STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365752	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foundation Park Care Center	1621 S Byrne Rd Toledo, OH 43614

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review, staff interviews, consultant interviews, and policy review, the facility failed to ensure the dishwashing machine was functional, failed to ensure appropriate hand hygiene was practiced during meal service, and failed to ensure emergency water was stored in a sanitary environment. This had the potential to affect all residents in the facility. Additionally, the facility failed to ensure residents received food without foreign substances. This affected one (#73) of four residents reviewed for food and nutrition. The facility census was 87. Findings include: 1. Observation and interview on 03/10/26 at approximately 10:35 A.M. with Dietary Manager (DM) #418 revealed a high-temperature dishwasher was used by the facility. Observation revealed no plastic or glass covers were over the washing temperature gauge or the rinsing temperature gauge. Further observation during a dishwashing cycle of the machine revealed the temperature gauges did not fluctuate through two washing and rinsing cycles. DM #418 confirmed the gauge needles did not fluctuate while the machine was in use. DM #418 further stated the dishwasher was serviced by an outside company and DM #418 was told by a company representative covers could not be placed over the gauges because it caused fogging.Review of the dishwasher's servicing company's service report, dated 01/27/26, revealed appropriate washing and rinsing temperatures.Observation on 03/11/26 at 11:34 A.M. revealed new gauges with covers were in place on the dishwasher. Interview with Company Representative (CR) #521 confirmed he replaced both temperature gauges on the dishwasher. CR #521 stated he serviced the dishwasher in the past and had not noticed whether the gauges moved. CR #521 stated he replaced the gauges on 03/11/26 because the probes going into the gauges were rusted. CR #521 stated he had not checked the probes in the past. Further observation revealed the gauges functioned appropriately and reflected adequate washing and rinsing temperatures upon initiating a cycle of the dishwasher. 2. Observation during meal service on 03/10/26, beginning at 11:21 A.M., revealed [NAME] #485 serving the noon meal. [NAME] #485 was wearing disposable gloves while touching service utensils, plates, and drawer handles. Continued observation, at approximately 11:29 A.M. revealed [NAME] #485 wore the same gloves to pick up a plastic bag of buns and manipulated the bun out of the bag and onto a plate without touching the bun. [NAME] #485 then used the same gloves to open the bun to place meat into the bun. Interview on 03/10/26 at 11:31 A.M. with [NAME] #485 confirmed she touched several multi-use items before touching the ready-to-eat bun. [NAME] #485 confirmed clean gloves should be used when touching ready-to-eat foods.Continued observations during the noon meal service revealed [NAME] #485 continued to touch multi-use items and then used the same pair of gloves to hold open a bun and place meat inside. Concurrent interview with [NAME] #485 confirmed the gloves had touched other surfaces in the kitchen before touching ready-to-eat buns.3. Observation on 03/09/2026 at 2:37 P.M. of the A-Hall communal bathroom and shower revealed the facility's emergency water storage of one and a half pallets of 16-ounce water bottles in 24-count packs wrapped in plastic on the top and bottom was in a shower stall. A shower curtain was the barrier between the shower stall and the remainder of the bathroom. Interview at this time between Director of Maintenance (DOM) #409 and the Safety and Health Consultant (SHC) confirmed the emergency water was stored in the communal (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	shower because the facility had no other storage for the pallets.Interview on 03/11/26 at 7:31 A.M. with Certified Nursing Assistant (CNA) #493 confirmed residents use the toilet and shower in the A-hall communal bathroom. Concurrent observation revealed staff taking Resident #24 into the shower room. Observation while the bathroom door was open revealed soiled clothing on the floor. 4. Observation during breakfast meal service on 03/09/26 at 8:05 A.M. revealed Resident #73 sitting at a table in the large dining room. Resident #73 had a plate of eggs, toast, and sliced banana in front of her. Resident #73 was eating slices of banana with her fingers. Further observation revealed a foreign substance was on Resident #73's eggs.Interview on 03/09/26 at 8:17 A.M. with the Director of Nursing (DON) and concurrent observation of Resident #73's plate confirmed a foreign substance was on Resident #73's eggs. The DON used Resident #73's fork to remove the item, stating the item may have been part of the jelly packet foil covering. The DON proceeded to attempt to feed Resident #73 who stated she did not want any more food. The DON spoke with CNA #457 who stated Resident #73 ate better with some assistance and CNA #457 asked the DON to cover the plate and CNA #457 would reheat it and provide assistance to Resident #73. The DON then covered Resident #73's plate, including the eggs from which the foreign substance was removed, for Resident #73 to consume later. Continued observation revealed CNA #457 took the plate to the kitchen to be microwaved and was advised the kitchen would provide a new plate with fresh, warm food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, policy review and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to ensure a risk assessment was developed with facility specific measures to prevent the growth of Legionella. Additionally, the facility failed to ensure monitoring of Legionella control measures. This had the potential to affect all residents. Furthermore, the facility failed to wear proper personal protective equipment (PPE) while providing care to residents with physician orders for enhanced barrier precautions (EBP). This affected two (#11 and #22) of four residents reviewed for EBP. The facility identified nine residents (#5, #6, #60, #13, #24, #12, #47, #11, and #22) requiring EBP. Finally, the facility failed to ensure three staff (#433, #472, and #492) completed annual Mantoux (Tuberculosis) risk assessments. This had the potential to affect all residents in the facility. The facility census was 87. Findings include: 1. Review of the facility Legionella Risk assessment dated [DATE] revealed the description of the water system had not identified the facility water source and site-specific water flow systems throughout the building including if dead-end plumbing was present. Control and monitoring measures included weekly temperature controls/checks of hot and cold water with monthly water heater inspections, weekly flushing of low use outlets, regular use of showers and sinks with quarterly shower head cleaning, routine monthly cleaning of ice machines, and aerators as well as routine inspection of heating ventilation and air conditioning (HVAC) components that may produce moisture. Additionally, the Legionella Risk Assessment revealed water temperature logs, flushing logs, equipment cleaning records, risk assessment updates and incident reports (if applicable) would be documented. Review of the facility documentation revealed the facility was monitoring and documenting water temperatures. There was no documentation for flushing or equipment cleaning. Interview on 03/11/26 at 12:10 P.M. with Maintenance Supervisor (MS) #409 revealed the facility was performing flushing of unused outlets, but was not aware documentation of the monitoring was needed. MS #409 also revealed no further monitoring was in place for the Legionella control measures. Additionally, MS #409 verified the control measures listed in the facility Legionella Risk Assessment were not being performed. Control measures listed included, weekly outlet flushing logs, quarterly shower head cleaning and monthly water heater inspection. Interview on 03/12/26 at 8:14 A.M. with the Administrator and MS #409 verified the current Legionella Risk Assessment had not identified the flow of water throughout the building and specific potential sources of Legionella growth within the facility. Control measures listed in the facility risk assessment were reviewed with the Administrator. The Administrator verified the control measures listed in the facility Legionella Risk Assessment were not being implemented. Control measures listed included: weekly outlet flushing logs, quarterly shower head cleaning and monthly water heater inspection. Review of the facility policy titled Legionnaire's Disease Policy, revealed the Administrator would be responsible for the establishment and maintenance of an effective practice and policy to limit the potential hazards posed by Legionella disease. The Environmental Services Director was responsible for the control of Legionella processes and would maintain all records of completed testing, maintenance, and controlling/monitoring measures. Further review of the policy revealed key personnel would have general knowledge of the principles, design, and function of the domestic hot and cold-water service. