STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365874	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hudson Elms Nursing Center	563 W Streetsboro Road Hudson, OH 44236

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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 observation, interviews and facility policy, the facility failed to ensure the kitchen was maintained in a clean sanitary manner and that food was stored and labeled properly. This had the potential to affect 43 out of 43 residents who ate meals in the facility's kitchen. The facility census was 43.Findings include:1.Interview and observation on 05/04/26 at 9:40 A.M. with Kitchen Director (KD) #875 during kitchen initial tour revealed the following:-A container of Pork and Beans dated 04/28/26. -An unlabeled potato salad container-Unlabeled pitched of orange Kool-Aid-Unlabeled pitched of purple Kool-Aid-Container of pork dated but unlabeled-The wall behind the bread shelf storage was dirty with various dried splatters-Various crumbs and debris on tray line shelving's-The standing fridge by KD #875 office was dirty with various crumbs and splatters-Multiple vents in the kitchen had visible dust build-upKD #875 confirmed observations at the time and revealed the facility keeps leftovers for 2 days.2. Further interview and observation on 05/06/26 at 1:50 P.M. with Regional Kitchen Director (RKD)#865 revealed the area behind the ice machine had built up dirt on the floor and trash including tape and a Styrofoam cup. Multiple moldy strawberry containers in the walk-in refrigerator. RKD #865 said the strawberries were delivered last night. He threw away the entire carton of strawberries. There was a hole in the wall behind the 3-part sink that RKD #865 revealed was from a pipe bursting. 3. Observation and interview on 05/07/26 at 10:35 A.M. with RKD #865 revealed a very strong odor by the dishwasher area. RKD #865 revealed the wall between the beverage area and the dishwasher area was rotting and moldy. He said the facility had contacted a company to replace the wall and this was causing the fruit flies and the strong odor.Review of facility policy titled, Food Safety and Sanitation, not dated revealed the following under food storage, when a food package is opened, the food item should be marked to indicate the open date. This date is used to determine when to discard the food. Left overs are used within 72 hours (or discarded).Review of facility policy titled, Food Safety-Director of Dining Services' Responsibilities, not dated revealed sanitary conditions will be maintained in the food storage, preparation and serving areas.

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 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ staff that are licensed, certified, or registered in accordance with state laws. THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review and staff interview, the facility failed to ensure Licensed Practical Nurse (LPN) #853 had a valid and active license. This had the potential to affect all 43 residents residing in the facility.Findings include:Review of the State licensure database for LPN's revealed LPN #853 did not have an active license. His nursing license was suspended.Email correspondence on 05/05/26 at 2:46 P.M. from the Chief of Compliance Ohio Board of Nursing (OBN) verified LPN #853 did not have an active license. LPN #853 license was noted to have been suspended on 11/20/25 and remains suspended since that date.Review of LPN #853's time punches revealed he worked 33 days on a suspended nursing license. 11/25/25, 12/01/25, 12/12/25, 12/13/25, 12/19/25, 12/27/25, 12/28/25, 12/31/25, 01/02/26, 01/10/26, 01/11/26, 01/12/26, 01/15/26, 01/22/26, 01/24/26, 01/25/26, 02/05/26, 02/07/26, 02/08/26, 02/09/26, 02/15/26, 02/16/26, 02/17/26, 02/20/26, 02/22/26, 02/25/26, 03/02/26, 03/05/26, 03/06/26, 03/07/26, 03/08/26, 03/09/26 and 03/12/26.Interview with the Administrator and the Regional Director of Clinical Services on 05/06/26 at 2:10 P.M. revealed LPN #853 did not notify anyone his nursing license was suspended. It was not known he had a suspended license. Once they knew, they notified OBN and corrected the issue. Interview with LPN #853 was attempted twice and the phone number was no longer valid. The deficient practice was corrected on 03/16/26 when the facility implemented the following corrective actions for affected residents:-On 03/16/26 the DON/Designee notified the Medical Director and OBN of the incident.