STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365828	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harvard Gardens Rehabilitation & Care Center	18810 Harvard Ave Cleveland, OH 44122

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. Based on observation, staff interview, and policy review, the facility failed to ensure residents' rights to privacy and confidentiality of their medical records were maintained. This had the potential to affect all 107 residents residing in the facility. The facility census was 107.Findings include:Observation and interview during medication administration on 02/25/26 at 8:48 A.M. revealed Licensed Practical Nurse (LPN) #556 was using her personal laptop computer to access and document resident medication administration. LPN #556 stated the use of personal laptops for documentation was normal within the facility and confirmed her device did not contain firewalls or protective security software to prevent unauthorized access to resident medical records.Observation and interview during a medication administration on 02/25/26 at 2:35 P.M. revealed LPN #541 was using her personal laptop computer to access and document resident medication administration. LPN #541 stated she used her personal laptop due to lack of availability of facility-issued laptops and confirmed her device did not contain firewalls or protective security software to prevent unauthorized access to resident medical records.Review of the facility policy titled, Medical Records, dated 07/01/23, revealed that every effort will be made to ensure records are confidential, secure, readily accessible to authorized staff, and retained in accordance with applicable laws and regulatory requirements. The policy further revealed medical records are confidential and protected under the Health Insurance Portability and Accountability Act (HIPAA). The observed practice was inconsistent with the facility's written policy and failed to ensure confidentiality of resident records.Review of the facility policy title, Protected Health Information (PHI), Management and Protection of, dated 04/01/07, revealed it is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release of disclosure.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on review of staffing schedules and timecard punches, review of resident census data, and staff interview, the facility failed to ensure a registered nurse worked in the facility for at least eight consecutive hours a day, seven days a week as required. This had the potential to affect all 107 residents residing in the facility. The census was 107. Findings include: Review of the facility staffing schedules and staff timecard punches dated from 12/25/25 through 12/31/25, revealed there was no registered nurse (RN) working in the facility on 12/25/25 and 12/31/25. Review of the facility census data for 12/25/25 and 13/31/25 revealed 97 were residing in the facility on those dates.Interview on 02/24/26 at 3:18 P.M. with the Director of Nursing (DON) verified there was no RN coverage on 12/25/25 and 12/31/25. She stated she was the only RN in the building on those days.This deficiency represents non-compliance investigated under Complaint Number 2671148 and Complaint Number 2603969.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of narcotic medication logs, medical record review, staff interview, and facility policy review, the facility failed to ensure all narcotic count sheets were signed, completed, and maintained the accurate receiving, dispensing, and reconciliation of all controlled substance medications, and failed to ensure administered medications were accurately documented within the medical record. This had the potential to affect all 107 residents residing in the facility. The facility census was 107.Findings include:1. Observation on 02/25/26 at 8:00 A.M. of the facility narcotic medication count binders revealed, the Two North (front) narcotic log was missing the second nurse narcotic count verifier on 02/25/26 at 7:00 A.M. The Two North (back) narcotic log was missing signatures on 02/22/26 at 7:00 A.M. and 02/22/26 at 7:00 P.M. The One North narcotic log (East) was missing count signatures on 02/21/26 at 7:00 P.M., 02/22/26 at 7:00 A.M., 02/18/26 at 7:00 P.M., 02/19/26 at 7:00 A.M., 02/24/26 at 7:00 A.M., 02/14/26 at 7:00 A.M., 02/14/26 at 7:00 P.M., 02/15/26 at 7:00 A.M., 02/10/26 at 7:00 P.M., 02/08/26 at 7:00 A.M., 02/08/26 at 7:00 P.M., 02/17/26 at 7:00 A.M., 02/02/26 at 7:00 A.M., 02/02/26 at 7:00 P.M., and 01/31/26 at 7:00 P.M.Interview with the Director of Nursing (DON) on 02/26/26 at 2:45 P.M. verified the missing signatures on the identified narcotic count sheets. The DON stated she would re-educate staff regarding change of shift narcotic counts and the importance of completing documentation verifying the accuracy of narcotic count logs per facility policy. Review of the undated facility policy titled, Best Practice for Medication Dispensing: Scheduled II Narcotics, revealed to decrease costs and increase accountability with scheduled II narcotics, a standard is implemented. Authorized personnel will follow the state and federal regulations regarding schedule II narcotics.2. Review of the medical record for Resident #4 revealed an admission date of 10/29/25 with diagnoses including diabetes mellitus, hypertension, and chronic kidney disease.Review of Resident #4's active physician orders as of February 2026 revealed the resident was ordered atorvastatin 40 milligrams (mg) at bedtime for high cholesterol on 10/29/25; aspirin 81 mg twice daily related to heart disease on 10/29/25; carvedilol 25 mg twice daily for heart disease on 10/29/25; buspirone 10 mg twice daily for anxiety on 10/29/25; gabapentin 300 mg three times a day for pain on 11/03/25; Ramelteon eight (8) mg at bedtime for insomnia on 12/11/25; and insulin glargine solution 40 units inject subcutaneously at bedtime for diabetes mellitus on 01/30/26.Review of Resident #4's medication administration record (MAR) for February 2026 revealed the resident's atorvastatin 40 mg at bedtime was not documented as given on 02/05/26, 02/06/26, 02/10/26, 02/13/26 and 02/19/26. Further review of the MAR revealed aspirin 81 mg at bedtime on 02/05/26, 02/06/26, 02/10/26, 02/13/26, and 02/19/26 was documented as not administered; carvedilol 25 mg at bedtime on 02/05/26, 02/06/26, 02/10/26, 02/13/26, and 02/19/26 was documented as not administered; buspirone 10 mg at bedtime on 02/05/26, 02/06/26, 02/10/26, 02/13/26, and 02/19/26 was documented as not administered; gabapentin 300 mg at 10:00 P.M. on 02/05/26, 02/10/26, 02/13/26, 02/19/26, and at 6:00 A.M. on 02/06/26, 02/11/26, 02/14/26, and 02/20/26 was documented as not administered; Ramelteon 8 mg at bedtime on 02/05/26, 02/06/26, 02/10/26, 02/13/26, and 02/19/26 was documented as not administered; and insulin glargine 40 units at 9:00 P.M. on 02/05/26, 02/10/26, 02/13/26, and 02/19/26 was documented as not administered.Interview on 02/25/26 at 12:51 P.M. with the DON verified the medications listed above for Resident #4 were not documented as administered on the February 2026 MAR. Review of the facility policy titled, Administering Medications, revised December 2012, revealed medication must be administered in accordance with orders, including any require time frame.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, resident interview, and staff interview, the facility failed to ensure all hot foods were served at adequate and palatable temperatures. This had the potential to affect 105 residents who received meals from the facility. The facility identified Resident #8 and Resident #67 received no food from the kitchen. The facility census was 107. Findings include: Interview with Resident #11 on 02/23/26 at 1:58 P.M. revealed the food was cold all the time. Interview with Resident #6 on 02/24/26 at 8:50 A.M. revealed the food was never hot.Observation and interview of a test meal tray with Dietary Manager (DM) #526 on 02/24/26 at 12:41 P.M. revealed the tray consisted of a chicken breast filet, rice, peas and carrots, and a grape drink. Temperatures were obtained in the presence of DM #526 with the food temperatures including the chicken breast was 122 degrees Fahrenheit (F), the peas and carrots were 122 degrees F, and the rice was 141 degrees F. The chicken and the peas and carrots were warm but not hot when consumed. DM #526 verified the findings of the test tray at the time of observation.This deficiency represents non-compliance investigated under Complaint Number 2671148.

