the functional assessment (admission and discharge) and pressure ulcer assessment dated [DATE] (the day after admission).Review of Resident #40's progress notes revealed there was a drafted note dated 11/26/25 at 1:38 P.M., authored by LPN #200 revealed the resident arrived via gurney accompanied by two staff and slid to bed. Wife arrived shortly after. Consents were signed, history obtained, and medication reviewed with the physician. No medications were ordered at this time. Morphine and Ativan for comfort. (Please note this is a contradictory statement identifying that no medications were ordered and then saying Morphine and Ativan for comfort) 14 French foley with 10 milliliter (ml) balloon patent draining dark yellow urine at this time. Hospice reported 72 hours of no intake with 200 ml urine output in the last 24 hours.Review of Resident #40's facility admission orders dated 11/26/25 revealed no evidence of medication orders (please note medications had been ordered on the hospice transfer sheet), no diet orders, or urinary catheter orders. The resident was ordered hospice services; Morphine 20 mg three times a day (6:00 A.M., 2;00 P.M., and 10:00 P.M.) for pain and shortness of breath. There was no evidence of an Ativan order per the drafted progress note on 11/26/25 at 1:38 P.M.Review of Resident #40's diet order and communication form dated 11/26/25 revealed the resident was on a pureed texture diet with pleasure foods as tolerated. The diet order (regular, no added salt, controlled carbohydrates, full liquids, clear liquids, or nothing by mouth) was blank. The communication form was signed by the previous Director of Nursing, (DON) #100.Review of Resident #40s' psychoactive medication authorization form dated 11/26/25 revealed Resident #40's wife and a facility representative had signed the section that psychoactive medications were (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	recommended by the physician and had been discussed with her, and she agreed to the use of the psychoactive medication as described to her and she understood the diagnosis and reasons for use of this/these medications.Review of Resident #40's Morphine control sheet dated November 2025 revealed the Morphine 20 mg was signed out at 7:30 P.M. on 11/26/25, 6:00 A.M., on 11/27/25, and 1:50 P.M. on 11/27/25. However, the 1:50 P.M. dose on 11/27/25 was not signed off/documented on the medication administration record as having been administered.Review of Resident #40's medication and treatment administration record dated November 2025 revealed the resident received two doses of Morphine 20 mg (one at bedtime on 11/26/25 and A.M. dose on 11/27/25). The two doses were signed off by a medication technician (MT) #706 and rated the resident's pain as zero. There was no evidence of a comprehensive assessment of the resident prior to the medication administration.There was one other progress note (a warning that populated over on the progress note when there is a warning, no author identified for this warning) dated 11/26/25 that the Morphine order was outside the recommended dose or frequency and the medical director for hospice gave orders to continue as ordered. There was no evidence of any other progress notes noted for 11/26/25.Review of Resident #40's progress notes dated 11/27/25 revealed at 5:55 A.M., Morphine 20 mg was administered. At 2:10 P.M., report given to emergency transport, the resident was transferred to the cot with maximum assistance of three. Report called to hospice facility. Wife at beside. At 4:46 P.M., late note entered that the wound Nurse Practitioner (NP) saw the resident and new orders were received. Resident and family aware. There was no other documentation for 11/27/25.Review of the visiting hospice note authored by Hospice Registered Nurse (RN) #1001 dated 11/27/25 revealed per the wife she wanted the resident to go back to the hospice facility for pain control. The resident had hypoactive bowel sounds and had not taken senna (laxative) due to no (oral) intakes. Will let the skilled nursing staff know. The facility staff (LPN #208) walked in, and the resident's legs were hanging off the bed and wife was at the bedside. The hospice nurse spoke to LPN #208 regarding when his medication was due and the wife's concerns. When the hospice nurse asked how the resident was doing, LPN #208 responded, He was fine until his wife got here. LPN #208 stated the wife was unrealistic to the resident's decline. The resident's pain level was assessed as nine out of ten (1-10 scale). LPN #208 reported she had given the resident an as needed Ativan (benzodiazepine used for the treatment of anxiety) (however, there was no order, control sheet, or record that Ativan was administered) at 10:00 A.M., and he was due for his scheduled Morphine at 2:00 P.M. The wife was very upset during the visit and didn't want the resident at the facility any longer. Review of Resident #40's discharge Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was admitted on [DATE] from a hospice institutional facility and discharged on 11/27/25 back to a hospice institutional facility. The resident had severe cognition impairment. There was no response to the mood, and he had no behaviors noted. The functional status was marked dependent on staff for all activities of daily living. He had an indwelling urinary catheter and was always continent of bowels. The resident was receiving scheduled pain medication regimen, and the pain assessment interview was blank. The resident had a life expectancy of less than six months. He weighed 165 pounds and was 65 inches tall. The resident was not receiving any tube feeding, no mechanically altered diet, or no therapeutic diet. The resident was admitted with one unstageable ulcer and two deep tissue injuries. The resident received opioids and no anti-anxiety medications. Resident #40 received hospice care.Review of Resident #40's census report dated 11/27/25 revealed the resident was discharged on 11/27/25 at 2:15 P.M.Review of Resident #40's hospice facility notes revealed on 11/27/25 (after discharge from the long-term care facility) the resident received Ativan 0.5 mg and Roxanol (morphine) 20 mg upon admission at 3:00 P.M. for pain and anxiety. At 6:00 P.M., he received Morphine for pain. At 10:20 P.M, he received Ativan and Morphine for pain and restlessness. On 11/28/25 at 12:50 A.M., he received Roxanol 20mg for pain. At 2:20 A.M., he received Haldol for restlessness, Ativan for restlessness, and Morphine 10 mg for pain. At 3:10 A.M., he received Ativan for restlessness, 4:30 A.M. and 6:30 A.M., Morphine for pain. At 8:45 A.M., he received Ativan and (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Roxanol for anxiety and pain. Interview on 03/10/26 at 1:22 P.M. and 2:32 P.M., with Corporate Clinical Director (CCD) #102 confirmed there was no evidence Resident #40 had medication orders except for the Morphine. CCD #102 confirmed the admission assessment along with vitals and pain evaluation were all blank. CCD #102 confirmed no orders were signed off on the medication and treatment records except for two doses of Morphine; however, the control sheet indicated three doses were administered. Interview on 03/10/25 at 2:15 P.M. with Hospice Representative (HR) #104 confirmed Resident #40 was a resident of their 12 bed in-facility hospice unit. The resident was discharged to a skilled (long-term care facility) per the wife's request on 11/26/25; however, she requested the resident to return to the inpatient hospice facility on 11/27/25 after some concerns with staffing at the skilled facility. HR #104 reported upon discharge from the inpatient hospice facility to the long-term care facility on 11/26/25 the resident had the following medications ordered for pain: Oxycodone 5 mg as needed, Morphine 0.5 mg every four hours as needed, MS Contin 15 mg at bedtime, and Tylenol 650 mg as needed. Review of Resident #40's closed medical record revealed no evidence the resident had received these medications while at the long-term care facility.Interview on 03/11/26 at 10:21 P.M., with CCD #102 revealed she had reached out to LPN #200, who no longer worked for the facility, and she could not recall any information regarding Resident #40's admission and why she didn't complete the resident assessment or orders. CCD #102 revealed the morphine order was sent to the pharmacy on 11/26/25 at 11:44 A.M., the medication was pulled from the emergency medication box at 4:29 P.M., however the Morphine was not administered at 2:00 P.M. or 6:00 P.M. per the orders. CCD #102 confirmed the first dose of Morphine was not administered until 11/26/25 at 7:30 P.M., per the control sheet. CCD #102 confirmed the nurse never wrote the Ativan order nor was the medication administered. Interview on 03/11/26 at 1:24 P.M, with LPN #208 confirmed she was the nurse assigned to Resident #40 on 11/27/25. The LPN revealed the