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2.Review of the medical record revealed Resident #11 was admitted to the facility on [DATE]. Diagnoses included dementia, severe protein calorie malnutrition, obstructive and reflux uropathy, and benign prostatic hyperplasia with lower urinary tract symptoms. Review of the Minimum Data Set (MDS) assessment completed on 02/22/26, revealed the Resident #11 had severe cognitive deficits and was dependent for activities of daily living. Review of the care plan for Resident #11 dated 02/03/26 revealed the resident had an indwelling urinary catheter. Interventions included for PPE to be located in or near the resident's room to be put on by staff before providing care for dressing, bathing/showering, transferring in the room, providing hygiene, changing lines, changing briefs or assisting with toileting, device care, and wound care with dressing changes. Review of the physician orders dated 02/10/26 for Resident #11 revealed an order for PPE, including a gown and gloves, located in or near the resident's room to be put on by staff before providing care for dressing, bathing / showering, transferring in the room, providing hygiene, changing lines, changing briefs or assisting with toileting, device care (central lines, urinary catheters, feeding tubes, tracheostomy care), and wound care with dressing changes. Observation and interviews on 03/10/26 at 10:43 A.M. revealed Certified Nursing Assistant (CNA) #506 assisted Licensed Practical Nurse (LPN) #464 with catheter care for Resident #11. LPN #464 wore a gown and gloves. CNA #506 was only wearing gloves. During an interview CNA #506 stated a gown was only needed when providing direct care for Resident #11's catheter. Once LPN #506 was complete with catheter care, CNA #506 closed and fastened the resident's incontinence brief. CNA #506 then proceeded to place the catheter drainage bag through the leg of a pair of grey sweatpants. CNA #506 assisted Resident #11 with rolling from side to side to pull the sweatpants up. CNA #414 then entered the room to assist CNA #506 in getting Resident #11 up from the bed into the wheelchair. CNA #506 and CNA #414 both had gloves on and neither were dressed in protective gowns. After Resident #11 was placed in his wheelchair, CNA #506 and CNA #414 verified they were not wearing protective gowns during the transfer. CNA #506 revealed a protective gown was not needed unless Resident #11 was being bathed or catheter care was being provided. CNA #506 stated if she was supposed to be wearing PPE at other times then she was not aware. Interview on 03/11/26 at 1:37 P.M., Infection Preventionist Registered Nurse (IPRN) #500 revealed the EBP signage outside of residents' rooms consisted of a laminated set of yellow hands placed next to the resident name. IPRN #500 stated direct care staff were educated on hire and annually on EBP practices and CNAs should also receive this information in report. IPRN #500 stated there is also signage at each nurses' station listing what to wear in EBP rooms. IPRN #500 verified CNAs should wear PPE when applying a brief and handling a urinary catheter drainage bag. Review of the facility policy titled Enhanced Barrier Precautions, dated 05/2024, revealed staff entering the identified resident's room would wear a protective gown and gloves prior to performing high-contact resident activities including dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator), and wound care. Review of Frequently Asked Questions about Enhanced Barrier Precautions released from the CDC on 06/28/24 provided by the facility revealed EBP was primarily intended to apply to care that occurs within a resident's room where high contact resident care activities, including transfers, were bundled (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	gowns and gloves, when providing care to Resident #22. The facility identified nine residents (#5, #6, #60, #13, #24, #12, #47, #11, and #22) requiring EBP. Interview on 03/12/26 at approximately 12:56 P.M., outside Resident #22's room, with RN Supervisor #471 confirmed an Enhanced Barrier sign should be posted outside Resident #22's room, and was not posted. 4. Review of Certified Nursing Assistant (CNA) #433's personnel file revealed a hire date of 12/20/23. Review of the required Mantoux testing revealed the CNA failed to complete the yearly risk assessment in the previous 12 months. Review of CNA #472's personnel file revealed a hire date of 06/15/25. Review of the required Mantoux testing revealed the CNA failed to complete the yearly risk assessment in the previous 12 months. Review of CNA #493's personnel file revealed a hire date of 02/10/24. Review of the Mantoux testing revealed the CNA failed to complete the yearly risk assessment in the previous 12 months. Interview with the Human Resource Manager on 03/12/26 at 2:20 P.M. verified the yearly assessments has not been completed. Review of the facility policy titled Tuberculosis Screening revised 2017 revealed an annual risk assessment will be completed each year in January. Employees will complete a questionnaire annually in January.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, and policy review the facility failed to ensure adequate monitoring for psychotropic medication effectiveness, side effects and adverse effects. This affected three (#15, #35, and #10) of five residents reviewed for unnecessary medications. The facility identified 66 residents receiving psychotropic medications. The facility census was 87.Findings include:1. Review of the medical record for Resident #15 revealed an admission date of 01/14/26. Diagnoses included psychosis, mood disorder, anxiety, frontotemporal neurocognitive disorder, and dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. Review of the plan of care initiated 10/02/25 revealed Resident #15 received psychotropic medications. Further review of the plan of care revealed an intervention to administer psychotropic medication as ordered by the physician and to monitor for side effects and effectiveness every shift. Also for staff to monitor/document/report as needed any adverse reactions of psychotropic medications. Review of the physician orders dated 10/02/25 revealed orders for escitalopram oxalate table 20 milligrams (mg) by mouth daily for mood, olanzapine tablet 2.5 mg daily for psychosis, and mirtazapine 15 mg tablet daily for depression with weight loss. There were no orders for monitoring for medication effectiveness, adverse effects and side effects. Review of the nurses' notes, medication administration records (MARs) and treatment administration records (TARs) from 02/01/26 through 03/09/26 revealed no documentation the resident was monitored for medication effectiveness, adverse effects, and side effects of the psychotropic medications. Interview of 03/10/26 at 9:20 A.M., the Director of Nursing (DON) verified there was no documentation Resident #15 was monitored for adverse effects and side effects of the psychotropic medications. 2. Review of Resident #35's medical record revealed and admission date of 09/11/25, with diagnoses including dementia, hallucinations, anxiety, restlessness and agitation. Review of the MDS assessment, dated 12/17/25, revealed Resident #35 received antipsychotic, antianxiety, and antidepressants medications. The medical record indicated Resident #35 was prescribed Clonazepam 0.5 mg, give half tablet (0.25 mg) by mouth every eight hours as needed for agitation. Review of the Controlled Drug Receipt/Record/Disposition Form revealed that the medication was administered six times in the month of February. Review of the medical records showed no documentation for the monitoring of potential side effects or effectiveness. Interview on 03/11/26 at 1:30 P. M. with MDS Coordinator #471 confirmed Resident #35's record contained no evidence of monitoring for side effects or efficacy of clonazepam. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record revealed Resident #10 admitted to facility on 08/14/25 with diagnoses including, dementia, Type II diabetes mellitus, lumbar vertebra fracture, neurocognitive disorder with Lewy bodies, hypertension, post traumatic stress disorder, depression, transient ischemic attack, and cerebral infarction. Review of the MDS assessment, dated 02/13/26, revealed Resident #10 was severely cognitively impaired and had delusions. Resident #10 received antipsychotic and antidepressant medications. Review of the plan of care, dated 08/15/25, revealed Resident #10 used prescribed psychotropic medications with a goal noting the resident would remain free of psychotropic drug related extrapyramidal symptoms (EPS - shuffling gait, rigid muscles, shaking) through the next review date. Interventions included the following: monitor/document/report as needed (PRN) any adverse reactions of psychotropic medications: tardive dyskinesia, EPS, suicidal ideations, and behavior symptoms not usual to the person. Review of the physician orders revealed on 01/23/26, Resident #10 was prescribed mirtazapine oral tablet, give 15 mg by mouth at bedtime for depression with weight loss and on 12/05/25, the resident was prescribed clozapine oral tablet, give 100 mg by mouth at bedtime related to violent behavior, hallucinations, post-traumatic stress disorder. Further review of the medical record revealed no evidence indicating the facility monitored for side effects for any adverse reactions of psychotropic medications, tardive dyskinesia, EPS, suicidal ideations, or behavior symptoms not usual to the person. Interview on 03/11/26 at 10:36 A.M. with the Director of Nursing (DON) verified no documentation was contained in Resident #10 medical record indicating the use of psychotropic medications were being monitored for side effects. Review of the undated facility policy titled, Free from Unnecessary Psychotropic Medications Use, revealed the facility would monitor for medication efficacy, medication side-effects, and adverse consequences.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, record reviews, staff interviews, and policy reviews, the facility failed to ensure dependent residents received assistance with activities of daily life. This affected five (#65, #82, #73, #53, and #11) of six residents reviewed for activities of daily living (ADLs). The facility census was 87.Findings include:1. Review of the medical record for Resident #65 revealed an admission date of 06/07/23 with diagnoses of dementia, Type II diabetes mellitus, epilepsy, anxiety, and traumatic brain injury. Review of the quarterly Minimum Data set (MDS) assessment, dated 02/11/26, revealed Resident #65 was rarely/never understood and was dependent on staff for eating. Review of a physician order dated 01/07/26 revealed Resident #65 received a regular diet with pureed textures and thin liquids, with double portions. Review of the medical record for Resident #82 revealed an admission date of 11/08/23 with diagnoses of dementia and aphasia. Review of the significant change comprehensive MDS assessment, dated 01/21/26, revealed Resident #82 was rarely/never understood and was dependent on staff for eating. Review of a physician order dated 09/09/25 revealed Resident #82 received a custom diet, regular texture, with regular/thin liquid consistency. Interview on 03/09/26 at approximately 6:15 A.M. with Dietary Aide (DA) #495 revealed breakfast service began at approximately 7:00 A.M. to 7:15 A.M. and hall trays, for residents who ate in their rooms, were delivered first. Observation on 03/09/26 at 7:36 A.M. revealed [NAME] #462 was observed walking down the hallway. Concurrent interview with [NAME] #462 revealed she had completed plating all resident meals. Observation on 03/09/26 at 8:40 A.M. revealed Resident #82 in bed with her eyes closed. A breakfast tray, with all items covered and closed, was on the nightstand. Interview on 03/09/26 at 8:53 A.M. with Certified Nursing Assistant (CNA) #457, in the hallway near Resident #65's room and Resident #82's room (the residents did not share a room) revealed CNA #457 was collecting meal trays from residents who had already eaten breakfast in their rooms. CNA #457 stated a CNA called off for the day and nobody was reassigned to the residents in the rooms occupied by Resident #65 and Resident #82. CNA #457 stated some residents in the section needed assistance with eating and had not been fed. Continued observation revealed CNA #457 continued down the hall collecting breakfast trays from residents who had already consumed their meals. Observation on 03/09/26 at 9:07 A.M. revealed Resident #65 lying in bed with his eyes closed. A meal tray with breakfast foods was out of reach on Resident #65's dresser, with all food items covered and closed. Observation on 03/09/26 at 9:14 A.M. revealed Resident #82 was being assisted out of bed by (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physical Therapist (PT) #523. Concurrent interview with PT #523 confirmed Resident #82's breakfast tray was on the nightstand and had not yet consumed. Observation on 03/09/26 at 9:28 A.M. revealed Resident #65 lying in bed with his eyes closed. The meal tray remained untouched on the dresser. Continued observation revealed at 9:34 A.M., Licensed Practical Nurse (LPN) #469 was feeding Resident #65. Concurrent interview with LPN #469 revealed a CNA called off and the section was not yet reassigned and, therefore, LPN #469 decided to feed Resident #65. Observation on 03/09/26 at 9:48 A.M. revealed CNA #457 feeding Resident #82 (one hour and eight minutes after the breakfast tray was first observed in the resident's room). 2. Review of the medical record for Resident #73 revealed an admission date of 06/29/23 with diagnoses of dementia, multiple sclerosis, epilepsy, and hypertension. Review of the quarterly MDS assessment, dated 01/21/26, revealed Resident #73 had impaired cognition, was able to eat with setup or clean-up assistance, and was dependent on staff for personal hygiene. Review of the care plan initiated 06/29/23 and revised 03/02/26 revealed Resident #73 had a potential ADLs self-care performance deficit. Interventions included checking nail length and trim and clean on bath day and as necessary. Observation on 03/09/26 at 8:05 A.M. revealed Resident #73 sitting alone at a table in the dining room. Resident #73 had a plate of food in front of her. Resident #73 used her right hand to feed herself pieces of sliced banana. Resident #73 had dark debris under each of her fingernails, visible from across the table. Interview on 03/09/26 at 8:17 A.M. with the Director of Nursing (DON) and concurrent observation of Resident #73's fingers, confirmed Resident #73's fingernails had dark debris under all fingers on her right hand, which she was using to pick up food to feed herself. 3. Review of the medical record revealed Resident #53 was admitted on [DATE], with diagnoses including dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the MDS quarterly assessment dated [DATE] revealed Resident #53 was dependent on staff for personal hygiene and grooming. Review of the care plan dated 01/12/26 revealed staff were to assist Resident #53 with grooming and hygiene to maintain personal cleanliness and dignity. Review of the shower schedule revealed Resident #53 received showers on Monday and Thursday evenings. Review of Resident #53's Shower and Skin Assessment, dated 03/09/26, revealed Resident #53 received a shower. Observation on 03/09/26 at 9:02 A.M. revealed Resident #53 was sitting in a wheelchair in the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	common area. Resident #53's fingernails were observed to contain visible dark debris under multiple fingernails. Interview on 03/09/26 at 9:02 A.M. with Resident Monitor/Activities (RMA) #408 revealed staff were responsible for assisting residents with grooming, including cleaning and maintaining fingernails. RMA #408 verified that Resident #53 had what appeared as feces under her fingernails on both hands. Staff did not address the resident's grooming needs during the observation period. Interview on 03/10/26 at 10:14 A.M. with LPN #469 confirmed that Resident #53 had her scheduled shower on the evening of 03/09/26, and the resident required assistance with grooming and should have had her fingernails cleaned during her scheduled shower. Interview on 03/11/26 at 5:55 A.M. with Registered Nurse (RN) #431, and concurrent observation of Resident #53, verified Resident #53 had a black substance under her fingernails on both of her hands, and verbalized Resident #53 needed her nails cut. Review of the undated facility policy titled, Bathing and Grooming, revealed skin and nail conditions were monitored with each bath. 4. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE]. Diagnoses included unspecified dementia, unspecified severe protein calorie malnutrition, obstructive and reflux uropathy, benign prostatic hyperplasia with lower urinary tract symptoms. Review of the admission MDS assessment for Resident #11 dated 02/22/26, revealed a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive deficits. Further review of the MDS revealed Resident #11 had limited functional abilities and was dependent on staff for toileting hygiene, showering/bathing and upper/lower body dressing. Review of the initial care plan dated 02/10/26 revealed Resident #11 had a self-care performance deficit with interventions including a need for assistance with dressing and personal hygiene. Observation on 03/10/26 at 10:55 A.M., during care, revealed CNA #506 dressed Resident #11 in a blue-gray hoodie sweatshirt with a fish on the front and gray sweatpants. Observation on 03/11/26 at 7:23 A.M. revealed Resident #11 was lying in his bed wearing the same blue-gray sweatshirt and gray sweatpants he was dressed in the previous day. Observation on 03/11/26 at 10:15 A.M. revealed Resident #11 was sitting in his wheelchair in the common area wearing the same blue-gray hoodie sweatshirt with a fish on the front as well as gray sweatpants with a brown stain on the upper right leg. Interview on 03/11/26 at 10:28 A.M. with CNA #457 revealed the clothes Resident #11 was wearing were not placed by her. CNA #457 stated Resident #11 had the blue-gray hoodie sweatshirt and gray sweatpants on when she arrived for her shift this morning. CNA #457 stated she was told by third shift staff that Resident #11 was dressed and ready to go. CNA #457 stated she assumed third shift staff had dressed Resident #11 in the blue-gray sweatshirt and gray sweatpants. Interview on 03/11/26 at 10:31 A.M. with CNA #414 verified that she was working on 03/10/26 and had assisted with transferring Resident #11. CNA #414 stated Resident #11 had on a sweatshirt the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	previous day. CNA #414 observed Resident #11 sitting in his wheelchair in the common area and verified that the clothes worn by Resident #11 appeared to be the same clothes that resident was dressed in yesterday. CNA #414 also verified that the gray sweatpants being worn by Resident #11 had a dried brown mark to the right thigh area. Interview with on 03/11/26 at 10:40 A.M. with LPN #464 revealed resident clothing should be changed every morning upon waking and every evening in preparation for bed. Review of the facility policy titled, Activities of Daily Living (ADLs), revised December 2025, revealed a resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, personal hygiene, and oral hygiene.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, and policy review, the facility failed to ensure pressure reducing measures were implemented as ordered. This affected three (#22, #2, and #5) of four residents reviewed for pressure ulcer prevention. The facility census was 87.Findings include:1. Review of the medical record for Resident #22 revealed an admission date of 7/31/19 with diagnoses of unspecified dementia, hemiplegia, gastrostomy status, dysphagia, and epilepsy. Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/17/25, revealed Resident #22 was rarely/never understood, was at risk for skin breakdown, and was dependent on staff for all activities of daily living (ADLs) and mobility. Review of a physician order, initiated 05/14/24, revealed Resident #22 should be turned or repositioned every couple of hours around the clock to rotate pressure points. An order dated 03/20/25 revealed Resident #22 should have a washcloth inside of the left hand as tolerated. An order dated 12/03/25 revealed Resident #22 was to be up in chair for no longer than two hours at a time, to relieve pressure from buttock wound. Observation on 03/09/26 at 7:22 A.M. revealed Resident #22 lying in bed on his back. No pillows or offloading assistive devices were observed under Resident #22. No washcloth was observed in Resident #22's left hand. Interview on 03/09/26 at 8:53 A.M. with Certified Nursing Assistant (CNA) #457 revealed a CNA called off for the day and nobody was reassigned to the section Resident #22 resided in. Observation on 03/09/26 at 9:07 A.M. revealed Resident #22 was lying on his back. No pillows were observed under him to change his position. Observation on 03/09/26 at 9:34 A.M. revealed Licensed Practical Nurse (LPN) #469 was feeding breakfast to Resident #22's roommate. Concurrent interview with LPN #469 revealed a CNA called off and this section was not yet reassigned and, therefore, cares had not been provided to the residents. Further interview with LPN #469 confirmed Resident #22 would not have been repositioned since the beginning of the shift which started at 6:00 A.M. Observation on 03/10/26 at 7:35 A.M. revealed Resident #22 in bed with a pillow under the right side of his back. No washcloth was observed in Resident #22's left hand. Interview on 03/10/26 at 9:32 A.M. with CNA #457 revealed she was preparing to provide care to Resident #22 and then place him into the wheelchair. LPN #469 entered Resident #22's room and confirmed she would return to assist CNA #457 in using the mechanical lift to transfer Resident #22 from the bed to the chair. Observation on 03/10/26 at 1:09 P.M. revealed Resident #22 was in the wheelchair in his room. Resident #22's head was to the left of the headrest and was not being supported by the wheelchair's headrest Observation on 03/10/26 at 1:23 P.M. and concurrent interview with LPN #469 confirmed Resident #22's head was off the right side of the head support and was therefore not being supported by the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	headrest on the wheelchair. Further interview with LPN #469 confirmed she assisted CNA #457 with transferring Resident #22 to his wheelchair shortly after the interview and observation conducted on 03/10/26 at 9:32 A.M. Continued interview with LPN #469 confirmed she was aware Resident #22 had a physician order to be up in the wheelchair for only two hours and Resident #22 should have been transferred back to bed. Observation on 03/11/26 at 1:55 P.M. with LPN #469 revealed Resident #22's left palm was clean and the skin was intact. LPN #469 confirmed no washcloth was in Resident #22's left hand. Further interview and concurrent review of Resident #22's orders revealed the washcloth should be removed and Resident #22's hand should be cleaned on second shift (approximately 2:00 P.M. to 10:00 P.M.) and the washcloth should be replaced by staff on third shift (approximately 10:00 P.M. to 6:00 A.M.). Interview on 03/12/26 at 9:04 A.M. with Certified Occupational Therapy Assistant (COTA) #522 revealed she was familiar with Resident #22 and stated Resident #22's left hand was contracted, and the therapy team determined the best intervention to protect Resident #22's left palm from skin breakdown was a washcloth. 2. Review of Resident #2's medical record revealed the resident admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, cerebellar stroke syndrome, major depression, anxiety disorder, benign prostatic hyperplasia, and hypertension. Review of the MDS assessment dated [DATE] revealed Resident #2 had severe cognitive impairment, was dependent on staff for the completion of ADLs, was incontinent of bowel and bladder, and was at risk for pressure ulcer development with no skin breakdown. Review of the pressure ulcer assessment, dated 02/02/26, revealed Resident #2 was assessed with a risk score of 14, indicating moderate risk for the development of pressure ulcers. Review of the plan of care, dated 02/02/26 and revised on 02/09/26, revealed Resident #2 was at risk for pressure ulcer development related to (r/t) cognitive impairment/communication deficits/decreased sensory perception, incontinence, mobility/balance deficits, weak gait, confined to either bed or chair, prescribed medications which could influence sensory perception to pressure, decreased ability to change body positions on own, easily fatigued, terminal condition, and resisted staff assistance with care at times. Interventions included the following: monitor/document/report as needed (PRN) any changes in skin status, including appearance, color, wound healing, sign and symptoms (s/sx) of infection, wound size (length by (X) width X depth), stage; inform the nurse / physician (MD)/wound specialist/resident's responsible party of any new areas of skin breakdown; dietitian to assess nutritional needs to support skin health/wound healing; consult surgical wound care to manage wound healing which included providing treatment orders and monitoring the wound healing process/measurements; nurse to complete skin assessment weekly on shower day; apply house barrier cream topically to buttocks/coccyx after each incontinent episode and PRN; and turn or reposition the resident every couple of hours around the clock to rotate pressure points. Review of a physician order dated 02/18/26 revealed the use of heel protectors to bilateral heels at all times, as tolerated. Heels to be offloaded while in bed. Observations on 03/10/26 at 7:29 A.M., 7:51 A.M., 10:10 A.M., 12:14 P.M. and 1:37 P.M. and on 03/11/26 at 5:54 A.M., 9:29 A.M., and 12:34 P.M. revealed Resident #2 had a heel protector to the right heel. No heel protector was observed in place to the left heel. Interview with CNA #493 on 03/11/26 at 12:35 P.M., during observation of Resident #2, verified heel protectors had not been applied to the resident's left heel. CNA #493 stated she was unaware heel protectors were to be applied to both heels. 