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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 observation and staff interview, the facility failed to ensure the kitchen environment, kitchen equipment, and food was maintained in a clean and sanitary manner. This had the potential to affect 105 residents who received meals from the facility. The facility identified Resident #8 and Resident #67 who received no food from the kitchen. The facility census was 107.Findings include: Observation of the kitchen area with Dietary Manager (DM) #526 on 02/23/26 between 9:03 A.M. and 9:21 A.M. revealed one loaf of bread on the bread rack was moldy, the oven and stove handles and knobs had accumulated grease and dirt, the floor throughout kitchen had spills and sticky areas and the floor in preparation area across from the steamer had dirt and crumbs, the counter in preparation area around the can opener had grease and a sticky substance on it, and the shelf over the oven had a coating of grease and dust.Interview with DM #526 on 02/23/26 between 9:03 A.M. and 9:21 A.M. confirmed the above findings at the time of discovery.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and staff interview, the facility failed to ensure its dumpster area was maintained in a clean and sanitary condition. This had the potential to affect all 107 residents residing in the facility. The facility census was 107.Findings include: Observation of the dumpster area on 02/23/26 at 8:00 A.M., upon entering the facility, revealed two dumpsters were overflowing with trash piled approximately two to three feet high. Further observation revealed three of the four dumpster lids were open.Interview and observation on 02/23/26 at 9:16 A.M. with Dietary Manager (DM) #525 verified the findings.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, business records review, and staff interview, the facility failed to ensure final accounting and conveyance of resident funds was completed within 30 days upon death. This affected three (#126, #127, and #128) of three residents reviewed for final conveyance of trust accounts. The facility census was 107.Findings include:1. Review of the medical record revealed Resident #126 was admitted to the facility on [DATE]. Resident #126 expired at the facility on [DATE].Review of the business records for Resident #126 revealed a check for Resident #126's personal funds balance remaining at the facility in the amount $1,1179.30 was dispensed on [DATE] to the states Medicaid recovery bureau.2. Review of the medical record revealed Resident #127 was admitted to the facility on [DATE]. Resident #127 expired at the facility at the facility on [DATE].Review of the business records for Resident #127 revealed a check for Resident #127's personal funds balance remaining at the facility in the amount $102.42 was dispensed on [DATE] to the states Medicaid recovery bureau.3. Review of the medical record revealed Resident #128 was admitted to the facility on [DATE]. Resident #128 expired at the facility at the facility on [DATE].Review of the business records for Resident #128 revealed a check for Resident #128's personal funds balance remaining at the facility in the amount $2,120.09 was dispensed on [DATE].Interview with the Administrator on [DATE] at 9:45 A.M. verified final accounting and conveyance of Resident #126, Resident #127, and Resident #128's personal funds were not completed within 30 days following their deaths.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and staff interview, the facility failed to ensure the physical environment was maintained in a clean, sanitary, and homelike manner. This affected 28 (#17, #34, #37, #38, #39, #43, #47, #50, #52, #53, #54, #58, #63, #64, #74, #77, #81, #83, #86, #87, #90, #92, #98, #99, #104, #107, #141, and #162) of 107 residents residing in the facility. The census was 107. Findings Include:1. Observation of Resident #64's room on 02/25/26 at 11:46 A.M. revealed no bathroom door was present.Interview with Licensed Practical Nurse (LPN) #634 on 02/26/25 at 11:50 A.M. verified the lack of a bathroom door in Resident #64's room.2. Observation of the facility environment with Housekeeping Director #700 on 02/26/26 between 1:15 P.M. and 1:45 P.M. revealed the air vent in Resident #50's room was heavily rusted; the privacy curtains in Resident #39, Resident #52, Resident #58, Resident #63, Resident #77, Resident #87, Resident #92, and Resident #107's rooms were visibly stained; the tile flooring in Resident #99 and Resident #162's room contained unidentified substance on the floor and visible staining; Resident #34 and Resident #90's room had thick dust accumulation on the ceiling, Resident #90's supplemental feeding administration pole had a large amount of dried supplement residue; the windowsill in Resident #141's room had a large brown stain; the air conditioning units in Resident #98 and Resident #104's room contained a bird nest and birds could be heard chirping from within the unit; Resident #53's fall mat was torn, worn, and soiled; Resident #54's dresser was missing drawers and the toilet in the room had brown staining; Resident #83's sink in the living area was cracked; Resident #64's light over the bed had a visible crack, and Resident #43's headboard was broken off and was resting beside the bed.Further observation on 02/26/26 between 1:15 P.M. and 1:45 P.M. revealed the closet doors were missing in the rooms for Resident #17, Resident #37, Resident #38, Resident #47, Resident #52, Resident #54, Resident #58, Resident #74, Resident #81, Resident #86, Resident #87, and Resident #92.The above findings were confirmed by Housekeeping Director #700 during the environmental tour on 02/26/26 at the time of discovery. This deficiency represents non-compliance investigated under Complaint Number 2671148 and Complaint Number 2659118.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to accurately code resident Minimum Data Set (MDS) assessments. This affected nine (#11, #29, #32, #52, #53, #62, #64, #87, and #102) of 24 residents reviewed for MDS assessment accuracy. The facility census was 107.Findings include:1. Review of the medical record for Resident #29 revealed the resident was admitted to the facility on [DATE] with diagnoses that included schizophrenia, dementia, and major depressive disorder. Review of the level two Preadmission Screening and Resident Review (PASRR) evaluation dated 03/21/07 revealed Resident #29 had a level two serious mental illness. Review of Resident #29's most recent comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the facility answered, No, to the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? 2. Review of the medical record revealed Resident #32 was admitted to the facility on [DATE] with diagnoses that included delusional disorder, hallucinations, and major depressive disorder. Review of the level two PASRR evaluation dated 06/16/23 revealed Resident #32 had a level two serious mental illness. Review of Resident #32's most recent comprehensive MDS assessment dated [DATE] revealed the facility answered, No, to the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? 3. Review of the medical record revealed Resident #52 was admitted to the facility on [DATE] with diagnoses that included heart failure, schizophrenia, and generalized anxiety disorder. Review of the level two PASRR evaluation dated 08/21/21 revealed Resident #52 had a level two serious mental illness. Review of Resident #52's most recent comprehensive MDS assessment dated [DATE] revealed the facility answered, No, to the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? 4. Review of the medical record revealed Resident #53 was admitted to the facility on [DATE] with diagnoses that included hypoxemia, schizophrenia and acute respiratory failure. Review of the level two PASRR evaluation dated 12/01/15 revealed Resident #53 had a level two serious mental illness. Review of Resident #53's most recent comprehensive MDS assessment dated [DATE] revealed the facility answered, No, to the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? 5. Review of the medical record revealed Resident #62 was admitted to the facility on [DATE] with diagnoses that included mood disorder, intermittent explosive disorder, and bipolar disorder. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the level two PASRR evaluation dated 11/14/24 revealed Resident #62 had a level two serious mental illness. Review of Resident #62's most recent comprehensive MDS assessment dated [DATE] revealed the facility answered, No, to the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? 6. Review of the medical record for Resident #64 revealed the resident was admitted to the facility on [DATE] with diagnoses that included mood disorder, intermittent explosive disorder, and bipolar disorder. Review of the level two PASARR evaluation dated 12/02/25 revealed Resident #64 had a level two serious mental illness. Review of Resident #64's most recent comprehensive MDS assessment dated [DATE] revealed the facility answered, No, to the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? 