resident's wife had voiced concerns about not having enough supervision and fall interventions and requested the resident to be transferred back to the hospice facility. LPN #208 stated she had administered morphine to the resident due to the resident having facial grimacing and yelling out. She couldn't remember if she administered Ativan or not. LPN #208 reported she trained the medication technicians, and they could document pain levels if the resident verbalized pain rating; however, non-verbal or cognitively impaired residents would have to be assessed by the nurse. LPN #208 reported Resident #40 could not verbalize pain rating and would have been assessed by a nurse. LPN #208 reported she doesn't know why LPN #200 did not follow up on the Ativan order and stated Ativan was available in the emergency box and there should not have been a delay in administration with the Morphine or the Ativan. LPN #208 stated she had administered the 1:50 P.M. dose of Morphine on 11/27/25, however she did not sign off the Morphine on the administration record. Interview on 03/11/26 at 6:08 P.M. with Resident #40's wife revealed on 11/26/25 when she arrived at the facility at 3:00 P.M. staff were trying to force feed her husband. The resident had not eaten for two days. She stated the staff stopped feeding him immediately after she entered. She stated she had rung the call light for pain medication, but no one responded. Before she left two aides were picking up food trays and they helped reposition Resident #40 to make him more comfortable, but no one came to give him pain medication. (Per the administration record (MAR) the Morphine was not administered until 7:30 P.M on 11/26/25). On 11/27/25 she stated she could see he was in a lot of pain, so she asked for liquid morphine for pain, and staff refused. The resident had been receiving Morphine and Ativan at the hospice facility. She stated she had asked the facility about the Ativan, and it was one excuse after another why they didn't have his Ativan. The resident was yelling out in pain, restless, and trying to get out of bed. Staff reported it wasn't time for his pain medication. At this point she stated she called the hospice nurse and she came to the facility and could see he was in a lot of pain and not being properly cared for so she called the hospice facility and had him transferred back that evening. The resident's wife voiced concerns the facility refused to give him pain medication when he was actively dying. She had told two nurses about his pain and they did nothing. The wife reported she (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	only moved her husband to the facility because it was only ten minutes from her house and she didn't like to drive far in the winter weather. The wife provided photo evidence of the resident on 11/27/25 (prior to being transferred back to the hospice facility) that confirmed he was restless (trying to get up) and had facial grimacing. Interview on 03/12/26 at 8:35 A.M., with CCD #102 confirmed she had reached out to hospice to verify the resident admission orders on 11/26/25 and it was the same paperwork that was sent on 11/21/25. CCD #102 reported there were several medications on the admission orders from hospice; however, the drafted note from LPN #200 indicated no medication ordered except Morphine and Ativan for comfort. CCD #102 confirmed the Ativan order was never entered into the electronic medical record or administered. CCD #102 reported hospice did not provide updated orders when the resident was admitted on [DATE] and all the facility had was the referral orders from 11/21/26 even though the hospice notes indicated records were faxed to the facility's number on 11/26/25. On 03/12/26 at 8:35 A.M. review of photos of Resident #40 (provided to the surveyor by the resident's wife) and shared with CCD #102 confirmed the photos were taken at the facility. CCD #102 confirmed the photos of Resident #40 which showed in one photo evidence the resident was at the edge of the bed, a second photo which reflected the resident was in pain as evidenced by the resident's facial expression, and a third photo of the pressure area on the resident's buttocks as evidenced by the staff initials on the dressing was one of the facility's employees.Interview on 03/12/26 at 2:14 P.M., with Pharmacy Technician #900 confirmed the facility's pharmacy had received a script on 11/26/25 for Morphine and two additional scripts on 11/28/25 for Morphine and Ativan; however, the scripts on 11/28/25 were not sent to the facility because the resident had already been discharged . Interview on 03/16/26 at 4:00 P.M., with Hospice Representative (HR) #104 confirmed the hospice nurse had submitted orders for Morphine and Ativan prior to the resident's arrival to the nursing home facility on 11/26/25.Interview on 03/16/26 at 4:05 P.M., with Director of Nursing (DON) #103 confirmed the photos provided by Resident #40's wife to the surveyor were taken in the facility. The DON confirmed the photo reflected the resident was in pain as evidenced by the resident's facial expression in the photos. Review of the facility's policy and procedure titled, Pain Management Program, last revised 03/19/25 revealed that based on a resident's comprehensive assessment, the facility would provide treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management.This deficiency represents non-compliance investigated under Master Complaint Number 2789590 and Complaint Number 2785293.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of concerns form, observation, interview, and policy review the facility failed to implement appropriate pressure relieving interventions timely to prevent pressure ulcers and failed to identify and treat pressure ulcer. This affected one resident (#28) of three residents reviewed for pressure ulcers.Findings Include:Medical record review revealed Resident #28 was admitted to the facility on [DATE] and re-admitted on [DATE] after sustaining a fall with left femur fracture. Review of Resident #28's risk for skin breakdown related to peripheral vascular disease and incontinence plan of care dated 03/02/18 and revised on 11/29/22 revealed weekly skin assessments, pressure redistribution mattress to bed, consult with wound nurse practitioner as needed, and tubi- grips to both legs on in the morning and off at bedtime. Review of Resident #28's re-admission skin assessment dated [DATE] revealed the resident had no skin issues except left hip surgical incision. There was no additional skin assessment completed until 02/16/26 when Resident #28's daughter had identified a skin alteration on the resident's coccyx. Review of Resident #28's Braden assessment (tool used for predicting pressure ulcer risk) dated 02/11/26 revealed the resident was at moderate risk for pressure ulcers. There was no evidence that new interventions were implemented to prevent pressure ulcers.Review of Resident #28's five-day minimum data set (MDS) dated [DATE] revealed the resident had cognition impairment. The residents had one to three days of rejection of care. The resident needs some help with self-care. The resident was dependent on staff for rolling left and right, sitting to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and toilet transfer. The resident was frequently incontinent of urine and always incontinent of bowel. The resident had fracture related to a fall in the last six months that required a repair of the fracture. Resident #28 was at risk for developing a pressure ulcer/injury. The resident did not have a pressure-reducing device for chair or bed, not on a turning/repositioning program, no nutritional or hydration interventions to manage skin problems, or pressure ulcer/injury care. The resident was receiving opioid and antiplatelet medications. Review of a concern form dated 02/16/26 and completed by Resident #28's daughter revealed on 02/08/26 her mother fractured her hip and had surgery on 02/09/26 and returned to the facility on [DATE] at 5:00 P.M. Her mother was not properly checked back into the facility by the registered nurse (RN). A decubitus (pressure) ulcer was noticed by the resident's daughter today. The staff were totally unaware. There was a great risk for infection due to the decubitus ulcer is on the coccyx and was approximately three inches wide by two inches long. This would be considered a facility acquired bedsore. The daughter had spoken with the previous director of nursing (DON) #100 on 02/16/26 at 11:20 A.M., and RN #204. RN #204 placed a protective dressing on the decubitus ulcer in the daughter's presence today 02/16/26. Staff was not able to take a photograph of the ulcer. DON #100's immediate plan of action was to have the wound nurse see the resident, air mattress, weekly skin assessment, and new treatment orders to open area on coccyx. DON #100 updated Resident #28's daughter. Review of Resident #28's skin assessment