3. Review of Resident #5's medical record revealed an admission date of 02/09/24. Diagnoses included Lewy body dementia, diabetes mellitus, cellulitis of the abdominal wall, and lymphedema. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5's change in condition MDS, dated [DATE], revealed the resident was dependent on staff for transfers and bed mobility. Review of Resident #5's most recent care plan revealed she had a history of bilateral heel skin alteration. Interventions were to protect the heels from skin breakdown, to offload the heels at all times while in bed, as tolerated. Review of the physician orders revealed Resident #5 had an order dated 08/11/25 to offload bilateral heels/heel protectors while in bed as tolerated every shift for reddened skin of heels. Observation on 03/10/26 at 10:02 A.M. revealed Resident #5 was lying in bed without heel protectors applied. Interview with CNA #503 on 03/10/26 at 10:13 A.M. verified that Resident #5 was lying in bed and failed to have her bilateral heel protectors applied. CNA #503 found one heel protector under some clothing on a chair, but could not locate the second protector. Observation of Resident #5's heels on 03/10/26 at 10:16 A.M. revealed the skin was intact and without redness. Review of the facility policy titled, Skin Care Prevention and Pressure Management, revised October 2019, revealed, based upon the assessment and resident's clinical condition, choices and identified needs, basic or routine care may include but not limited to appropriate pressure-redistributing, support surfaces and provide non-irritating surfaces. Because the heels and elbows have relatively little surface area, it was difficult to redistribute pressure on these two surfaces. Therefore, it was important to pay particular attention to reducing the pressure on these areas for the resident at risk in accord with resident's overall goals and conditions. Additionally, for the resident at risk for developing, or who had a pressure ulcer, an individualized care plan that addressed prevention, care and treatment of any existing pressure ulcers, including specific interventions, measurable objectives and approximate time frames would be completed. This deficiency is continued non-compliance from the complaint survey dated 02/26/26.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, record review, staff interview, recipe review, menu review, and policy review, the facility failed to ensure staff followed menus and recipes for residents on a pureed diet. This affected 10 (#8, #11, #19, #29, #39, #42, #49, #53, #60, and #65) residents who received the pureed diet. Additionally, the facility failed to ensure residents received double portions as ordered by the physician. This affected one (#65) of four residents reviewed for food and nutrition. The facility census was 87. Findings include:1. Review of the planned menu for the midday meal on 03/10/26 revealed residents would receive fried fish, parmesan pasta, seasoned vegetable blend, and fruit cobbler. Observation on 03/10/26 at approximately 10:40 A.M. revealed [NAME] #462 preparing to puree parmesan pasta for 10 residents on a pureed diet. [NAME] #462 portioned 10 servings of pasta into the mixer and poured in an unmeasured amount of hot water. [NAME] #462 obtained two more servings of pasta, added them to the mixer, and added an additional unmeasured amount of hot water. Concurrent interview with [NAME] #462 confirmed she used hot water to thin the pasta to the desired consistency.Review of the recipe for pureed parmesan pasta indicated chicken broth should be included in the preparation. The instructions noted: If product needs thinning, gradually add an appropriate amount of liquid (NOT WATER) to achieve a smooth, pudding or soft mashed potato consistency. Interview on 03/10/26 at 11:24 A.M. with Dietary Manager (DM) #418 revealed she directed [NAME] #462 to puree Philly cheesesteak meat leftover from the previous evening's meal rather than providing fried fish as indicated on the menu. DM #418 stated she liked to use up leftovers, and confirmed no pureed fish was prepared. Observation during meal service on 03/10/26 beginning at 11:25 A.M. revealed [NAME] #462 used a 4-ounce scoop for the pureed Philly cheesesteak. Interview at this time with [NAME] #462 confirmed the scoop size.Interview on 03/10/26 at 12:03 P.M. with [NAME] #462 revealed she added one hamburger bun to the Philly cheesesteak meat she prepared for the ten residents on a pureed diet.Review of the menu spreadsheet revealed the portion of Philly cheesesteak provided to residents on a pureed diet was five and 1/3 ounces. Review of the recipe for pureed Philly Cheesesteak revealed the whole sandwich should be prepared, then pureed for each resident. Interview on 03/10/26 at approximately 12:04 P.M. with DM #418 verified the serving size of the Philly cheesesteak and verified one whole sandwich for each resident should have been used to puree the entree rather than one hamburger bun for ten portions of meat. DM #418 verified the recipe for pureed parmesan pasta indicated chicken broth should be included in the preparation and the pureed mixture was not thinned according to the recipe. The facility identified ten (#8, #11, #19, #29, #39, #42, #49, #53, #60, and #65) residents who received the pureed diet. 2. Review of the medical record for Resident #65 revealed an admission date of 06/07/23. Diagnoses included dementia, type 2 diabetes mellitus, epilepsy, anxiety, and traumatic brain injury. Review of the Minimum Data set (MDS) assessment, dated 02/11/26, revealed Resident #65 was dependent on staff for eating.Review of the current physician order, initiated 01/07/26, revealed Resident #65 received a regular type diet with pureed textures, thin liquids, and with double portions.Observation and interview on 03/09/26 at 9:34 A.M. revealed Licensed Practical Nurse (LPN) #469 feeding Resident #65. LPN #469 stated Resident #65's meal ticket revealed he received a pureed diet with double portions. LPN #469 stated Resident #65 received one bowl of eggs, one bowl of an unidentified substance, potentially bread, a bowl of oatmeal, and a bowl of pureed fruit. LPN #469 stated Resident #65 did not receive double portions. Continued observation revealed Resident #65 consumed the food LPN #469 fed him without refusing the meal.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, staff interview, record review, review of the wheelchair cleaning schedule, and policy review, the facility failed to ensure floor mats and wheelchairs were maintained in a clean sanitary condition. This affected three (#22, #65, and #82) of three residents reviewed for environment. The facility census was 87. Findings include: 1. Review of the medical record for Resident #22 revealed an admission date of 7/31/19 with diagnoses of unspecified dementia, hemiplegia, gastrostomy status, dysphagia, and epilepsy.Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/17/25, revealed Resident #22 was rarely/never understood, had impairment to both sides and was dependent for all activities of daily life. Review of Resident #22's physician order, dated 11/12/24, revealed staff should place a bedside floor mattress next to bed when resident was in bed. Observation on 03/09/26 at 9:34 A.M. revealed Resident #22 lying in bed with his eyes closed. A fall matt was on the floor next to Resident #22's bed. The fall matt was discolored and stained over approximately three-fourths of the matt. Concurrent interview with Licensed Practical Nurse (LPN) #469 confirmed Resident #22's fall matt was stained and discolored and did not provide a homelike environment. LPN #469 stated fall matts were usually covered with a fitted sheet, but Resident #22's was uncovered.2. Review of the medical record for Resident #65 revealed an admission date of 06/07/23 with diagnoses of dementia, type 2 diabetes mellitus, epilepsy, anxiety, and traumatic brain injury. Review of the quarterly MDS assessment, dated 02/11/26, revealed Resident #65 was rarely/never understood, used a wheelchair for mobility and was dependent on staff for mobility. Observation of the posted Wheelchair Cleaning Schedule, posted at the nurses station, revealed Resident #65's wheelchair should have been cleaned during third shift on Tuesday nights. Observation on 03/09/26 at 2:47 P.M. revealed Resident #65 in his wheelchair in the common area. Further observation revealed the frame on both sides of Resident #65's wheelchair was dirty and covered in debris. Concurrent interview with Activities Director (AD) #445 confirmed Resident #65's wheelchair was dirty with buildup of debris on both sides of the wheelchair frame. Further interview confirmed the wheelchair would have been cleaned on third shift 03/03/26. AD #445 could not say if the debris appeared to be more than would accumulate over a week.3. Review of the medical record for Resident #82 revealed an admission date of 11/08/23 with diagnoses of dementia and aphasia.Review of the significant change comprehensive MDS assessment, dated 01/21/26, revealed Resident #82 was rarely/never understood, used a wheelchair for mobility, and was dependent on staff for wheelchair mobility. Review of the Wheelchair Cleaning Schedule posted at the nurse's station revealed Resident #82's wheelchair should have been cleaned on the previous night shift. Observation on 03/11/26 at 1:42 P.M. of Resident #82's wheelchair revealed a buildup of debris and food on both sides of the rails, including pieces of food in the space between the seat and the frame. Concurrent interview with AD #445 confirmed Resident #82's wheelchair was dirty with debris buildup and food pieces. AD #445 revealed Resident #82's wheelchair should have been cleaned on the previous night shift. Review of the facility policy titled Quality of Life - Homelike Environment, dated 04/2014, revealed the facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: cleanliness and order.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, and policy review the facility failed to ensure accurate resident assessments were completed. This affected one (#05) of six residents reviewed for accidents. The facility census was 87.Findings include:Review of Resident #05's medical record revealed an admission date of 02/09/24. Diagnoses included Lewy body dementia, diabetes mellitus, cellulitis of the abdominal wall, and left femur fracture.Review of Resident #05's Minimum Data Set (MDS) assessment, dated 01/21/26, revealed she had moderately intact cognition. She utilized a wheelchair and was dependent on staff for all activities of daily living (ADLs).Review of Resident #05's most recent care plan revealed she was at risk for falls related to cognitive impairment and a communication deficit. The resident was known to overestimate or forget her limits due to decreased safety awareness, decreased judgement, impulsivity, history of falling, mobility/balance deficits, incontinence, and prescribed medications. Review of Resident #05's Fall Risk Evaluation dated 02/10/26 revealed she was at risk for falls.Review of the physician orders revealed an order dated 02/27/26 for warfarin sodium (blood thinner) four milligrams (mg) to be administered once a day every Wednesday and Sunday for atrial fibrillation.Review of Resident #05's Weekly Skin assessment dated [DATE] revealed Licensed Practical Nurse (LPN) #463 completed the assessment and the resident was free of chest bruising.Observation of Resident #05 on 03/12/26 at 7:14 A.M. revealed she was lying in bed with the blankets up to her chest. Further observation revealed a large healing bruise just below the mid clavicular area, which was green and yellow in color. The bruise measured approximately four by four inches. The resident had no shirt on and was covered only with her blanket, which was tucked in under her arms.Interview with Resident #05 on 03/12/26 at 7:15 A.M. revealed she was unaware of having a bruise and did not know how she received it, denying any injury. Interview with LPN #421 on 03/12/26 at 7:15 A.M. revealed she was Resident #05's nurse that day, but was unaware of the chest bruise and had not received any information in the report from the previous shift nursing staff.Interview with Certified Nursing Assistant (CNA) #457 on 03/12/26 at 7:20 A.M. revealed she was Resident #05's CNA for the day and was unaware of any bruising to her chest. Interview with the Director of Nursing (DON) on 03/12/26 at 7:26 A.M., an concurrent observation of Resident #05, confirmed the resident had a large, healing bruise. The DON was unaware of the bruising.Interview with LPN #463 on 03/12/26 at 2:22 P.M. revealed she completed Resident #05's skin assessment on 03/10/26 and verified no bruising was noted to the resident's upper chest.Review of the DON's nursing note dated 03/12/26 8:32 A.M. revealed it was brought to nurse's attention by the State surveyor, that Resident #05 had a discoloration to her chest. Upon exam, a somewhat circular area of yellow/green discoloration was noted to the upper chest. The area was approximately four by four inches. When the resident was asked how this happened she stated, I didn't even know it was there. She further stated she didn't know what could have caused it. She was not aware of an injury. No first aid was required. The incident was reported to The Administrator and her power of attorney (POA) was notifed. Review of the facility policy titled, Skin Care Prevention and Pressure Management, revised October 2019, revealed weekly skin assessments were completed on admission and then weekly to reassess. Bi-weekly showers with completion of a shower sheet by the State Tested Nursing Aide (STNA) was to be completed. The nurse must visualize each shower and document a skin assessment in the medical record. This deficiency is continued non-compliance from the complaint survey dated 02/26/26.

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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. Based on observations, medical record review, staff interview, and policy review the facility failed to implement fall safety precautions. This affected one (#5) of three residents reviewed for falls. The facility census was 87. Findings included:Review of Resident #5's medical record revealed an admission date of 02/09/24. Diagnoses included Lewy body dementia, diabetes mellitus, cellulitis of the abdominal wall, and lymphedema. Review of Resident #5's change in condition Minimum Data Set (MDS) assessment, dated 01/21/26, revealed she had a moderate cognition. The resident was dependent on staff for transfers and bed mobility. Review of Resident #5's most recent care plan revealed the resident was at risk for falls related to cognitive impairment and communication deficits. The resident overestimated or forgot limits due to decreased safety awareness, decreased judgement, impulsivity, history of falling, mobility/balance deficits, weakness, incontinence, prescribed medications which could affect balance, requirement for assistive device for balance/mobility, easily fatigued, and wheelchair bound/non-ambulatory. Interventions included a bedside mattress to the floor when in bed. Review of Resident #5's Fall Risk Assessment completed 02/10/26 revealed the resident was at high risk for falls. Review of the physician orders revealed Resident #5 had an order dated 10/16/25 to place a floor mat next to the bed when the resident was in bed every shift due to poor safety awareness. Observation on 03/10/26 at 10:02 A.M. revealed Resident #5 was lying in bed awake. The bedside mat was observed leaning against a chair on the opposite side of the room. Interview with Certified Nursing Assistant (CNA) #503 on 03/10/26 at 10:13 A.M. verified that Resident #5 was lying in bed and the fall prevention/floor mat was not in place at bedside. The CNA stated the staff probable took up the mat when the resident was served breakfast and failed to replace it. Review of the facility policy titled, Falls - Clinical Protocol, revised September 2012, revealed the staff and physician would identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, review of the Centers for Disease Control (CDC) recommended guidelines for indwelling urinary catheter insertion and maintenance, and policy review, the facility failed to provide an indwelling urinary catheter (IUC) securement device. This affected one (#42) of one resident reviewed for indwelling urinary catheters. The facility identified one resident with an indwelling urinary catheter. The facility census was 87.Findings include:Review of the medical record revealed Resident #11 was admitted to the facility on [DATE]. Diagnoses included unspecified dementia, unspecified severe protein calorie malnutrition, obstructive and reflux uropathy, and benign prostatic hyperplasia with lower urinary tract symptoms.Review of the admission Minimum Data Set (MDS) assessment for Resident #11, dated 02/22/26, revealed a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive deficits. Further review of the MDS revealed Resident #11 had limited functional abilities and was dependent on others for toileting hygiene, showering/bathing and upper/lower body dressing. Review of the initial care plan dated 02/11/26 revealed Resident #11 had an IUC due to a history of urinary retention and obstructive uropathy. There were no interventions for securing the catheter tubing.Review of a physician order dated 02/10/26 revealed the resident had orders for an 18 French IUC due to obstructive and reflex uropathy. Review of a nurses note dated 02/18/26 at 4:41 A.M. revealed the resident continued to disconnect the catheter bag and was physically combative with staff during care. Observation on 03/10/26 at 10:43 A.M. revealed Licensed Practical Nurse (LPN) #464 performing IUC care per physician orders for Resident #11. Further observation revealed Certified Nursing Assistant (CNA) #506 then began to dress Resident #11. No IUC securement device was observed in place. Interview on 03/10/26 at 10:50 A.M. with LPN #464 verified Resident #11 had no IUC securement device in place. LPN #464 also verified that Resident #11, and any resident having an IUC, should have an IUC securement device in place. LPN #464 then obtained and applied a securement device. Interview on 03/11/26 at 2:16 P.M. with the Director of Nursing (DON) revealed an IUC securement devices was not necessarily needed. The DON stated if a resident arrived to the facility with a securement device in place, then the facility would continue its use. The progress note dated 02/18/26 regarding the resident disconnecting the catheter bag was reviewed with the DON. The DON confirmed if Resident #11 was pulling at his IUC, then a securement device should have been in place.Interview on 03/11/26 at 2:13 P.M. with Registered Nurse (RN) Supervisor #471 revealed he was unsure of the standards of care for IUC securement devices. RN Supervisor #471 continued to state that he felt IUC securement devices would cause more discomfort to residents with cognitive deficits and if the resident was not pulling on the IUC device then no securement device was needed. Review of a CDC power point with guidelines for Indwelling Urinary Catheter Insertion and Maintenance, revealed maintenance of an IUC included proper securement of catheters to prevent movement and urethral traction. Review of the facility policy titled, Catheter Care, revised 2023, provided no direction on the use of IUC securement devices.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, record review and staff interview, the facility failed to ensure residents received enteral nutrition (tube feeding) as ordered by the physician. This affected one (#22) of two residents reviewed for tube feedings. The facility census was 87.Findings include:Review of the medical record for Resident #22 revealed an admission date of 7/31/19 with diagnoses of unspecified dementia, hemiplegia, gastrostomy status, dysphagia, and epilepsy.Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/17/25, revealed Resident #22 was rarely/never understood, had a gastrostomy tube, and relied on enteral nutrition to meet 51 percent (%) or more of his fluid and nutrition needs.Review of the current physician order dated 06/13/25 revealed Resident #22 received Isosource HN (high nitrogen) (a tube feeding formula) at 80 milliliters (ml) per hour. Observation on 03/10/26 at 1:09 P.M. revealed Resident #22 had tube feeding Fibersource HN running at 80 ml per hour. Further observation revealed the tube feeding bag was dated 03/10/26 at 4:00 A.M. Concurrent interview with Licensed Practical Nurse (LPN) #469 confirmed Resident #22 was receiving the wrong tube feeding formula. LPN #469 stated the bag was hung by the previous shift. LPN #469 stopped the tube feeding pump and proceeded to obtain and hang a bag of Isosource HN.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, staff interview, record review, and policy review, the facility failed to ensure a resident was receiving oxygen therapy per physician orders. This affected one (#56) of one resident reviewed for respiratory. The facility identified six residents who required supplemental oxygen. The facility census was 87.Findings include:Review of Resident #56's medical record revealed an admission date of 04/24/25. Diagnoses included vascular dementia, emphysema, Raynaud's syndrome, and peripheral vascular disease. Review of Resident #56's quarterly Minimum Data Set assessment, dated 01/07/26, revealed the resident required continuous oxygen therapy. Review of Resident #56's most recent care plan revealed she had emphysema and had a history of shortness of breath on exertion, when sitting, and laying flat. Interventions included oxygen per nasal canula per physician orders. Review of Resident #56's medical record revealed a physician's order dated 04/25/25 to apply oxygen at two liters per minute per nasal canula every shift for chronic respiratory deficit/shortness of breath/oxygen saturations less than 90% related to emphysema. Observation on 03/09/26 at 7:27 A.M. revealed Resident #56 was lying in bed with her nasal canula in place attached to a concentrator. Observation of the oxygen setting revealed it was running at five liters of oxygen per minute. Interview with Certified Nursing Assistant (CNA) #414 on 03/09/26 at 7:29 A.M. revealed she was just assigned to the hall and was unaware of what setting Resident #56's oxygen was ordered. Interview with Licensed Practical Nurse (LPN) #405 on 03/09/26 at 7:34 A.M. verified that Resident #56's oxygen was not at the liters ordered by the physician. Observation of Resident #56 on 03/12/26 at 7:10 A.M. revealed the resident was walking down the hall with a rollator walker and a portable oxygen concentrator sitting on the seat of the walker. Observation of the concentrator settings revealed the resident was receiving four liters of oxygen per minute. Interview with LPN #463 on 03/10/26 7:14 A.M. verified Resident #56's portable oxygen setting was not at the liters ordered by the physician. Review of the facility policy titled Oxygen Therapy - Mask and Nasal Canula, revised 02/13/23, revealed oxygen is administered by a licensed nurse and required a physician order. Oxygen is administered appropriately to residents to improve oxygenation and provide comfort to residents experiencing respiratory difficulties.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview and policy review, the facility failed to secure a provider agreement with a hemodialysis provider prior to the current annual survey. Additionally, the facility failed to ensure collaborative communication was shared between the facility and the hemodialysis center. This affected one (#12) of one resident reviewed for dialysis. The facility identified one resident receiving dialysis services The facility census was 87. Findings include: Review of the medical record revealed Resident #12 was admitted to the facility on [DATE]. Diagnoses included unspecified dementia with other behavioral disturbances, end stage renal disease, type two diabetes, and hypertensive chronic kidney disease. Review of the Resident #12's care plan for end stage renal disease, revised 11/13/25, revealed interventions, including the assessment of central line site used for hemodialysis, to be completed every shift. Dialysis on Tuesdays, Thursdays and Saturdays. Resident to leave the facility around 10:00 A.M. for an 11:00 A.M. chair time. There were no interventions for communication with the dialysis center. Review of dialysis communication notes from 01/01/26 to 03/12/26 revealed communication forms for dialysis treatment for 01/13/26, 01/17/26, 02/05/26, 02/28/26, and 