7. Review of the medical record for Resident #87 revealed the resident was admitted to the facility on [DATE] with diagnoses that included mood disorder, schizophrenia, and schizoaffective disorder. Review of the level two PASRR evaluation dated 12/04/24 (from previous facility that resident transferred from) revealed Resident #87 had a level two serious mental illness. Review of Resident #87's most recent comprehensive MDS assessment dated [DATE] revealed the facility answered, No, to the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? 8. Review of the medical record revealed Resident #102 was admitted to the facility on [DATE] with diagnoses that included cocaine dependence, schizophrenia, and schizoaffective disorder. Review of the level two PASRR evaluation dated 08/07/24 (from previous facility that resident transferred from) revealed Resident #87 had a level two serious mental illness. Review of Resident #102's most recent comprehensive MDS assessment dated [DATE] revealed the facility answered, No, to the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? Interview with MDS Nurse #609 on 02/27/26 at 11:00 A.M. verified Resident #29, Resident #32, Resident #52, Resident #53, Resident #62, Resident #64, Resident #87, and Resident #102 all had their PASRR status incorrectly coded on MDS assessments as noted above. 9. Record review for Resident #11 revealed an admission date of 10/30/25. Diagnoses included pain in the left hip, unilateral primary osteoarthritis, left knee, intervertebral disc degeneration, lumbar back pain, and pain in right foot. Review of the MDS assessment dated [DATE] revealed Resident #11 was cognitively intact and did not receive scheduled pain medication. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician orders for January 2026 revealed Resident #11 had active orders for the narcotic pain medication oxycodone extended release (ER) 12-hour abuse deterrent 10 milligrams (mg) by mouth two times a day for pain initiated on 01/06/26, and the nerve pain medication Lyrica oral capsule 75 mg by mouth three times a day initiated on 11/20/25. Interview and record review on 02/27/26 at 12:05 P.M. with MDS Nurse #609 verified the MDS assessment dated [DATE] was incorrect and confirmed Resident #11 was on routine pain medication in January 2026, including during the five-day look back period the MDS assessment was completed for.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, medical record review, and review of the facility policy, the facility failed to ensure residents needs and preferences were met regarding appropriate linens on beds and maintaining bathing equipment for use to accommodate resident preference. This affected two residents (#105 and #22) of 13 residents reviewed for accommodation of needs. The facility census was 107.Findings include:1. Record review for Resident #105 revealed an admission date of 10/24/24. Diagnoses included dislocation of an unspecified knee, morbid severe obesity, and encounter for orthopedic aftercare. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #105 was cognitively intact. Resident #105 had impairment on one side of the lower extremities, used a wheelchair for mobility, required set up or clean up assist with toileting hygiene, supervision or touch assist with personal hygiene, and partial/moderate assist with bed mobility and transfers. Observation on 02/24/26 at 10:25 A.M. revealed Resident #105 was lying in bed with her eyes closed. The bed was noted to be a bariatric (larger bed) bed and there was no fitted sheet on the mattress. Resident #105 was resting on the bare mattress.Observation and interview 02/24/26 at 4:33 P.M. revealed Resident #105 was still lying in her bed directly on the mattress with no fitted sheet under her. Resident #105 stated, They do not have a lot of bed sheets, the fitted ones. I have to lay on the bare mattress and I do not like it but they are always running out. Resident #105 revealed she does not refuse the sheet; the facility just does not have them available and revealed they also frequently run out of gowns and towels. Observation and interview on 02/24/26 at 4:46 P.M. with Licensed Practical Nurse (LPN) #637 confirmed Resident #105 was lying on the bare mattress. Observation of the available linens on the south halls where Resident #105 resided confirmed there were no bariatric fitted sheets available. Observation and interview on 02/24/26 at 4:52 P.M. with the Director of Nursing (DON) of the North linen closet and the second floor confirmed there were no bariatric fitted sheets. The DON confirmed there were no bariatric fitted sheets in the residential areas for staff to use. Observation of the laundry area located in the basement of the facility with the DON revealed, after searching, Housekeeping/Laundry Director #540 found two bariatric fitted sheets.2. Record review for Resident #22 revealed an admission date of 12/18/24. Diagnosis included cerebral infarction, cellulitis, type two diabetes mellitus, and morbid, severe obesity. Review of the MDS assessment dated [DATE] revealed Resident #22 was cognitively intact. Resident #22 had impairment on one side of the upper extremities and both sides of the lower extremities and was dependent for bathing and showers. Review of the care plan initiated 12/19/24 revealed Resident #22 had an activity of daily living (ADL) self-care performance deficit. Interventions included Resident #22 required assistance with ADLs (i.e.: dressing, grooming, personal hygiene, locomotion, oral care, etc.) as needed and to honor the resident's choices and preferences whenever possible. Record review of the activity interview for daily preference document for Resident #22 dated 12/21/24 revealed for the question asking how important it was to the resident to choose between a tub bath, shower, bed bath, or sponge bath, Resident #22 answered it was very important. Record review of the resident preference evaluation for Resident #22 dated 08/23/25 revealed it was very important to Resident #22 to choose between a tub bath, shower, bed bath, or sponge bath and revealed Resident #22 chose a shower as his preference.Review of the shower records from 12/01/26 through 02/27/26 for Resident #22 revealed Resident #22 only received bed baths during that period.Interview on 02/25/26 at 10:00 A.M. with Resident #22 revealed he had not received a shower in the past two and a half to three months. Resident #22 confirmed he could only take a shower using the shower bed due to his physical condition and revealed he was told by the staff he could not receive a shower because the shower bed was broken. Resident #22 was only able to receive bed baths as he did not feel as clean and preferred showers. Observation and interview on 02/25/26 at 10:06 A.M. with LPN #541 of the shower bed confirmed the bed was missing pins that held the frame together. LPN #541 confirmed (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #22 was unable to receive showers due to the shower bed being the only shower bed in the facility. LPN #541 revealed the bed had been broke at least a few weeks. Interview on 02/25/26 at 10:26 A.M. with Certified Nurse Aide (CNA) #575 revealed the shower bed Resident #22 used had not been working for at least a couple months.Interview on 02/25/26 at 11:47 A.M. with the Administrator revealed there were issues with the shower bed and stated it was not working a month or so, maybe a little more. This deficiency represents non-compliance investigated under Complaint Number 2710289.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to complete a significant change Minimum Data Set (MDS) assessment within 14 days after hospice services were discontinued for one resident (#3) of three residents reviewed for hospice services. The facility census was 107.Findings include:Record review for Resident #3 revealed an admission date of 07/19/19. The resident had a diagnosis of benign prostatic hyperplasia. Record review revealed a hospice order dated 10/23/24 to admit Resident #3 to hospice services.Review of the progress note dated 11/14/25 at 12:11 P.M., completed by Licensed Practical Nurse (LPN) #543, revealed Resident #3 was transferred to the hospital via stretcher with two paramedics and hospice was aware.Review of the progress note dated 11/25/25 at 3:16 P.M., completed by LPN #552, revealed Resident #3 returned from the hospital. Resident #3 was admitted for hypernatremia, urinary tract infection, and aspiration pneumonia. Record review revealed a hospice order dated 11/20/25 confirming hospice services were discontinued for Resident #3.Review of the Minimum Data Set (MDS) assessment submission log from 11/25/25 through 03/02/26 for Resident #3 revealed there was no significant change MDS assessments completed after discontinuing hospice services.Interview on 03/02/26 at 5:10 P.M. with MDS Nurse #609 confirmed a significant change MDS assessment should have been completed after Resident #3 returned from the hospital on [DATE] with no hospice services.