completed by the consulting wound nurse practitioner dated 02/16/26 revealed the resident was [AGE] years old and was re-admitted for a left hip fracture with open reduction and internal fixation. The resident had a new in-house acquired wound on the pelvis/sacrococcygeal area that was staged as partial thickness (Stage II) that measured 7.5 centimeters (cm) by 6.5 cm by 0.1cm with moderate serosanguineous drainage. The wound bed was 80 percent epithelial; however, there was no documentation what the other 20% of the wound bed appeared to be. Interventions included barrier cream per facility's protocol (already implemented twice a shift since 06/02/23), float heels, low air loss mattress (was not implemented until 03/05/26), and turn and reposition per facility policy. Review of the facility wound assessment dated [DATE] revealed Resident #28 had unstageable pressure ulcer (full thickness tissue loss) on the coccyx/sacral area that measured 7.5 cm by 6.5 cm and unable to determine depth due eschar covered 80% of the wound bed and the other 20% was (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	granulation. The wound was draining moderate serosanguinous drainage. Review of Resident #28's unstageable on coccyx/sacral bilateral buttocks and hembullas on bilateral heels plan of care initiated on 02/16/26 and revised on 03/09/26 revealed only one intervention to apply treatment to areas as ordered. Review of the facility wound notes revealed no evidence of skin alteration to the heels on 03/08/26.Review of consulting wound nurse practitioner note dated 03/09/26 revealed the pelvis/sacrococcygeal wound was now unstageable measuring 3.0 cm by 5cm by 0.1 cm and was being treated with Cipro for an infection with proteus and pseudomonas. The pelvis area was still unstageable and measured 3.0 cm by 5.0 cm by 0.1 cm. The nurse reported the resident had new wounds on the heels onset 03/08/26. The left heel measured 4.5 cm by 7.3 cm x 0.1 cm and was a suspected deep tissue injury. There were no measurements of the right heel until an amendment note was added on 03/13/26 that indicated the right heel measured 4 cm by 7 cm and depth was undetermined. Treatment plan indicated mesalt (debriding agent) daily to pelvis and A&D twice daily and as needed to heel. Further review revealed wound notes dated 03/09/26 that revealed the resident had suspected deep tissue injuries to the right and left heels. The resident's right heel measured 0.4 cm by 7.5 cm and the left heel measured 4.5 cm by 7.3 cm. Review of Resident #28's medication administration record dated 03/2026 revealed the resident received Cipro 500 milligrams (mg) twice a day for positive wound culture from 03/07/26 to 03/16/26. Review of Resident #28's treatment administration record dated March 2026 revealed on 02/24/26 the resident was ordered to cleanse coccyx/sacral bilateral buttocks with normal saline or wound cleanser and apply mesalt (debriding agent) and dry dressing daily.There was no documented evidence that the treatment was administered on 03/03/26 or 03/11/26. On 03/05/26 an air mattress was added to the treatment administration record (TAR) (which was part of the plan of correction to the concern form completed by Resident #28's daughter on 02/16/26), on 03/08/26 heel boots as tolerated was added for prevention, since 02/17/26 staff were to encourage resident to offload (not specified what to offload) twice daily as prevention, and the resident had been receiving barrier cream to coccyx/buttocks twice daily and as needed for preventions since 06/02/23. On 03/10/26 there was an order added to cleanse bilateral heels with mild soap and water and apply A&D twice daily. There was no documented evidence that the treatment was administered on 03/11/26 for day shift. Further review of the TAR revealed no evidence the resident refused heel boots. Observation on 03/12/26 at 8:12 A.M., of Resident #28 revealed the resident was in bed and the heel boots were not in-place. Registered Nurse (RN) #204 confirmed findings and indicated the heel boots were tolerated, and she would have to check the TAR. Interview on 03/16/26 at 2:13 P.M. with the Director of Nursing (DON) #103 confirmed the resident had a Stage II pressure ulcer on the coccyx area that was not initially identified by the staff, however, was identified by a family member. The DON confirmed upon the resident's readmission that the resident's Braden scale was re-assessed, and it was determined the resident went from low risk to moderate risk for skin breakdown and the staff didn't implement any new intervention until the resident had acquired a pressure ulcer. The DON reported her expectation would have been to review previous interventions and implement new interventions such as pressure relieving devices. The DON reported originally the wound nurse had assessed the wound as unstageable, however the same day the facility contracted wound nurse practitioner had visited and staged the coccyx wound as a Stage II. The DON confirmed there was documented evidence that the resident had received treatments to the coccyx on 03/03/26 or 03/11/26 or the heels on 03/11/26. The DON confirmed she had reached out to the nurses that worked on dayshift and nightshift and both confirmed they did not administer the treatment. The DON confirmed there was no documented evidence on the TAR that resident had refused heel boots. The DON reported turning and positioning was part of all resident's daily care. The DON confirmed the only intervention on the plan of care for the pressure ulcers was to provide treatments as ordered. Review of the facility wound policy titled Wound and Skin Care Program dated 12/20/24 revealed the resident would be assessed for the risk of skin breakdown and appropriate interventions would be initiated. The resident would have a full skin (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment conducted by the admitting nurse and will have appropriate resident specific interventions and treatments initiated. A second skin assessment would be completed in 24-72 hours to verify existing skin alterations. Be reviewed by the Interdisciplinary team (IDT) to identify resident specific interventions to promote skin integrity (i.e. off-loading of heel post hip fracture repair). Once identified interventions to promote skin integrity will be communicated to licensed nurses and nursing assistants through physician orders, care planning, and point of care. Any newly identified skin impairments would be reported to the nurse for assessment. Assessment findings would then be reported to the physician for treatment guidance and evaluation of further interventions. Newly identified skin impairments will be documented under risk management and in point click care. Wound treatment/dressing will be supported by the physician order. This deficiency represents non-compliance investigated under Complaint Number 2789590.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, interviews, and policy review the facility failed to ensure fall interventions were in-place per the resident's plan of care. This affected one resident (#28) of three residents reviewed for accident/hazards. Findings Include: Medical record review revealed Resident #28 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including displaced intertrochanteric fracture of left femur, hypotension, urinary incontinence, dizziness, difficulty walking, and muscle weakness. Review of Resident #28's risk for falls/injury related to dizziness, impaired gait, muscle weakness, and use of psychoactive medication plan of care dated 03/02/18 and revised 10/21/25 revealed on 10/21/25 bright color paper used for visual aide to ask for help and use the call light system was added to the interventions. Additional intervention included bright colored tape applied to brake handles as visual reminders, and dycem to seat of wheelchair. Observation on 03/12/26 at 8:15 A.M., with Registered Nurse (RN) #204 of Resident #28 revealed there was no evidence the bright color paper used for visual aide to ask for help and use the call light system per the plan of care. In addition there was no evidence of bright colored tape on brake handles on the wheelchair or dycem to seat of wheelchair. The RN reported Resident #28 had a fall with fracture last month and had received new wheelchair and staff did not apply the bright colored tape or dycem to the new wheelchair. The RN also confirmed the signs in the resident's room were not bright colored per the fall plan of care. Interview on 03/12/26 at 10:59 A.M., with Resident #28's daughter revealed she felt the facility failed to implement preventive measure to prevent her mother's fall which resulted in a fracture. She had requested information regarding the fall and care plan, however the information had not been provided to her at this time. Review of the facility's policy titled Fall Policy and Procedures dated 07/04/05 and revised on 01/27/20 revealed based upon the assessment, the interdisciplinary team will develop interventions based upon the resident risk factors and individual needs and implement a fall plan of care in point click care. The fall care plan would be reviewed at least quarterly and as needed by the team and updated in point click care. This deficiency represents non-compliance investigated under Complaint Number 2789590.