03/10/26. There was no communication forms from the dialysis center for dialysis treatments completed on 01/01/26, 01/03/26, 01/06/26, 01/08/26, 01/10/26, 01/15/26, 01/20/26, 01/22/26, 01/24/26, 01/27/26, 01/29/26, 02/03/26, 02/07/26, 02/10/26, 02/12/26, 02/14/26, 02/17/26, 02/19/26, 02/21/26, 02/26/26, 03/03/26, 03/05/26, and 03/07/26. Interview on 03/10/26 at 7:17 A.M. Licensed Practical Nurse (LPN) #464 revealed no knowledge of the communication process with dialysis and was not aware of a dialysis communication book. Interview on 03/10/26 at 7:21 A.M. with LPN #469 revealed there was a dialysis communication book at one time but that she was unsure of what happened to the book or what the new process was for communication between the facility and the dialysis center. Interview on 03/10/26 at 7:37 A.M., the Director of Nursing (DON) revealed the facility had a dialysis communication book. The DON stated she would find the book so that communication sheets could be reviewed. Interview on 03/11/26 at 3:22 P.M. with Registered Nurse (RN) Supervisor #471 revealed there were no further dialysis communication forms other than the five that were found on 03/10/26. RN Supervisor #471 also revealed the current process for the facility communicating with the dialysis center was to send a face sheet, a blank progress note, a medication list and a blank order form. These items were placed in a folder and sent with the caregiver that sits with Resident #12 on dialysis days. RN Supervisor #471 further revealed if Resident #12 had a change in condition of any kind nursing staff at the facility would send this information to the dialysis center using a progress note. Interview on 03/11/26 at 3:44 P.M. the DON revealed a call was made to the dialysis facility to request copies of past communication forms. The DON was told copies were not kept. The DON also stated many times the dialysis center would not send communication forms back with Resident #12. The DON verified she has not called the dialysis center requesting communication forms be sent daily. Interview on 03/12/26 at approximately 12:00 P.M. with the Administrator revealed that prior to the effective date of 03/12/26 listed on the dialysis agreement, there was no previous agreement between the facility and the dialysis provider used by Resident #12. Review of the facility policy titled Hemodialysis, revised on 01/2026, revealed the facility would coordinate and collaborate with the dialysis facility including dialysis treatment provided and the resident's response to treatment. Also included within the policy is the licensed nurse will communicate to the dialysis facility via telephonic communication or written format such information as: timely medication administration, physician/treatment orders, nutritional/fluid management including compliance with food/fluid restrictions, changes and/or declines in condition as well as the occurrence or risk of falls.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on observation, medical record review, resident representative interview, and staff interview, the facility failed to ensure specific interventions were provided to address triggers and care for post-traumatic stress disorde (PTSD). This affected one (#10) of one resident reviewed for PTSD care and treatment. The facility census was 87. Findings include:Review of the medical record revealed Resident #10 admitted to facility on 08/14/25. Diagnoses included dementia, type 2 diabetes mellitus, lumbar vertebra fracture, neurocognitive disorder with Lewy bodies, hypertension, PTSD, depression, transient ischemic attack, and cerebral infarction. Review of the Minimum Data Set assessment, dated 02/13/26, Resident #10 had severely impaired cognition, delusions, rejection of care one to three days during assessment period, and received antipsychotic and antidepressant medications. On 08/14/25 a Social History and Assessment was completed and signed by Social Services Director #408. Diagnoses included PTSD. No additional documentation contained in the medical record indicated the cause or treatment regarding PTSD. Review of the social services plan of care dated 11/12/25 addressed Resident #10's mood problem related to (r/t) cognitive impairment, diagnosis mood disorder: hallucinations, unspecified PTSD, unspecified major depressive disorder, and recurrent anxiety disorder. No specific triggers, causes, behaviors, interventions to address Resident #10 diagnosis of PTSD were documented. Review of current physician medication orders noted the following; 12/05/25 clozapine 100 milligram (mg) at bedtime related to violent behavior, hallucinations, and unspecified PTSD. Interview on 03/11/26 at 12:25 P.M. Resident #10's Power Of Attorney (POA) revealed Resident #10 experienced PTSD related to an assault while serving in the military. The POA stated they had previously informed the Director of Nursing (DON), indicating only female care givers should be provided due to potential behavior trigger related to male caregivers.Review of the medical record revealed no documentation instructing caregivers to be female in order to prevent PTSD behaviors. Interview on 03/11/26 at 12:33 P.M. the DON verified no knowledge of Resident #10's PTSD triggers related to male assault in military. The DON confirmed Resident #10 had previously received care by male caregivers. The DON also confirmed the PTSD plan of care did not indicate specific interventions related to Resident #10 and interventions to address potential cause. Interview on 03/11/26 at 1:14 P.M. Social Services Director #408 revealed they were unaware of Resident #10's cause for PSTD or potential triggers. Social Service Director #408 verified no specific plan of care or assessment was completed addressing Resident #10's diagnosis of PTSD. Observation on 03/12/26 at 6:48 A.M. noted male Certified Nurse Aide (CNA) #520 in Resident #10's room providing morning activities of daily living, including personal care. Interview with CNA #520 on 03/12/26 at 6:51 A.M. revealed he was unaware of Resident #10's request for female direct care staff or care related to the diagnosis of PTSD. CNA #520 stated he worked with Resident #10 during the night shift between 10:00 P.M. and 6:30 A.M.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on record review and staff interview, the facility failed to ensure nutrition assessments were completed accurately and updated with new diet orders. This affected one (#65) for four residents reviewed for food and nutrition. The facility census was 87. Findings include:Review of the medical record for Resident #65 revealed an admission date of 06/07/23. Diagnoses included dementia, type 2 diabetes mellitus, epilepsy, anxiety, and traumatic brain injury. Review of the quarterly Minimum Data set (MDS) assessment, dated 02/11/26, revealed Resident #65 was rarely/never understood and was dependent on staff for eating.Review of the current physician order, initiated 12/14/23, revealed Resident #65 should receive a cream cookie twice daily for nutritional adequacy.Review of Resident #65's progress notes, dated 01/01/26 through 03/12/26, revealed no incidents or concerns regarding eating, swallowing, or choking.Review of the Speech Language Pathology Evaluation and Plan of Treatment, dated 01/07/26, revealed Resident #65 was referred for therapy due to pocketing food.Review of the current physician order, initiated 01/07/26, revealed Resident #65 received a regular type diet with pureed textures and thin liquids, with double portions.Review of the quarterly Nutritional Assessment, dated 02/06/26, revealed Resident #65 was on a regular textured diet and received a cookie for a snack. Interview on 03/10/26 at 2:33 P.M. with Licensed Practical Nurse (LPN) #423 confirmed Resident #65 would still receive an oatmeal cookie for snacks even though he was on a pureed diet.Interview on 03/12/26 at 9:46 A.M. with Registered Dietitian (RD) #487 confirmed she completed Resident #65's nutrition assessment, dated 02/06/26, inaccurately. RD #487 stated she was unaware Resident #65 was on a pureed diet at the time of the assessment. Additionally, RD #487 stated it was inappropriate for Resident #65 to continue to receive an oatmeal cookie on a pureed diet. Follow-up interview on 03/12/26 at 10:26 A.M. with RD #487 revealed the facility did not notify her regarding the change in Resident #65's diet. She stated she did not have access to speech therapy notes through the electronic medical record (EMR) and further confirmed Resident #65's progress notes revealed nothing regarding difficulty chewing or swallowing on or around 01/07/26.