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, medical record review, and facility policy, the facility failed to develop and effective means of communication for a resident who spoke limited English to ensure the resident was able to effectively communicate requests and needs. This affected one (#89) of 24 residents interviewed for the provision of care. The facility census was 107.Findings include:Review of Resident #89's medical record revealed an admission date of 07/17/25. Diagnoses included age-related osteoporosis with pathological fracture, adult failure to thrive, protein calorie malnutrition, major depressive disorder, unspecified dementia, systolic heart failure and alcohol abuse. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed with severely impaired cognition and required maximum assistance and cuing for all activities of daily living.Observation and interview with Resident #89 on 02/23/26 at 9:35 A.M. revealed the resident had difficulties in communicating to the surveyor and his roommate (Resident #101) during initial interview due to Resident #89 speaking only Spanish. Resident #89 was not able to respond effectively to questions regarding care or treatment at facility. There was no communication board in room for Resident #89 to use for communicating needs and activities of daily living (ADLs) including pain, bathroom, food, water, and hygiene needs. Resident #89 was able to understand some simple words, but had difficulty expressing thoughts and needs. Attempts with a telephone translation application on the surveyor's telephone provided some additional communication with the resident, however; due to on-going oral problems with Resident #89, he could not speak effectively into the translation application device and have his words translate correctly from Spanish to English. Resident #89 was able to understand some translations from English to Spanish with device.Interview with Resident #101 on 02/23/26 at 9:45 A.M. revealed he, looks out for him (Resident #89). Resident #101 stated he frequently uses the translator application on his telephone to assist Resident #89's needs and will call for assistance from staff for Resident #89. Resident #101 stated staff do not use a communication board or electronic translator when providing care and Resident #89 does not understand what staff are speaking to him about. Resident #101 stated staff do not take the time to ensure Resident #89 understands directions.Additional interview with Resident #89 on 02/25/26 at 12:10 P.M., using the electronic Spanish translator telephone application, revealed he had difficulties communicating with staff. Resident #89 had not been eating well and had lost weight due to his teeth. He did not like the pureed diet and his mouth hurt when he was trying to eat. Resident #89 stated he had not had dental care and was requesting services to improve his oral care and diet. Resident #89 was able to answer yes and no to simple questions but could not appropriately speak his on-going concerns or needs. Communication with the resident was difficult as the Spanish to English translation on the telephone application could not understand all of his words due to oral difficulties and poor annunciation into the device.Interview with Speech Therapist #630 on 02/26/26 at 11:21 A.M. stated Resident #89 understood very simple words and commands such as pain, bathroom, food, water in English, but could not have a conversation with staff. Speech Therapist #630 stated she would supply the resident with a communication board in his room. She also verified Resident #89 had had oral problems and could not annunciate words correctly and had his diet changed from mechanical soft to puree due to oral issues. Speech Therapist #630 stated Resident #89 did not understand most English language but could not answer effectively or communicate all needs and concerns.Interview with Licensed Practical Nurse #556 (LPN) on 02/26/26 at 2:15 P.M. revealed Resident #89 did understand some English but could not speak English except for simple words. She stated Resident #89 did understand what staff are saying to him and LPN #556 verified no communication board or tools were present in the resident's room for Resident #89 to utilize.Interview with Certified Nurse Aide (CNA) #588 on 02/27/26 at 9:47 A.M. confirmed there was no communication board or posted (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	frequently used words for translation from Spanish to English for Resident #89. She stated he did understand English but cannot speak English well. She also stated Intake/admission Director (IAD) #654 was able to translate important concerns for the resident when she was onsite at the facility. Of note, Intake/admission Director #654 was not always available or onsite at facility since she also traveled to another regional facility.Interview with IAD #654 on 03/03/26 at 11:00 A.M. revealed she was fluent in Spanish and was often called upon to translate Spanish to residents at the facility. She stated she had translated and explained pertinent clinical and procedural information to Resident #89 since his admission. IAD #654 stated staff will call when having difficulties communicating with the resident. AID #654 confirmed speech therapy does have communication boards for residents if needed but confirmed she had not seen them used with Resident #89.Review of facility policy titled, Communication for Residents with Limited English Proficiency, dated July 2024, revealed the facility may provide qualified interpreter services when needed, including telephone, video, or in-person interpreters. Staff may use translator applications to assist in communication, and residents will receive safe, effective, and understandable communication regarding their care, rights, and services.

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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, medical record review, and staff interview, the facility failed to label, date, or initial supplemental tube feeding containers to notify when the supplement was hung and by which staff as ordered. This affected one (#70) of two residents reviewed for tube feedings. The census was 107.Findings include:Review of the medical record for Resident #70 revealed an admission date of 12/09/25. Diagnoses included dysphagia, severe protein-calorie malnutrition, and hemiplegia and hemiparesis following cerebral infarction.Review of Resident #70's active physician orders for February 2026 identified orders to change the feeding administration set with each new bottle; label the formula container, syringe, and administrative set with the resident's name, date, time, and the nurse's initials.Observation on 02/23/26 at 11:01 A.M. revealed Resident #70's tube-feeding container was hung but not labeled, dated, or initialed.Interview on 02/23/26 at 11:01 A.M. with Registered Nurse (RN) #571 verified Resident #70's tube feeding container was not labeled, dated, or initialed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, resident interview, and staff interview, the facility failed to ensure a resident had active orders for use of supplemental oxygen. This affected one (#53) of one residents reviewed for respiratory care. The census was 107.Findings include:Review of the medical record for Resident #53 revealed an admission date of 12/30/15 with diagnoses including paranoid schizophrenia, dyskinesia, asthma, respiratory failure, anxiety, dyskinesia, and nicotine dependence.Review of Resident #53's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact.Observation and interview of Resident #53 on 02/23/26 at 1:12 P.M. revealed an oxygen concentrator was turned on in the room and set to four liters per minute flow rate. When asked about the usage of his oxygen, Resident #53 stated he wore the oxygen intermittently for shortness of breath or after smoking outside. Resident #53 stated he used the oxygen daily for a long time.Review of Resident #53's current physician orders revealed the resident had no active orders for supplemental oxygen use. Review of completed and discontinued physician orders revealed an order for oxygen was discontinued on 12/13/25 and was only originally ordered for two liters per minute per nasal cannula.Interview with Licensed Practical Nurse (LPN) #519 and Assistant Director of Nursing (ADON) #608 on 02/27/25 at 2:02 P.M. verified there was no active order for oxygen and confirmed Resident #53 had been using the oxygen for months. LPN #519 and ADON #608 did not know the order for oxygen was discontinued on 12/29/25 which was two months earlier.