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of concern forms, review of meal ticket, observation, and interview the facility failed to ensure a resident received fluids per order. This affected one resident (#28) of three residents reviewed for hydration.Findings Include: Medical record review revealed Resident #28 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including urinary tract infections, hypotension, gastric reflux, protein-calorie malnutrition, and dysphagia. Review of Resident #28's dietary note dated 07/17/25 revealed the fluid intake recommendation was 1950 milliliters (ml). Review of a concern form dated 02/12/26 revealed Resident #28's daughter had concerns after her mother fractured left femur, she would be less mobile and had concerns with urinary tract infections and hydration. The resolution included therapy to evaluate, dietary would offer extra fluids as tolerated, would obtain order for UTI stat, (supplement) from physician, and have dietician evaluate resident. The daughter was fully satisfied with recommendations on 02/13/26 and signed off on the concern form. Review of Resident #28's dietary note dated 02/12/26 revealed the resident was re-admitted on [DATE] after fracturing her left hip; 240 milliliters (ml) extra fluids with lunch and dinner. No edema was noted. The resident meets criteria for malnutrition related to decreased energy intake and muscle wasting. Recommend magic cup daily at lunch. Review of Resident #28's order dated 02/11/26 revealed 240 ml fluids extra with lunch and dinner. Review of Resident #28's diet order and communication form dated 02/12/26 revealed extra 240 ml at lunch and supper. Review of Resident #28's supper meal ticket dated 03/11/26 revealed no evidence of extra 240 ml of fluids. Review of Resident #28's fluid intakes dated 02/11/26 to 03/12/26 revealed the residents' intakes varied from 60-240 ml for each meal. There were two days (02/18/26 and 02/23/26) there were only intakes recorded for two meals and four meals recorded the resident refused fluids. The resident average intake was 760 ml daily. Review of Resident #28's orders revealed no evidence the resident was receiving a diuretic medication. Review of Resident #28's potential for decreased fluid volume due to diuretic medication use care plan dated 03/02/18 and revised 03/04/20 revealed record intakes and outputs as ordered or nursing judgement. There was no evidence of extra 240 ml of fluids at lunch and dinner. Review of Resident #28's risk for altered nutrition plan of care dated 10/15/18 and revised 02/18/26 revealed to encourage intakes. There was no evidence of extra 240 ml of fluids at lunch and dinner. Observation on 03/11/26 at 4:20 P.M., of Resident #28 revealed the resident had one 240 ml cup of pink drink with ice and 120 ml cup of light orange colored drink. Interview on 03/11/26 at 4:38 P.M. with Dietary Manger (DM) #205 revealed she was unaware the resident was to receive an extra 240 ml with lunch and dinner. DM #205 confirmed if there were special dietary instructions it would be documented on the meal ticket and she had also had a sheet hung in the kitchenette to remind staff. DM #205 showed the surveyor the list from the kitchenette, and the order for extra fluids for lunch and dinner was not listed on the list in the kitchenette. Licensed Practical Nurse (LPN) #208 was near the kitchenette and reviewed Resident #28's orders with the surveyor and DM and confirmed Resident #28 was to receive an extra 240 ml of fluids with lunch and dinner. LPN #208 wrote a new dietary communication form and gave it the DM to add to the resident meal ticket. The DM confirmed the resident only had one 240 ml cup of fluids and the 120 ml cup was the UTI stat (supplement) the nurse gave her during medication administration. It was not the extra 240 ml of fluids because she was unaware of the order. Interview on 03/12/26 at 10:59 A.M., with Resident #28's daughter revealed she was concerned her mother was not provided adequate hydration due to decreased urination, dark urine, and urinary tract infections. She had spoken to the facility regarding her concerns regarding her mother's hydration needs but didn't feel they were addressed. This deficiency represents non-compliance investigated under Complaint Number 2789590.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, review of hospital records, policy review and interview, the facility failed to implement a comprehensive, individualized and effective pain management program for Resident #41, who had a diagnosis of migraines. Actual harm occurred on 11/29/25 (three days after admission) when Resident #41, who was diagnosed with severe intractable migraines prior to admission to the facility, did not receive ordered anti-migraine medication resulting in the resident's transfer to the hospital for intractable headaches with vomiting and hypertension. The resident was hospitalized from [DATE] until 12/06/25 for management of intractable migraines. Findings Include: Closed medical record review revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including migraine without aura, intractable, with status migrainosus (a severe debilitating migraine attack lasting longer than 72 hours that does not respond to standard treatment and is considered a neurological emergency), anxiety, depression, cerebrovascular disease, fibromyalgia, and hypertension.Review of Resident #41's admission medication orders revealed the resident was ordered Aspirin 81 milligrams (mg) daily for pain, Gabapentin (a prescription anticonvulsant used to treat partial seizures and nerve pain. It works by calming overactive nerves), 300 mg daily for pain until 11/29/25, then every two days starting on 11/30/25, Losartan (a medication used to treat high blood pressure) 100 mg daily for blood pressure, Metoprolol (a medication used to treat high blood pressure) 50 mg twice a day, and Acetaminophen 325 mg two tablets every four hours as needed for pain. Review of Resident #41's vital signs and pain evaluation dated 11/26/25 revealed the vital and pain assessments were not completed (blank).Review of Resident #41's admission assessment dated [DATE] revealed on 11/27/25 the resident had rated her pain level four out of 10 (1-10 scale) with verbal complaints of pain. The pain location was posterior neck, was described as aching and occurred daily. The resident was assessed to be alert and oriented times three (to person, place and time). Review of Resident #41's care plan titled potential for alteration in comfort related to fibromyalgia dated 11/28/25 and revised on 12/05/25 revealed to administer medication as ordered and per resident's preference/request, encourage resident to report pain early prior to becoming severe, and observe for any signs and symptoms of pain. Review of Resident #41's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was intact. The resident received scheduled and as needed pain medication. The resident had pain in the last five days rated 10 out of 10. The pain was frequent, occasionally affected her sleep and frequently affected her day-to-day activities.Review of Resident #41's vital signs revealed the resident's blood pressure was taken on 11/27/25 at 3:32 A.M. in the left arm sitting and the results were 157/82 mm/Hg (normal blood pressure is considered 120/80 mm/Hg) and on 11/28/25 at 6:06 P.M., in the left arm sitting and the results were 154/78 mm/Hg. There was no documented evidence that the resident's blood pressure was obtained on 11/29/25.Review of Resident #41's progress notes authored by Licensed Practical Nurse (LPN) #208 revealed on 11/27/25 at 2:30 P.M. the resident was administered Acetaminophen 325 milligrams (mg) two tablets by mouth for a headache that was unrelieved by low lighting and quiet environment. The medication was documented as being effective.Review of Resident #41's progress note authored by LPN #608 dated 11/28/25 at 3:16 A.M., revealed the resident was in her room vomiting and complaints of headaches which were causing her to vomit per resident statement. Tylenol 325 mg two tablets were administered by mouth, and the medication was documented as being effective.Review of Resident #41's progress note authored by LPN #208 dated 11/28/25 at 5:15 P.M., revealed the nurse, resident, and resident's daughter had spoken to the Nurse Practitioner #1002. New orders were received for Topamax (a prescription anticonvulsant medication used to treat certain types of seizures (epilepsy), prevent migraine headaches), Imitrex (a prescription medication used to treat, not prevent, acute migraine or cluster headaches in adults), Magnesium (nutrient for preventing and reducing the frequency and intensity of migraines), (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Perphenazine (antipsychotic) and to consult the consulting psychiatrist. Review of Resident #41's orders dated 11/28/25 revealed new orders for Magnesium 400 mg daily for supplement, Perphenazine 4 mg tablet daily for obsessive compulsive disorder (OCD), Topamax 100 mg daily for migraines until 12/06/25 then decrease to 50 mg daily on 12/07/25, and Imitrex 50 mg every two hours as needed for migraine maximum dose of two every 24 hours.Review of Resident #41's medication administration record (MAR) and treatment administration record (TAR) dated November 2025 revealed the resident's pain level on 11/27/25 was zero and on 11/28/25 and 11/29/25 the pain level was marked not applicable (NA); however, the resident had received Acetaminophen 325 mg two tablets on 11/27/25 for a pain of eight and 11/28/25 for a pain of 10. Further review revealed no evidence the resident had received Topamax or the Imitrex per the orders dated 11/28/25.Review of Resident #41's progress note authored by LPN #200 dated 11/29/25 at 12:17 P.M., revealed the resident's daughter was in the facility at this time requesting that the nurse send her mother to the emergency room for complaints of headache and nausea. The daughter stated, My mother is vomiting all over herself and she was not getting any better here. The Nurse Practitioner was notified and new orders received to send to emergency room for evaluation and treatment. Spoke to daughter earlier regarding concerns of the resident not getting medication. At that time daughter phoned, and the nurse was preparing to give the resident her medication.Review of Resident #41's progress note dated 11/29/25 at 12:23 P.M., revealed the squad was in the facility to transport the resident to the hospital. Review of Resident #41's late entry Nurse Practitioner #1002 Discharge summary dated [DATE] revealed the resident was a [AGE] year-old female who was in no acute distress; staff advised that the resident was complaining of headache, she was given Topamax (Please note-there was no documented evidence the Topamax was given) for her headache. The daughter came in to see her mother and came out and reported her mother was now vomiting and she wanted her mother to be sent to the emergency room. The resident was admitted to the hospital with vomiting and headache.Further review of Resident #41's medical record revealed no evidence of a transfer notice to the hospital. Review of Resident #41's hospital notes dated 11/29/25 revealed the resident was admitted for intractable headaches with vomiting and hypertension. The residents' blood pressure was 200/100 mm/Hg in the emergency room. The resident reported she wasn't feeling well today with a severe headache and vomiting. The resident was given a dose of Dilaudid (opioid medication) in the emergency room for headache and developed severe bradycardia in the 30's (pulse). The resident's pulse did come up spontaneously to the 50's and 60's. The resident reported that she had a severe headache rating the pain nine out of 10 with severe vomiting. The resident's blood pressure was still elevated despite the intravenous hydralazine (vasodilator) which was a contributing factor to the resident's history of migraines. Neurology and cardiology were consulted. Thorazine (a medication that can be used in the treatment of severe nausea) 12.5 mg every eight hours intramuscular ordered, vital signs every four hours and magnetic resonance imaging (MRI) of the brain was ordered. The resident was admitted to the hospital for intractable headaches. Review of Resident #41's hospital Discharge summary dated [DATE] revealed the resident's primary admission diagnoses were intractable headaches/migraines and hypertensive emergency. The MRI showed no acute findings on 11/29/25. The resident's condition improved during her stay, and she was stable to be discharged . The resident was discharged home with a home health referral. Interview on 03/11/26 at 2:00 P.M., with LPN #200 confirmed she was the nurse who was assigned to Resident #41 on 11/29/25. The LPN revealed on this date she was responsible to provide nursing care for residents in the Assisted Living and the skilled unit on the Skilled Nursing Home side. On 11/29/25, Resident #41's daughter had called stating her mom hadn't received her medications yet. The LPN could not recall the time she had received the call from the resident's daughter. LPN #200 reported she told the resident's daughter that she was outside her room and was getting ready to pull her mom's medications to administer. The resident had complained of a headache; however, LPN #200 never administered the Topamax because the medication was scheduled to be administered in the afternoon and in addition, she was (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	not aware the resident had a new order received the day prior for Imitrex. Later, the resident's daughter arrived and asked why her mom was still here after she had requested her to be sent to the emergency room. LPN #200 reported she explained to the daughter that she had asked the resident, and the resident wanted to wait to see if the medication (gabapentin) was effective. The daughter requested the resident be sent to the hospital and LPN #200 spoke to the resident, and the resident agreed she wanted to go to the hospital, so LPN #200 called the provider and received new orders to send the resident to the emergency room. LPN #200 confirmed if she had known the resident had an order for Imitrex she would have administered it for the resident's headache. LPN #200 confirmed the resident was ordered Topamax and Imitrex on 11/28/25 and those medications had not been administered. LPN #200 confirmed she did not administer the as needed Tylenol for the residents' headache/migraine and had just administered her scheduled gabapentin. LPN #200 confirmed she did not complete the transfer form to send to the hospital as well.Interview on 03/12/26 at 10:26 A.M., with Resident #41's daughter (#302) confirmed she was Resident #41's daughter and was the family member who had called and came to the facility on [DATE] as stated in the nursing progress note. The daughter reported the resident and family had a bad experience with the facility. The daughter voiced concerns Resident #41 had to be re-hospitalized three days after her admission due to the facility's neglect to administer medication and monitor her mother's blood pressure adequately. Daughter #302 reported she visited the facility every day her mother was there and had concerns regarding her mother's care; however, the Director of Nursing (DON) never returned her call to discuss. Daughter #302 voiced concerns that when she was visiting she could never find staff and when she called the facility no one would answer the phone. Daughter #302 revealed on 11/29/25 her mom called her crying because she had a migraine and had vomited and was nauseated. The daughter stated the facility had every excuse why she hadn't received her medication yet. The daughter reported she tried calling the facility and tried continuously on her way to the facility to follow up on her mom's condition; however, no one answered the phone. When she arrived Resident #41 was covered in vomit and there was vomit on the floor and she had to clean the resident up. The daughter reported that her mom didn't receive her migraine medications as ordered and had to be transferred to the emergency room. When they arrived at the hospital her mom's blood pressure was critically high and she was admitted for seven days before she was stable to be discharged . Her mom refused to return to the facility and said she would rather die. The daughter reported the experience left her mom terrified to go to any nursing facility and it has caused a burden on the family and her mother to be at home. Interview on 03/12/26 at 10:40 A.M., with Resident #41 revealed she was hospitalized (on 11/29/25), which had prolonged her recovery a month due to the facility lack of administering medication as ordered. The resident reported she had a horrible migraine, and she didn't receive her medication as ordered, which resulted in her blood pressure going up. The resident reported she begged her family and the hospital not to send her back to the facility. The resident reported there wasn't adequate staffing to assist her needs and administer medication as ordered. During an interview, the resident reported prior to her hospitalization and nursing home admission she took Hydralazine 25 mg by mouth for her migraines. At the hospital they were administering the hydralazine by injection, and she stated she believed she was supposed to receive the medication again orally when she got to the facility (beginning 11/26/25). However, she did not think she was getting all her medication correctly at the facility. During an interview on 03/16/26 at 8:53 A.M. with the DON, concerns with Resident #41 not being administered ordered medications to treat and alleviate pain associated with the resident's migraine headaches and nausea and vomiting was shared. The DON confirmed Resident #41 did not receive her medications and staff failed to monitor her blood pressure. Review of the facility's Pain Management policy and procedure dated 04/29/99 and revised 03/19/25 revealed purpose of the policy was to recognize when the resident was experiencing pain and identify circumstances when pain can be anticipated. Evaluate existing pain and identify the cause and manage or prevent pain, consistent with comprehensive assessment and (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	plan of care, current professional standards of practice and the resident's goals and preferences. Resident's pain level would be monitored daily, and prior to administering as needed pain medication and after administration to assess effectiveness. This deficiency represents non-compliance investigated under Complaint Number 2785293.