-On 03/16/26 the DON/Designee completed head-to-toe assessments for all residents to ensure no injuries of unknown origin were identified. -On 03/16/26 Social Services/Designee completed psychosocial assessments for all residents to ensure residents remained at their baseline mental status.-On 03/16/26 Human Resources/Designee completed licensure verification for all nursing staff to ensure all staff had unincumbered licensure.-On 03/16/26 the Administrator/Designee reviewed the facility's hiring process/procedure including verification of licensure for nurses upon hire and annually thereafter. No revisions were needed.-On 03/16/26 the Administrator/Designee educated the Human Resource Manager on the process/procedure used to verify licensure for nurses. -On 03/16/26 the DON/Designee educated all nurses on the OBN licensure requirements for nurses and the facility's process/procedure for licensure verification. -Beginning 03/16/26 Human Resources/Designee will monitor new hires and verify nurses have a current/valid license upon hire and per the facility's protocol. The Human Resources/Designee will audit three new nurse hires a week, for four weeks and randomly thereafter to ensure compliance. -On 03/16/26 an Ad Hoc QAPI was held with the IDT and Medical Director to discuss the incident and the plan to correct.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on record reviews and interviews, the facility failed to implement a quality assurance plan to ensure resident pharmacy recommendations were acted upon timely. This finding had the potential to affect all 43 residents in the facility. Findings include:Review of Resident #2, #4, #5, and #40's medical record revealed ongoing recommendations from pharmacy starting in July 2025 to make modifications to their medication administration regimen without timely response and justification of declination of the recommendations from Physician #854.Telephone interview on 05/05/26 at 1:52 P.M. with Consultant Pharmacist #857 she had come to the building to talk to Physician #854 about the usage of narcotics for residents with no clear indication of use at some point in the Fall of 2025 and the physician had asked her who made the rules for narcotics. She stated Physician #854 wanted to know who to talk to about administering narcotics and was told Centers for Medicare and Medicaid (CMS) guidelines. Telephone interview on 05/06/26 at 10:29 A.M. with Physician #863 revealed she was aware Physician #854 was over prescribing narcotics to residents and she counseled the physician on several occasions. Physician #863 indicated she had urged the facility on multiple occasions to discontinue association with Physician #854 and the facility refused. Physician #863 indicated Physician #854 would assess her residents and order narcotics for these residents and then bill for visit when the resident was not his to assess. Physician #863 revealed she parted with the facility in 02/2026.Review of the QAPI Policy and Procedure dated 2026 revealed to ensure continuous evaluation of the Facility's systems with the objectives of ensuring that care delivery systems function consistently, accurately, and incorporate current and evidence-based practice standards where available; preventing deviation from care processes, to the extent possible; identifying issues and concerns with the facility's systems, as well as identifying opportunities for improvement; and developing and implementing plans to correct and/or improve identified areas.Review of the QAPI report dated 05/06/26 authored by the Administrator revealed gradual dose reductions (GDR) and pharmacy recommendations were not being completed timely and accurately. There was no evidence the facility implemented a QAPI plan prior to 05/06/26.Interviews on 05/12/26 at 3:18 P.M. with the Administrator, Registered Nurse (RN) Regional Director of Clinical Services #860, Regional Director of Operations #862 and Regional MDS #855 revealed the QA meets quarterly to discuss resident care which included the Medical Director. The QAPIs were implemented during the survey for narcotics at the lowest effective dose and GDR and pharmacy recommendations to be addressed timely.