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F 0697 Level of Harm - Minimal harm or potential for 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 medical record review, resident and staff interview, review of medication administration audit reports, and review of a facility policy, the facility failed to ensure pain medications were administered as ordered to effectively manage a resident's pain. This affected one (#11) of seven residents reviewed for medication administration. The facility census was 107.Findings include:Record review for Resident #11 revealed an admission date of 10/30/25. Diagnoses included pain in the left hip; unilateral primary osteoarthritis, left knee; intervertebral disc degeneration; lumbar back pain; and pain in the right foot.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 was cognitively intact and had pain frequently.Review of the care plan for Resident #11 dated 11/03/25 revealed Resident #11 was at risk for back pain, fatigue, anxiety, and bone pain. An intervention included to administer medications as prescribed.Review of the physician orders for January and February 2026 revealed Resident #11 had active orders for the narcotic pain medication oxycodone extended release (ER) 12 hour abuse deterrent 10 milligrams (mg), give 10 mg by mouth two times a day scheduled for upon rising and at 7:00 P.M. for pain. The order was initiated on 01/06/26. Resident #11 was also ordered oxycodone 10 mg by mouth every four (4) hours as needed for pain on 11/07/25 and oxycodone five (5) mg by mouth every 4 hours as needed for mile to moderate pain on 02/10/26. On 10/31/25, the resident was ordered a lidocaine external 4 percent (%) patch topically to the effected area upon rising for pain. On 02/18/26, the resident was ordered the muscle relaxing medication Baclofen 10 mg by mouth three times daily scheduled for upon rising, at dinner, and 7:00 P.M. Further review of Resident #11's physician orders revealed the resident was ordered the pain medication Lyrica oral capsule 75 mg by mouth three times a day (scheduled for 6:00 A.M., 2:00 P.M., and 10:00 P.M.). This order was initiated on 11/20/25 and discontinued 02/19/26. Resident #11 was also ordered muscle relaxing medication methocarbamol 750 mg by mouth three times daily which was initiated on 02/16/26 and discontinued on 02/18/26 at 8:26 P.M.Review of the medication administration time codes provided by the Director of Nursing (DON) revealed upon rising was between 6:00 A.M. to 10:00 A.M. or between 7:00 A.M. to 11:00 A.M.; dinner was between 2:00 P.M. to 5:00 P.M.; and bedtime was between 7:00 P.M. to 11:00 P.M.Review of the medication administration audit report for January 2026 and February 2026 for Resident #11 revealed the audit report included the actual time each medication was administered. Further review of the audit report revealed on 01/02/26 Lyrica 75 mg was to be administered at 2:00 P.M. and was administered at 4:10 P.M.; on 01/03/26 lidocaine 4% patch ordered for upon rising was administered at 1:43 P.M.; on 01/03/26 Lyrica 75 mg was to be administered at 2:00 P.M. and was administered at 4:06 P.M.; on 01/04/26 lidocaine 4% patch ordered for upon rising was administered at 1:12 P.M.; on 01/06/26 Lyrica 75 mg was to be administered at 2:00 P.M. and was administered at 4:47 P.M.; on 01/06/26 Lyrica 75 mg was to be administered at 10:00 P.M. and was administered on 01/07/26 at 7:43 A.M.; on 01/08/26 lidocaine 4% patch ordered for upon rising was administered at 12:18 P.M.; on 01/08/26 Lyrica 75 mg was to be administered at 2:00 P.M. and was administered at 4:38 P.M.; on 01/09/26 oxycodone ER 10 mg ordered for upon rising was administered at 1:20 P.M.; on 01/09/26 lidocaine 4% patch ordered for upon rising was administered at 1:19 P.M.; on 01/10/26 Lyrica 75 mg was to be administered at 10:00 P.M. and was administered on 01/11/26 at 6:52 A.M. (The 6:00 A.M. dose was also administered on 01/11/26 at 6:51 A.M.); on 01/11/26 Lyrica 75 mg was to be administered at 2:00 P.M. and was administered at 4:33 P.M.; on 01/12/26 Lyrica 75 mg was to be administered at 2:00 P.M. and was administered at 5:02 P.M.; on 01/12/26 oxycodone ER 10 mg ordered for 7:00 P.M. was administered on 01/13/26 at 12:12 A.M. (an as needed dose of oxycodone 10 mg was administered on 01/12/26 at 9:25 P.M.); on 01/13/26 oxycodone ER 10 mg ordered for 7:00 P.M. was administered at 11:14 P.M. for a pain rated a six out of 10; on 01/14/26 lidocaine 4% patch ordered for upon rising was administered at 2:08 P.M.; on 01/14/26 oxycodone ER 10 mg ordered for 7:00 P.M. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was administered on 01/15/26 at 12:54 A.M. (an as needed dose of oxycodone 10 mg was given at 9:55 P.M. for pain rated a seven out of 10); on 01/15/26 oxycodone ER 10 mg ordered for upon rising was administered at 11:26 P.M. with a pain rating of 10 out of 10; on 01/16/26 lidocaine 4% patch ordered for upon rising was administered at 12:06 P.M.; on 01/16/26 oxycodone ER 10 mg ordered for upon rising was administered at 12:07 P.M. and the resident rated pain a 10 out of 10; on 01/19/26 oxycodone ER 10 mg ordered for 7:00 P.M. was administered on 01/20/26 at 8:51 A.M. and rated pain a seven out of 10; and on 01/19/26 Lyrica 75 mg was to be administered at 7:00 P.M. and was administered on 01/20/26 at 8:50 A.M. (The 6:00 A.M. dose was documented as administered on 01/20/26 at 8:49 A.M.)Review of the electronic medication administration record (e-MAR) progress note revealed on 01/21/26 Lyrica to be administered at 6:00 A.M. and 2:00 P.M. was not available. Review of the e-MAR progress note revealed on 01/22/26 Lyrica to be administered at 2:00 P.M. was not available. Review of the MAR revealed Resident #11 rated her pain a six out of 10. Review of the e-MAR progress note revealed on 01/23/26 Lyrica to be administered at 6:00 A.M., 2:00 P.M., and 10:00 P.M. was not available. Review of the MAR revealed Resident #11 rated her pain a 10 out of 10 for all shifts.Further review of Resident #11's MARs and medication audit reports for January and February 2026 revealed on 01/24/26 oxycodone ER 10 mg ordered for upon rising was administered at 4:21 P.M. (The oxycodone scheduled to be administered at 7:00 P.M. was documented as administered on 01/24/26 at 7:07 A.M.); on 01/24/26 lidocaine 4% patch ordered for upon rising was administered at 4:21 P.M.; on 01/25/26 Lyrica 75 mg was to be administered at 2:00 P.M. and was administered at 5:27 P.M.; on 01/26/26 oxycodone ER 10 mg ordered for upon rising was administered at 6:46 P.M.; on 01/26/26 lidocaine 4% patch ordered for upon rising was administered at 6:46 P.M.; on 01/28/26 Lyrica 75 mg was to be administered at 10:00 P.M. and was administered on 01/29/26 at 4:08 A.M. (The 6:00 A.M. dose was administered at 6:22 A.M.); on 02/03/26 oxycodone ER 10 mg ordered for 7:00 P.M. was administered on 02/04/26 at 1:04 A.M.; on 02/04/26 Lyrica 75 mg was to be administered at 2:00 P.M. and was administered at 4:22 P.M.; on 02/05/26 oxycodone ER 10 mg ordered for 7:00 P.M. was administered on 02/06/26 at 3:37 A.M.; on 02/05/26 Lyrica 75 mg was to be administered at 10:00 P.M. and was administered on 02/06/26 at 3:36 A.M.; on 02/09/26 oxycodone ER 10 mg ordered for upon rising was not administered; on 02/09/26 Lyrica 75 mg was to be administered at 2:00 P.M. and was administered at 6:22 P.M.; on 02/18/26 Lyrica 75 mg was to be administered at 2:00 P.M. and was administered at 4:47 P.M.; on 02/18/26 methocarbamol 750 mg was to be administered at 4:00 P.M. was not administered; on 02/20/26 oxycodone ER 10 mg ordered for 7:00 P.M. was administered on 02/21/26 at 3:26 A.M.; on 02/20/26 Baclofen 10 mg scheduled to be given at 7:00 P.M. was administered on 02/21/26 at 3:26 A.M.; on 02/22/26 Baclofen 