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to maintain an accurate medical record. This affected three residents (#18, #27 and #30) of 11 residents reviewed for accuracy of medical records.Findings include:1.Review of Resident #30's medical record revealed the resident was admitted to the facility on [DATE] admission. Review of the medical record revealed there were no diagnoses listed under the medical diagnoses category, with the medication orders or in the care plan.Interview on 04/01/26 at 8:06 P.M. with the Director of Nursing (DON) verified the facility missed adding the resident's diagnoses on admission. She verified the diagnoses were added to the medical record on 04/01/26, six days after admission.2. Review of Resident #18's medical record revealed the resident was admitted to the facility on [DATE] and re-admitted on [DATE] after sustaining a fall with left femur fracture.Review of current physician orders included an order dated 06/02/23 for nonskid strips to the bathroom floor in front of commode every shift. There was an order dated 04/22/24 for visual reminders in the bathroom to use call light for assistance with transfers twice a day.Review of the March and April 2026 treatment sheets revealed staff were signing off twice a day that the resident had nonskid strips to bathroom floor in front of commode and that she had a visual reminder in bathroom to use call light for assistance with transfers. Interview on 04/01/26 at 4:16 P.M. with the DON verified the resident did not have fall strips in front of the toilet or a sign as a reminder to call for assistance. The DON revealed the facility did an audit and removed the strips in front of the commode and signage from the plan of care since the resident was not using the bathroom after returning from the hospital after breaking her hip. She verified they failed to remove the interventions from the resident's physician orders. The DON further verified the nursing staff were signing off treatments as in place that were not in place. 3. Review of Resident #27's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including a cerebral infarction, protein calorie malnutrition, adjustment disorder with anxiety, anorexia, chronic sinus, gastroesophageal reflux disease, constipation, glaucoma, vascular disease, history of falling, muscle weakness, and difficulty in walking.The resident had an in house Stage II pressure ulcer to the left outer ankle that measured 0.2 centimeter (cm) x 0.3 cm x .1 cm described as 100 percent crust with no drainage.Physician orders included an order dated 07/19/24 to pad and protect a healed left lateral ankle pressure ulcer two times a week (every Monday and Thursday) and as needed for prevention. Physician orders included an order dated 03/16/26 to cleanse left outer ankle with normal saline or wound cleanser and apply duoderm one time a day every Monday, Thursday and Saturday for wound healing and as needed.Interview on 04/01/26 at 3:24 P.M. with the DON verified there were two contradicting orders in the active orders. The DON verified the pad and protect order was in the physician orders but was not showing up as a treatment to be signed off on the treatment sheet.

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	365699	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 - Many	Provide and implement an infection prevention and control program. Based on review of infection control log, interview, and policy review the facility failed to ensure the facility had a comprehensive infection control program that including tracking and monitoring for infection trends. This had the potential to affect all 37 residents residing in the facility.Findings Include: Review of the infection control trending of infections dated 10/2025 to 03/2026 revealed no evidence the facility was trending for infections. The facility was utilizing a map for trending. In the corner of the map was the key that indicated respiratory was blue, gastrointestinal was green, urinary tract infections (UTI) were yellow, wounds were pink and others were purple. There was no evidence of the type of infections to ensure there was not a pattern. Further review of the infection log dated 12/2025 to 03/2026 revealed the facility started utilizing a new log. In December 2025 the facility had four UTI's that didn't indicate the organism, in January 2026 three UTI's that didn't include organisms, February 2026 seven UTI's that didn't include organisms and two infections that didn't include the site of infection or organism, and March 2026 one UTI that didn't include the organism. Interview on 03/16/26 at 9:15 A.M., with Infection Preventionist (IP)/Licensed Practical Nurse (LPN) confirmed the infections were not monitoring for trends to indicate the type of infections to ensure there was not a pattern and most of the UTI's she did not have a culture to identify if there was a trend with organisms. The IP reported she had voiced concerns with the previous director of nursing (DON) #100 was told not to contact the providers and to administer antibiotics as ordered. Review of the infection control policy dated 10/19/29 revealed the purpose of the policy was to establish a process that investigates, monitors, identifies, controls, and surveys infections. When a resident was admitted to the facility with an infection or when a resident acquires an infection, an infection report will be completed by the infection preventionist (IP). Antibiotic orders will be obtained from the physician and implemented upon proper microorganism identification, if necessary. When a resident acquired an infection, the IP will update the surveillance map by reviewing the location the residents, type and location of infections. If there is a pattern, this will be discussed in the weekly QA program meeting. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 2789590.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to implement an antibiotic stewardship program that included ensuring appropriate antibiotic use. This affected three residents (#24, #30, and #31) of three residents reviewed for antibiotic use. The facility census was 39.Findings include:1.Interview on 03/31/26 at 5:08 P.M. with Registered Nurse (RN) #99 revealed Residents #24 and #30 were currently receiving antibiotics.Review of the March 2026 Infection Incidence Rate for the Month log revealed there were three residents (#10, #15, and #31) entered on the log. The log indicated Residents #15 and #31 met McGeer criteria (McGeer criteria are standardized surveillance definitions used to identify and track infections (UTIs, respiratory, GI, skin) in long-term care facilities (LTCFs). They are applied retrospectively to monitor infection rates and ensure consistency across facilities, rather than for initial clinical decision-making). Residents #24 and #30 were not entered on the log.Interview on 03/31/26 at 5:47 P.M. with the Director of Nursing (DON) and Licensed Practical Nurse (LPN) #97 revealed LPN #97 was the Infection Preventionist and was off the weekend (03/28/26, 03/29/26) and returned to work Monday, 03/30/26. Residents #24 and #30 were started on antibiotics on 03/28/26 and 03/29/26. There was no determination as to whether the residents met McGeer criteria for the use of antibiotics. The DON and LPN #97 revealed when the Infection Preventionist (IP) is off work on the weekend or has days off no one does her work. When residents are admitted or placed on antibiotics (when the IP is not working) the residents are receiving antibiotics before it is determined if they meet criteria for antibiotic use. Further, the facility is