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interviews and facility policy, the facility failed to ensure the kitchen walk-in freezer was in functional working conditions. This had the potential to affect 43 out of 43 residents who ate meals in the facility's kitchen. The facility census was 43.Findings include:Interview and observation on 05/04/26 at 9:40 A.M. with Kitchen Director (KD) #875 during initial tour of kitchen revealed the large walk-in freezer was broken. There were two standing freezers in the beverage area where facility was storing frozen items.Interview and observation on 05/07/26 at 10:35 A.M. with KD #875, Regional Kitchen Director #865 and Registered Dietitian #871 revealed the freezer had been broken for a few months. When asked to see the substitution log, KD #865 revealed that he is substituting a lot of food items due to not having a freezer. He said they were supposed to have pork for dinner that night, but he had to substitute the pork because he did not have a freezer to store the pork in. Regional Kitchen Director #865 said he would get pork for dinner tonight. He said facility had received 9 quotes for the freezer repair. Interview and observation on 05/07/26 at 04:55 P.M. with KD #875 and Regional Kitchen Director #865 revealed dinner was ham and cheese sandwiches. When asked about not serving the pork KD #875 revealed he did not have a freezer to store the pork and that the residents do not like pork.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a clean, sanitary and homelike environment. This finding affected 16 residents who smoke (Residents #2, #4, #7, #9, #13, #14, #17, #23, #24, #31, #35, #36, #37, #39, #40 and #56) and had the potential to affect all 43 residents at the facility. The facility census was 43.Findings include:1. Interview and observation on 05/11/26 at 3:48 P.M. with Registered Nurse Travel Director of Nursing #861 in Resident #5 and Resident #2 room of paint peeling off above the floor board by the window. Observation of Resident #10 revealed a white wooden cover under the window that was being held up with black duct tape. Interview and observation on 05/11/26 at 3:49 P.M. with Resident #11 in room revealed four 1/2-inch by 1/2-inch holes in the wall with crumbling dry wall exposed to be below the window and above the heat register. Resident #11 said the holes were from a shelf that was removed 3 years ago and that were never fixed. Interview and observations on 05/11/26 at 4:08 P.M. with the Director of Maintenance (DM) #877 and Regional Traveling Administrator (RTA) #876 revealed the following concerns during facility tour: -In Resident #10 room part of the privacy curtain track was missing above bed 2. -In the central bathroom on the 100 Hall there were 2 broken wall tiles near the bottom of the wall by the shower. -Confirmed observation of holes in the wall in Resident #11 room. -Resident #44 room had a large area where popcorn ceiling was peeled off. -Resident #26 room had a 1 foot (ft) by 1 ft water stain on the ceiling. -The wall between room [ROOM NUMBER] and #205 had dried liquid stains on it by the floor vent. Multiple areas in the hallway had dried stains on the wall and dust along the handrailing's. -The wall to the right of the central bath on the 200 Hall revealed a large area with paint peeling and dry wall exposed due to a previous item being removed from wall. -Resident #21 room had multiple dry wall patches that had not been painted over. -In the dining room there were three chairs with the arm rest unbolted to the chair arm and two chairs missing arm rest. Review of facility policy titled, Homelike Environment, with a revised date of February 2021 revealed, The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a clean, sanitary and orderly environment. 2. Observations of the resident smoke break on 05/04/26 at 11:22 A.M. revealed cigarette butts on ground greater than 25 butts observed during smoke break on 05/04/26 at 11:20 a.m. revealed (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Residents #2, #4, #7, #9, #13, #14, #17, #23, #24, #31, #35, #36, #37, #39, #40 and #56 were observed in the smoking area. Approximately 25 cigarette butts were located on the ground and in the rocks of the smoking area. Interview on 05/04/25 at 11:22 A.M. with Activities Director (AD) #832 confirmed the resident smoking area had a large number of cigarette butts on the ground and was not maintained in a clean manner. Review of the Smoker list revealed 23 residents currently reside in the facility who smoke including Residents #2, #4, #6, #9, #13, #14, #16, #17, #18, #23, #24, #29, #31, #32, #33, #35, #36, #37, #38, #39, #43, #44 and #56. The facility census was 43. Review of the Resident Smoking Policy and Procedure dated 2025 revealed to accommodate the individual needs and preferences of residents while still protecting the safety and health of individuals residing in the facility, the facility will maintain an environment that remains as free from accident hazards as possible and the facility will ensure that each resident receives adequate supervision and assistance to prevent accidents. The Facility will also provide accommodation for individual needs and preferences without endangering the health or safety of any resident in the Facility. This deficiency represents non-compliance investigated under Complaint Number 2708314, 2721208, and 2682116.