10 mg scheduled to be given at 7:00 P.M. was administered on 02/22/26 at 10:25 P.M.; on 02/23/26 Baclofen 10 mg scheduled to be given at 7:00 P.M. was administered on 02/24/26 at 12:21 A.M.; on 02/25/26 oxycodone ER 10 mg ordered for upon rising was administered at 12:12 P.M.; and on 02/25/26 Baclofen 10 mg scheduled to be given at 7:00 P.M. was administered at 11:45 P.M.Record review of Resident #11's nursing progress notes for January and February 2026 revealed no documentation of reasons for late medication administration on all occasions with exception as documented above. Interview on 02/26/26 at 9:23 A.M. with Resident #11 stated the facility did not always administer her pain medications on time. Resident #11 revealed she had chronic back pain and was able to tolerate pain some of the time. Resident #11 revealed she was receiving therapy with a goal to return home, and she needed to keep her pain tolerable to be able to complete her therapy. Resident #11 stated when her pain rating was at a five or six out of 10, she could not tolerate it without intervention. Interview on 03/03/26 at 12:49 P.M. with the DON verified the late times for Resident #11 pain medication administration in January and February 2026 for the above mentioned dates and medications. The DON revealed she had never seen a medication administration audit report before and was not aware the medications were being administered late. The DON stated she did not know why Resident #11's pain medications were administered late. Review of the facility policy titled, (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administering Medication, revised December 2012, revealed medications shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required time frame.This deficiency represents non-compliance investigated under Complaint Number 2639149 and Complaint Number 2603969.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and staff interview, and facility policy review, the facility failed to ensure residents were seen by a physician in a timely manner as required. This affected one (#89) of 24 sampled residents reviewed for physician visits. The facility census was 107.Findings include:Review of medical record for Resident #89 revealed an admission date of 07/17/25 with diagnoses including osteoporosis, adult failure to thrive, protein calorie malnutrition, major depressive disorder, unspecified dementia, systolic heart failure, and alcohol abuse.Review of Resident #89's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of three which indicated severely impaired cognition. Review of provider notes from 07/17/25 to 02/27/26 revealed only one visit note by the facility physician. The physician admission note for Resident #89 was not conducted until 10/15/25 which was almost three months after initial admission to facility and no follow up visits/assessments were documented by provider since admission note.Interview with Resident #89 02/23/26 at 9:35 A.M revealed the resident could not recall any provider visits completed at facility.Interview with the Director of Nursing (DON) on 03/02/26 at 1:30 P.M. confirmed the physician for Resident #89 did not perform an assessment until 10/15/25. The DON also verified no other provider notes or visits were documented in the electronic medical record. The DON confirmed the medical provider does not utilize a nurse practitioner in his practice and was solely responsible for all residents managed under his care.Review of facility policy titled, Physician Visits, dated 2001, revealed the attending physician must visit patients at least once every thirty days for the first ninety days following the resident's admission, and then at least every sixty days thereafter. Additionally, a physician visit is considered timely if it occurs not later than ten days after the date the visit was required.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, medical record review, and facility policy review, the facility failed to ensure timely dental care was provided to address resident needs. This affected one (#89) of 24 sampled residents observed for dental concerns. The facility census was 107.Findings include:Review of the medical record for Resident #89 revealed an admission date of 07/17/25 with diagnoses including osteoporosis with pathological fracture, adult failure to thrive, protein-calorie malnutrition, major depressive disorder, unspecified dementia, systolic heart failure, and alcohol abuse.Review of Resident #89's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of three which indicated severely impaired cognition. Review of the care plan dated 12/16/26 revealed goals and interventions for Resident #89's dental problems related to missing teeth. Interventions included daily oral hygiene, notification to the provider with complaints of pain or changes in nutritional status, provide medications per order, and refer to dental services as needed.Review of speech therapy progress notes on 12/31/25 revealed Resident #89 was edentulous and required pureed food due to decreased activity tolerance to complete meals. The resident's swallowing was within normal limits and no further treatment was indicated at that time. Speech therapy progress notes also revealed no signs or symptoms of esophageal dysphagia were present.Interview and observation of Resident #89 on 02/25/26 at 12:10 P.M. revealed the resident had poor oral hygiene. Resident #89 was noted to have buildup of food debris left in his mouth, purplish/reddened oral membranes, and was edentulous. The resident also had impaired communication due to poor oral health which impacted nutrition and poor annunciation of Spanish words. Interview with Resident #89 using an electronic telephone translator application revealed he has not been eating well, had oral pain, and had lost weight due to his poor oral health. Resident #89 stated he did not like the pureed diet and his mouth hurt when he was trying to eat. Resident #89 denied any dental care from the facility and was requesting services to improve his oral care and diet. Resident #89 was able to answer simple responses such as, yes and no, to pointed questions but could not expand or communicate concerns or needs. Due to on-going oral and dental problems, communication was difficult as the Spanish to English translation on the telephone application could not understand all of Resident #89's responses due to poor annunciation into the device from oral health problems.Interview with Speech Therapist #630 on 02/26/26 at 11:21 A.M. revealed Resident #89 was provided a mechanical soft diet when admitted to facility in July of 2025 but was changed to pureed diet on 07/18/25 because of intolerance of mechanical soft diet due to oral issues and not from swallowing or aspiration concerns. Speech Therapist #630 referred the resident to Social Worker to address need for dental services.Interview with Social Worker #610 on 02/26/26 at 8:41 A.M. revealed Resident #89 did not have any current insurance including Medicare or Medicaid services to cover dental services for the resident. Social Worker #610 stated Resident #89 had no family or contacts. Social Worker #610 was going to reach out to free dental clinics and other supportive agencies/providers regarding dental care for resident.Interview with the Director of Nursing (DON) on 03/02/26 at 11:10 A.M. revealed Resident #89 has now been scheduled for a dental exam on 03/03/26 at a local dentist office and facility will now cover cost of exam and treatment plan.Review of facility policy titled, Dental, Vision, Audiology, and Podiatry Services Referrals, dated May 2024, revealed the facility will assist residents in obtaining routine and 24 hour emergency dental care. Social services staff will work to assist and/or coordinate services.