administering antibiotics prior to the facility notifying the physician of a resident not meeting criteria and discontinuing the antibiotic or receiving the rationale for administering antibiotics without meeting criteria for use. 2.Review of the medical record for Resident #31 revealed the resident was admitted to the facility on [DATE] with diagnoses of acute respiratory failure with hypoxia, chronic pain syndrome, hypertension, hyperlipidemia, morbid severe obesity, syncope and collapse, chronic distal congestive heart failure, depression, gastrointestinal reflux disease, insomnia, osteoarthritis and weakness.Review of a certified wound nurse note dated 03/23/26 revealed the resident was an [AGE] year-old female seen for a follow up for a wound of the left great toe and left third toe. The left third toe had an injury and was first seen on 03/09/26. The third toe was a full thickness injury 0.5 centimeters (cm) by 0.7 cm x 0.1 cm with serosanguinous drainage and erythema. The wound nurse documented exposed bone, tenderness, warmth and slight edema. The wound nurse practitioner ordered Clindamycin (antibiotic) 300 milligrams (mg) orally until sent to the emergency room in the morning due to suspected exposed bone and infection. A nurse progress note dated 03/24/26 included the emergency room nurse stated the resident does not have any bone infection and will be sent back on antibiotics for a wound infection.The resident returned from the emergency room with orders for doxycycline (antibiotic) 100 mg one tablet by mouth two times a day for wound infection until 04/03/26.Review of the March 2026 Infection Incidence Rate for the Month log revealed Resident #31 was entered on the log and met McGeer criteria. Review of the McGeer Infection Report Form revealed under cellulitis, soft tissue or wound infection one or more of the following criteria must be present: 1. Pus present at a wound, skin or soft tissue site;2. New or increasing presence of at least four of of the following sign or symptom sub-criteria: heat at the affected site, redness at the affected site, swelling at the affected site, tenderness or pain at the affected site, serous drainage at the affected site; one constitutional criteria; fever, leukocytosis, acute change in mental status from baseline and acute functional decline. LPN #97 had check marked the resident had redness and swelling at the site. LPN #97 checked that the infection met McGeer criteria when two of the criteria were met under signs and symptoms instead of the required four.Interview on 03/31/26 at 5:47 P.M. with LPN #97 revealed she was told that only one of the signs and symptoms had to be checked to meet criteria. She included she had not done infection control since 2019 and this was why she did (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not know the McGeer criteria. LPN #97 stated she did not phone the physician and discuss the use of the antibiotic when the resident did not meet criteria because she had marked the resident did meet the criteria.Review of the facility policies and procedures manual included an Antibiotic Stewardship Program (revised 11/30/17). The policy included all residents with newly diagnosed infections utilizing antibiotics will be reviewed for appropriate utilization. Residents without proof of review of infection symptoms prior to the initiation of an antibiotic will be reviewed for antibiotic holiday, culture and sensitivity results will be obtained/reviewed for sensitivity. The results of the testing and the recommendation for treatment will be discussed with the primary care (physician) to ensure antibiotics are utilized in a responsible effective manner. Prescribers will be required to document dose, duration and indication for all antibiotic use.3. Interview on 03/31/26 at 5:08 P.M. with Registered Nurse (RN) #99 revealed Resident #24 was receiving antibiotics.Review of the March 2026 Infection Incidence Rate for the Month log revealed Resident #24 was not entered on the log. There was no evidence of a McGeer Infection Report Form being filled out. Review of Resident #24 revealed a 01/25/24 admission with diagnoses including acquired absence of left leg above knee, anxiety disorder, diabetes, hypertension, hyperlipidemia, major depressive disorder, and muscle weakness.A Physician Progress Note dated 03/28/26 included staff reported the resident reported having a large abscess to her right breast. There was no drainage and it was hard with no yellow center. The plan was to apply warm compresses three times a day, Bactrim DS (antibiotic) 800/120 mg twice a day for 10 days and Bactroban (a prescription topical antibiotic cream or ointment used to treat bacterial skin infections like impetigo, folliculitis, and small infected wounds) three times a day, consult wound nurse Monday. Physician orders revealed an order dated 03/28/26 order for Bactrim DS 800/120 mg twice a day for an abscess for 10 days and Mupirocin (Bactroban) external cream 2% apply to right breast abscess topically three times a day, start 03/29/26.A Nurse Progress Note dated 03/28/26 revealed the resident had a large purple/red colored hard abscess to the underside of right breast. The area was warm to touch with no drainage. The resident was afebrile.Interview on 03/31/26 at 5:47 P.M. with LPN #97 verified she had not completed an Infection Report Form for Resident #24 because she was off on Saturday and did not return to work until Tuesday. She reported there was not anyone who checked antibiotic orders against the McGeer criteria in her absence.A Nurse Progress Note dated 03/31/26 at 11:45 P.M. revealed the wound under Resident #24's breast was draining. The area had yellow slough and surrounding redness. Skin warm to touch. The resident's temperature was 99.2 degrees Fahrenheit. A Nurse Progress Note dated 04/01/26 included the Nurse Practitioner wishes to continue Bactrim until culture results. There was no further explanation.A McGeer Infection Report Form dated 04/01/26 was presented five days after the antibiotic was ordered. The form indicated under cellulitis, soft tissue or wound infection one or more of the following criteria must be present. 1. Pus present at a wound, skin or soft tissue site;2. New or increasing presence of at least four of the following sign or symptom sub criteria: heat at the affected site, redness at the affected site, swelling at the affected site, tenderness or pain at the affected site, serous drainage at the affected site; one constitutional criteria; fever, leukocytosis, acute change in mental status from baseline and acute functional decline. LPN #97 had check marked the resident had heat and redness at the affected site as well as serous drainage at the affected site and fever. The LPN #97 did not indicate on the form whether the resident did or did not meet antibiotic use criteria. A new March 2026 Infection Incidence Rate for the Month log was presented to the surveyor. Resident #24 was now listed on the log and the log indicated Resident #24 did not meet criteria for the use of antibiotics. Interview on 04/01/26 at 5:58 P.M. with LPN #97 revealed she filled out a McGeer Infection Report Form on 04/01/26, five days after the antibiotic was ordered for Resident #24. LPN #97 verified she had answered on the log no, the resident did not meet criteria for the use of an antibiotic, when she had indicated on the form, the resident had the presence of four criteria which would have met the McGeer standard for the use of antibiotic. However, on 04/03/26 at 2:26 P.M. interview with the Director of Nursing verified Resident #24 only had one documented temperature (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	above 99 degrees which would not have met the constitutional criteria for a fever, making the marking of a fever an error. 4. Interview on 03/31/26 at 5:08 P.M. with Registered Nurse (RN) #99 revealed Resident #30 was currently receiving an antibiotic.Review of the March 2026 Infection Incidence Rate for the Month log revealed Resident #30 was not entered on the log. There was no evidence of a McGeer Infection Report Form being completed. Review of Resident #30's medical record revealed the resident was admitted to the facility on [DATE]. There were no diagnoses listed. Review of physician orders included the resident was on Levaquin (antibiotic) 750 milligrams (mg) give one tablet by mouth one time a day every two days, for culture infection, for five administrations every 48 hours. The start date was 03/28/26 and was to be completed on 04/07/26.Interview on 03/31/26 at 5:47 P.M. with LPN #97 verified she had the Infection Report Form for Resident #30 started on her desk. It was not completed. LPN #97 stated the resident was not going to meet criteria because the resident had an upper respiratory infection.Review of an infection report form dated 04/01/26 indicated Resident #30 had pneumonia. All three criteria needed to be met for the residents to meet the criteria for the use of antibiotics. The areas of interpretation of a chest radiograph as demonstrating pneumonia or the presence of a new infiltrate, new or changed lung examination abnormalities and leukocytosis were all checked as being present. A new March 2026 Infection Incidence Rate for the Month log was presented to the surveyor. Resident #30 was now listed on the log and the log indicated Resident #30 did meet criteria for the use of antibiotics. The log included the resident had pneumonia, hypoxia and shortness of breath as well as gram negative rods.Interview on 04/01/26 at 5:58 P.M. with LPN #97 verified the McGeer Infection Report Form was not completed timely to determine antibiotic stewardship for Resident #30 and it was not timely identified if the physician needed to be called if the criteria was not met.