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interviews and facility policy, the facility failed to maintain an effective pest control management system in the kitchen. This had the potential to affect 43 out of 43 residents who ate meals in the facility's kitchen. The facility census was 43. Findings include:Interview and observation on 05/04/26 at 9:40 A.M. with Kitchen Director (KD) #875 during kitchen initial tour revealed the beverage area had multiple fruit flies flying around the covered trash can. When trash can lid was lifted numerous fruit flies flew out of the trash can. By the dishwashing area uncovered trash can with no bag and a piece of bread in the can with fruit flies.Observation and interview on 05/06/26 at 4:47 P.M. with KD #875 and Regional Kitchen Director (RKD) #865 of dinner tray line revealed numerous fruit flies around the brownies that were on the tray line and being served to residents. Confirmed observation with both KD #875 and RKD #865.Interview on 05/07/26 at 9:11 A.M. with Registered Dietitian #871 revealed she had observed fruit flies in the kitchen ceiling, in the ceiling lights and behind the wallpaper by the dishwasher area. She said facility had repeatedly flushed the drains but was not sure what they were flushing them with. Observation and interview on 05/07/26 at 10:35 A.M. with Registered Dietitian #871 of the kitchen. Interview with KD #875 revealed staff flushed the drains weekly with an enzyme cleaner. The dishwasher area had a bad smell and Regional Kitchen Director #865 revealed the wall between the beverage area and the dishwasher area was rotting and moldy. He said this was the cause of the strong odor and the fruit fly issue. Facility had contacted a contracting company to replace the wall but RKD #865 did not provide any further information regarding repairs.Review of Orkin Service Report dated 03/23/26 revealed drains were foamed to help break down organic material that caused drain and phorid fly activity. Food debris and buildup was present in the floor drains, in the track of the pull-down door that the flies were congregating in, and in the garbage disposal. Recommended facility regularly deep cleaned to remove conducive conditions. The garbage disposal most likely needed servicing and clean out. Fly activity will continue until cleanliness levels are maintained.Review of facility policy titled, Pest Control, not dated revealed routine pest control procedures will be in place. If pests are seen in the kitchen, the director of food and nutrition services or designee shall be informed, describing where the pest was seen and when. Appropriate action will be taken to eliminate any reported pest situation in the department.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records review and interviews, the facility failed to ensure Residents #2, #5, #6, #21, #27 and #31 Pre-admission Screening and Resident Review (PASRR) forms accurately reflected the resident's psychiatric diagnoses. This finding affected six (Residents #2, #5, #6, #21, #27 and #31) of seven residents reviewed for PASRR requirements. The facility census was 43.Findings include:1. Review of Resident #31's medical record revealed she was admitted to the facility on [DATE] with diagnoses including bipolar disorder, borderline personality disorder, major depressive disorder recurrent, suicidal ideations and personal history of suicidal behavior. Review Resident #31's discharge (DC)-return anticipated Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #31 required modified independence for cognitive skills for daily decision making. Review of Resident #31's PASRR Identification Screen dated 03/19/26 revealed she did not have any indications of serious mental illness and/or developmental disability effective 03/18/26. Review of Resident #31's PASRR Identification Screen was not updated to reflect the resident's admission diagnosis of personality disorder, bipolar disorder and major depressive disorder. Interview on 05/06/26 at 3:30 P.M. with Social Service Designee (SSD) #839 confirmed Resident #31's PASRR was not updated to reflect the serious diagnosed mental issues. 