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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 observation, resident and staff interview, medical record review, and facility policy review, the facility failed to ensure complete and accurate documentation was maintained in resident medical records. This affected three (#2, #6, and #14) of four residents reviewed for accuracy of documentation. The facility census was 107.Findings include:1. Record review for Resident #6 revealed an admission date of 03/24/14. Diagnoses included hemiplegia and hemiparesis following unspecified cerebrovascular disease, contracture of muscle, and muscle weakness. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 was cognitively intact. Resident #6 had impairment to one side of the upper and lower extremities and was dependent for upper and lower body dressing. Review of the care plan for Resident #6 dated 12/31/25 revealed Resident #6 had the potential for alteration in skin integrity related to impaired mobility and decreased functional ability. Interventions included application of a left palm protector upon rising to be removed at night as tolerated. Review of the physician orders for Resident #6 revealed an order dated 03/07/25 for a left palm protector applied upon rising and removed at night with instructions the resident may wear as tolerated and provide range of motion before and after use. Staff are to check the resident's skin before and after use. Observation and interview on 02/24/26 at 4:20 P.M. revealed Resident #6 was up in her chair. Resident #6 was not wearing her left-hand palm protector and revealed it made her hand sweat. Licensed Practical Nurse (LPN) #609 was present and verified Resident #6 did not have the left-hand palm protector on. Interview on 02/24/26 at 4:27 P.M. with LPN #545 revealed Resident #6 wore her palm guard when she wanted to. LPN #545 confirmed Resident #6 did not have the palm guard on at all on that day and revealed the certified nurse aides (CNAs) usually applied it. Observation and interview on 02/25/26 at 9:10 A.M. revealed Resident #6 did not have a palm guard on. Resident #6 revealed she has not worn the palm guard at all over past year. Interview on 02/25/26 at 9:14 A.M. with CNA #572 revealed she worked consistently with Resident #6 for several years. CNA #572 stated Resident #6 had not worn the palm guard in a long time. CNA #572 verified Resident #6 did not have a palm guard in her room and revealed she never offered Resident #6 the palm guard because she does not wear one. Review of the February 2026 medication administration record (MAR) revealed the order initiated 03/07/25 for Resident #6's left palm protector upon rising to be removed at night with instruction the resident may wear it as tolerated was included. Further review of the MAR revealed specific codes were available if the order was not completed and revealed a check mark indicated the order was administered. Review of the order on the February 2026 MAR from 02/01/26 through 02/24/26 revealed each day was initialed with a check mark by a nurse confirming the order was completed with the exception of 02/05/26 and 02/19/26 on night shift which were left blank. The MAR indicated LPN #557 worked 02/02/26, 02/04/26, 02/07/26, and 02/22/26, and LPN #557 also placed a check (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mark revealing on those days Resident #6's order for the left palm protector was completed. The MAR also indicated on 02/24/26, LPN #545 also initialed Resident #6's order for the palm guard indicating the order was completed. Interview on 02/25/26 at 9:16 A.M. with LPN #557 confirmed Resident #6 had not worn a palm guard in months and confirmed she signed the MAR each day she worked confirming the palm guard was applied per the order. LPN #557 stated, That was an error on my end. Interview on 02/25/26 at 10:14 A.M. with the Director of Nursing (DON) revealed the nurses should not be signing the order was completed if it was not. 2. Record review for Resident #2 revealed an admission date of 04/12/25. Diagnoses included constipation, altered mental status, and vascular dementia. Review of the MDS assessment dated [DATE] revealed Resident #2 had long-term and short-term memory impairments and was always continent of bowel and bladder and independent with toileting. Review of the medical record including the certified nurse aide (CNA) documentation in the electronical medical record revealed no documentation of bowel movements. Interview on 02/25/26 at 3:51 P.M. with LPN #552 revealed Resident #2 took himself to the bathroom unassisted. LPN #552 revealed the staff would ask him if he had a bowel movement then the CNAs would document it. If the resident did not have a bowel movement after three days, the nurses were supposed to give him a laxative. Interview on 02/25/26 at 4:09 P.M. with Resident #2 revealed he had a bowel movement one to two times a month. Resident #2 revealed staff never asked him if he had a bowel movement. Interview on 02/25/26 at 4:15 P.M. with CNA #577 revealed Resident #2 stayed to himself in his room, came out only to eat, and took himself to the bathroom. CNA #577 revealed she documented daily in the electronical medical record if her assigned residents had a bowel movement. Interview on 02/25/26 at 4:22 P.M. with the DON revealed the facility had a protocol for monitoring each resident bowel movements to assure residents were having routine bowel movements. The CNAs documented each bowel movement in the electronical medical record then Assistant Director of Nursing (ADON) #608 monitored those records to make sure the residents had routine bowel movements. Review of Resident #2's medical record with the DON during the interview for the previous 30 days revealed there was no documentation of Resident #2 having a bowel movement. The DON revealed the CNAs would not have known to monitor Resident #2 for bowel movements because the tab for stools was discontinued for Resident #2, so it would not have shown up for the CNAs to alert them of the task to be completed. The DON revealed they were supposed to monitor everyone for bowel movements daily and confirmed Resident #2 was not being monitored for a bowel movement for an unconfirmed amount of time (at least more than a month). Review of the facility policy titled, Bowel and Bladder Management, dated July 2023, revealed to ensure residents receive appropriate assessment, monitoring, and care related to bowel and bladder function in order to maintain dignity, prevent complications, and promote the highest practicable level of function. The procedure included assessment, care planning with interventions based on assessment findings, staff will monitor bowel and bladder activity and measures will be implemented (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to prevent constipation and fecal impactions. 3. Record review for Resident #14 revealed an admission date of 10/23/25. Diagnoses included contusion of other parts of the head and Parkinson's disease. Review of the MDS assessment dated [DATE] revealed Resident #14 was cognitively intact and assessed with no ulcers, wounds, or skin problems. Review of the care plan dated 01/26/26 revealed Resident #14 had potential of skin impairment related to a history of wounds, fragile skin, and immobility. Interventions included to complete wound evaluations to monitor the progress of the resident's skin condition; notify the nurse of any new areas of skin breakdown noted during bathing or daily care, redness, blisters, bruises, discoloration; notify the physician/nurse practitioner/physician assistant of noted worsening of a skin condition or any new areas of skin breakdown. Review of the skin observation form dated 02/24/26 at 10:51 A.M. completed by LPN #569 revealed Resident #14's skin was warm, dry, and intact with normal color an no rash, lesions, or edema. Review of the bath and skin report dated 02/24/26, completed by CNA #594, for Resident #14 revealed on the form was a diagram of a body with the typed directions, If abnormal, please check the type and circle the location of the affected areas (swelling, skin tear, dressing, bruising, red areas, dry skin, open areas, blisters, moles, and scabs. Review of the form revealed, None, was hand written. Further record review of Resident #14's bath and skin reports dated 01/02/26, 01/09/26, 01/13/26, 01/16/26, 01/20/26, 01/23/26, 01/27/26, 01/30/26, 02/10/26, 02/13/26, 02/17/26, and 02/24/26 revealed Resident #14 had no skin issues marked. Review of the skilled assessment