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of infection-Antibiotic (ATB) Surveillance logs and facility policy, the facility failed to have a qualified designated infection preventionist (IP) who effectively monitored and implemented the facility's Antibiotic Stewardship Program. This had the potential to affect all 39 residents residing in the facility. The facility census was 39.Findings include: Upon entrance to the facility on [DATE], the facility identified Licensed Practical Nurse (LPN) #97 as the Infection Preventionist (IP).Review of the facility infection control log for March 2026 revealed the facility did not meet the requirements for antibiotic stewardship. Review of the antibiotic stewardship documentation provided by the facility demonstrated a lack of understanding of the importance of receiving hospital documentation to support the need for antibiotics upon return to the facility. In addition, review revealed the timing and accuracy of completing McGeer's evaluations that led to errors in the decision making process as to whether a resident met criteria for antibiotic use affecting the effectiveness of the facility's antibiotic stewardship program.Interview on 03/31/26 at 5:47 P.M. with LPN #97 related to the accuracy of the antibiotic stewardship program revealed she had not performed the infection control (IP) role since 2019. The surveyor requested the Infection Preventionist certification of training and testing.Interview on 04/01/26 at 5:23 P.M. with LPN #97 revealed she was hired 10/16/25 as the Minimum Data Set (MDS) Assessment nurse. She took over infection control in December of 2025 when former Director of Nursing (DON #110) asked her to be the Infection Preventionist. Prior to that, the Former DON #110 was in charge of infection control since her hire in August 2025. LPN #97 revealed she provided Former DON #110 her Infection Preventionist Certificate but it was not in her personnel file. LPN #97 provided a form stating she completed the Infection Preventionist course on 02/12/21. LPN #97 stated that would be the same date she would have successfully passed the examination and received the Infection Preventionist certificate. However, LPN #97 was unable to provide a certificate. LPN #97 indicated she called her former employer who was unable to provide her her certificates and continuing education. LPN #97 stated they could send the information 04/02/26. She indicated the only other infection control classes she had taken since completing the Infection Preventionist Course was standard infection control bloodborne pathogen education provided through Relias, this was with her former employer. LPN #97 verified she did not renew her training every two years to reflect the updated guidelines and stay current with updated training. During the course of the survey (03/31/26-04/03/26) the facility did not provide an Infection Preventionist Certificate for LPN #97. The facility provided an Infection Preventionist Certificate of Training dated 08/29/25 for LPN #58. The Administrator and DON indicated LPN #58 worked part time on midnight shift, when she was going to school to be a registered nurse. The Administrator and DON said LPN #58 was returning full time as of 04/01/26 and the plan was LPN #58 would become the Infection Preventionist at some point.Review of the facility Infection Preventionist policy (last reviewed 11/30/23) did not include the requirement for a certificate of completion of an infection preventionist program professional and continuing education to maintain competency in updates. It also did not specifically address antibiotic stewardship in the nursing home setting.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on review of concerns forms, review of email communication, interviews, observation, and policy review the facility failed to ensure a functioning call light system that was not able to be turned off until the call light was responded to by staff. This had the potential to affect all 37 residents residing in the facility.Findings Include: Review of an email dated 02/20/26 to the previous Director of Nursing (DON) #100 from Resident #28's daughter revealed Resident #28's daughters' friend was visiting her mother and had called her because the visitor had asked someone walking down the hall to check Resident #28 after waiting a long time for someone to come. That person checked her mom and said she was dry. The friend knew that Resident #28 was not dry because she could smell the urine. Two other people and the physical therapist came in and took Resident #28 to the bathroom. The physical therapist said that since Resident #28 was not bearing any weight on her legs, they would not be able to continue to get her into the bathroom. The daughter was also concerned her mom would be incontinent of urine and stool and she would have to lay in it for hours before getting changed. Even with calling out for help, it takes an extended amount of time for assistance to come if they come at all. The Certified Nursing Assistant (CNA's) were supposed to check on residents every two hours, but they do not. Resident #28's daughter reported she had witnessed this every time she had been in the facility. The DON's response was that the nurses are aware to make sure Resident #28 was checked on often and assisted as needed. Review of a concern form, which was not on the concern form log, dated 02/16/26 revealed Resident #28's daughter had concerns that incontinence care was not performed timely and pressure ulcer was not identified by staff. The corrective action didn't address the daughter's concerns regarding incontinence care not performed timely. Interview on 03/12/26 at 10:59 A.M., with Resident #28's daughter revealed there had been concerns recently while a friend was visiting her mom on 02/20/26 and she had to wait an extended amount of time for someone to respond to the call light.Observation on 03/12/26 at 2:22 P.M., of Resident #15's call light revealed the state surveyor activated the resident's call light. At 2:33 P.M., the surveyor activated the call light again even though it was red (indicating it was alarming). At 2:38 P.M., the surveyor activated the light again due to the red light having disappeared. At 2:40 P.M., Certified Nurse Aide (CNA) #405 answered the call light and confirmed the walkie talkie alerted her to the room but she could not tell the surveyor the time it was activated, however the computer should be able to give the exact times. Resident #15 revealed he was not sure if his call light was working properly or if staff were just not answering it timely. Interview on 03/12/26 at 3:04 P.M., with Maintenance Director (MD) and Maintenance Director Assistant (MDA) confirmed Resident #15's call light was activated on 03/12/26 at 2:22 P.M. for 16 minutes and 15 seconds and then activated again at 2:38 P.M. The MD and MDA reported the call light resets after 16 minutes and 15 seconds, which would require the resident to re-activate the call light again. The MDA showed the surveyor on the computer the activation date and times and how long the call light was on but unable to print results due to when they tried to print it would crash the computer. The Administrator arrived during interview and reported the company was in the process of buying a new computer and was aware of the issue. Interview with anonymous Staff Member #500 during the survey confirmed currently call lights were not answered timely, and residents have voiced concerns to her as well. Interview on 03/16/26 at 7:43 A.M., with Corporate Clinical Director (CCD) #102 confirmed the concern form was not on the concern log, and she had found it in the Director of Nursing's office. Review of the facility's policy titled Call Lights dated 03/12/16 revealed staff will strive to answer call lights and meet residents' needs as promptly as possible. Call lights will be silent only after the residents' needs are met. This deficiency represents non-compliance investigated under Complaint Number 2789590 and 2785293.