for Resident #14 dated 02/26/26 at 5:59 A.M. completed by LPN #549 revealed Resident #14 had no new changes to skin integrity. Observation and interview on 02/26/26 at 9:03 A.M. with Resident #14 revealed the resident was sitting up in bed. Resident #14 did not have a shirt or gown on and had a sheet covering his lap. Further observation revealed Resident #14 had multiple open and scabbed sores in addition to abrasions on his entire upper chest and both upper arms. The areas were of various sizes and shapes with many of the opened areas being circular, red, and with multiple scratch marks/abrasions throughout the chest and upper arms. Resident #14 stated the areas had been there a few months, were very itchy, and revealed the staff already knew about it but never gave him anything to relieve the itching. Interview on 02/26/26 at 9:09 A.M. with CNA #592, during observation of Resident #14's wounds on the chest and upper arms, confirmed the open areas. CNA #592 revealed he started working with Resident #14 in December 2025 and revealed the areas have been there since then and they have not changed. Interview on 02/26/26 at 9:16 A.M. with Registered Nurse (RN) #569, during observation of Resident #14's wounds on the chest and upper arms, confirmed the open areas. RN #569 revealed she did not know the wounds were there as Resident #14 usually had a gown on when she worked with him. Resident #14 confirmed to the nurse the wounds had been there for two months and revealed they were very itchy and requested something to help. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 02/26/26 at 9:49 A.M. completed by RN #569 revealed Resident #14 had some irritation noted to the chest and bilateral arms with scabs covering some. Resident #14 complained of itching to the areas and the resident informed the nurse that he scratches from time to time. Telephone interview on 02/26/26 4:16 P.M. with CNA #594 revealed Resident #14 had that rash on his chest and arms since about the end of January 2026. CNA #594 stated she told a nurse about it but could not remember who. CNA #592 confirmed she did fill out the bath and skin report on 02/24/26 and stated, I did not mark anything because I thought it was for redness or bruising. I though his was just from dry skin. Review of the facility policy titled, Change in Resident's Condition or Status, dated August 2024, revealed the nurse will record in the resident's medical record information relative to the changes in the resident's medical/mental condition or status.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, resident and staff interview, and policy review, the facility failed to ensure infection control practices were maintained for residents on enhanced barrier precautions and proper cleaning of bodily fluids was completed. This affected two (#1 and #99) of seven residents reviewed infection control practices. The facility census was 107.Findings include: 1. Record review revealed Resident #1 was admitted to the facility on [DATE]. Diagnoses included benign prostatic hyperplasia with lower urinary tract symptoms, bacteremia, and retention of urine. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was mildly cognitively impaired. Resident #1 had an indwelling catheter and required substantial/maximal assistants with toileting hygiene. Review of the care plan for Resident #1 dated 10/28/25 revealed the had a need for a urinary (Foley) catheter related to urinary retention. An interventions included to document the urinary output. Review of an additional care plan dated 05/13/25 revealed Resident #1 required enhanced barrier precautions (EBP) due to a Foley catheter. Interventions included staff to wear gloves and a gown for the high-contact resident care activities including device care or use of a central line, urinary catheter, feeding tube, or tracheostomy. Review of the physician orders for Resident #1 revealed an order dated 12/01/25 for catheter care every shift and as needed and EBP due to the urinary catheter, every shift. Observation and interview on 02/26/26 at 8:47 A.M. revealed Licensed Practical Nurse (LPN) #543 emptied Resident #1's indwelling catheter bag and LPN #543 did not put an isolation gown prior to emptying the urine from the catheter bag. LPN #543 confirmed there was 100 cubic centimeters (cc) of urine drained from the bag. LPN #543 confirmed she never wore an isolation gown while emptying the catheter bag and stated, I do not need to wear one. Further observation revealed a sign near Resident #1's door entrance that indicated the resident was on EBP. The Director of Nursing (DON) was standing at the doorway and confirmed LPN #543 never wore an isolation gown during interview at that time. The DON confirmed an isolation gown was required with any care of the indwelling catheter for Resident #1. Interview on 02/26/26 at 8:56 A.M. with Resident #1 revealed when staff does care for his catheter, they do not always wear an isolation gown. 2. Record review for Resident #99 revealed an admission date of 07/29/25. Diagnoses included long term use of anticoagulants, longstanding persistent atrial fibrillation, and blindness in one eye. Review of the MDS assessment dated [DATE] revealed Resident #99 was cognitively intact. Observation and interview on 02/27/26 at 1:24 P.M. revealed Resident #99 was sitting up in his wheelchair in his room. Resident #99 did not have a sock on his right foot. The top of the right foot and between each toe was covered with dried blood. The floor in front of Resident #99's bed and trailing to the opposite side of the room had multiple large droplets of dried blood. Resident #99 stated the blood on his foot and on the floor was from a nose bleed the day before and as his nose bled, he was leaning forward in his chair causing the blood to drip on his foot. Resident #99 confirmed staff did (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not clean him or the floor up. Continued observation and interview revealed Certified Nurse Aide (CNA) #584 entered the room and confirmed the dried blood on Resident #99's foot and on the floor in front of his bed and trailing across the room. Observation and interview on 02/27/26 at 1:41 P.M. with LPN #549 verified Resident #99 was sitting in his wheelchair with dried blood covering the top of his right foot and on the floor. LPN #549 stated the blood on the floor and on his foot was from the nosebleed the resident had the previous day. LPN #549 verified several dried blood droppings on the floor. Interview on 02/27/26 at 1:46 P.M. with the DON revealed the blood on Resident #99 and on his floor should have been cleaned up as soon as possible after it occurred. Review of the facility policy titled, Blood and Body Fluid Spill Cleanup Policy, dated July 2023, revealed the facility will ensure prompt and safe cleanup of blood and body fluid spills to prevent transmission of infection in accordance with Occupational Safety and Health Administration (OSHA) bloodborne pathogen standards and the Centers for Disease Control and Prevention (CDC) standard precautions. The purpose was to protect residents, staff, and visitors from exposure to bloodborne pathogens.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility assessment and staff interview, the facility failed to ensure the facility assessment contained all required information. This had the potential to affect all 107 residents residing in the facility. The facility census was 107.Findings include:Review the facility assessment dated [DATE] revealed the assessment did not contain evidence of direct input into the assessment from direct care staff, including but not limited to, registered nurses (RNs), licensed practical nurses (LPNs), certified nurse aide (CNAs) and other representatives of the direct care staff; consideration of specific staffing needs for each shift (day, evening, and night) or plans to adjust, as necessary, based on any changes to its resident population; and consideration of specific staffing needs for each resident unit in the facility and plans to adjust, as necessary, based on changes to its resident population. Further review revealed the assessment did not include consideration of workforce challenges such as staff turnover, availability of staff in the local market, and the facility's ability to recruit and retain qualified staff and furthermore did not identify recruitment and retention strategies necessary to ensure sufficient staffing.Interview on 02/27/26 at 2:15 P.M. with the Administrator verified the lack of required information in the facility assessment.