2. Review of Resident #6's medical record revealed an admission date of 03/26/24 and continues to reside in the facility. Diagnoses included schizoaffective disorder bipolar type, vascular dementia, altered mental status and unspecified psychosis not due to a substance or known physiological condition. Review of Resident #6's Annual MDS 3.0 assessment dated [DATE] revealed he was cognitively intact. Review of Resident #6's PASRR Identification Screen dated 03/26/24 revealed no indications of serious mental illness and/or developmental disability effective date: 03/26/24. Review of Resident #6's PASRR Identification screen was not updated to reflect the resident's admission diagnosis of Schizoaffective disorder bipolar type. Interview on 05/06/26 at 3:30 P.M. with SSD #839 confirmed Resident #6's PASRR was not updated to reflect the serious diagnosed mental issues. 3. Review of Resident #27's medical record revealed the resident was admitted on [DATE] and discharged on 05/05/26 with diagnoses including major depressive disorder, generalized anxiety disorder and bipolar disorder (all listed as 02/26/26). Review of Resident #27's admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment. Review of Resident #27's PASRR Identification Screen dated 03/11/26 revealed a diagnosis of mood (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disorder. Review of Resident #27's PASRR Identification Screen was not updated to reflect the resident's admission diagnosis of major depressive disorder. Interview on 05/06/26 at 3:25 P.M. with SSD #839 confirmed Resident #27's PASRR was not updated to reflect the accurate diagnosis of major depressive disorder. 4. Review of Resident #2's medical record revealed an admission date of 01/09/26 with diagnosis of malignant neoplasm of prostate, schizoaffective disorder, anxiety, major depressive disorder, insomnia, secondary malignant neoplasm of lung, pain, acute cystitis without hematuria, hemiplegia and hemiparesis, chronic obstructive pulmonary disease, essential hypertension, epilepsy, metabolic encephalopathy, chronic viral hepatitis C, and cerebral infarction due to unspecified occlusion. Review of PASRR Result Notice dated 11/08/24 revealed No indications of serious mental illness and/or developmental disability. Resident #2's PASRR did not reflect the resident's diagnosis of schizoaffective disorder, anxiety and major depressive disorder. Interview on 05/06/26 at 12:20 P.M. with SSD #839 revealed she had worked at the facility for about a month and had been trying to go through residents PASSR's to make sure they were accurate. SSD #839 confirmed Resident #2's PASRR was not accurate. 5. Review of Resident #5's medical record revealed an admission date of 03/08/23 with diagnosis that included dementia, peripheral vascular disease, schizophrenia, intellectual disabilities, hallucinations, delusional disorder, essential hypertension, hyperlipidemia, and insomnia. Review of Resident #5's MDS quarterly assessment dated [DATE] revealed BIMS score was unable to be completed due to resident's non-verbal status and inability to answer questions. Review of PASRR completed on 04/24/23 revealed resident was marked under Section E: Indications of Serious Mental Illness question 1) Does the individual have a diagnosis (es) of any of the mental disorders listed below? was marked as No. Resident #5's PASRR did not reflect the resident's diagnosis of schizophrenia and delusional disorder. Interview on 05/06/26 at 12:20 P.M. with SSD #839 revealed she had worked at the facility for about a month and had been trying to go through residents PASSR's to make sure they were accurate. SSD #839 confirmed Resident #5's PASRR was not accurate. 6. Review of Resident #21's medical record revealed an admission date of 04/02/26 with diagnosis that included dysphagia, bipolar disorder, depression, anxiety, chronic systolic heart failure, edema, obesity, cerebrovascular disease, hemiplegia, DM 2, essential hypertension, paroxysmal atrial fibrillation, schizoaffective disorder, neuroleptic parkinsonism, chronic kidney disease and anemia. Review of PASRR completed on 04/02/26 revealed Section E: Indications of Serious Mental Illness question 1) Does the individual have a diagnosis (es) of any of the mental disorders listed below? was marked as No. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #21's PASRR did not reflect the resident's diagnosis of bipolar disorder and schizoaffective disorder. Interview on 05/06/26 at 12:20 P.M. with SSD #839 revealed she had worked at the facility for about a month and had been trying to go through residents PASSR's to make sure they were accurate. SSD #839 confirmed Resident #21's PASRR was not accurate. Review of the undated PASRR Statutes form provided by the facility revealed such assessments shall be coordinated with any State-required preadmission screening program to the maximum extent practicable in order to avoid duplicative testing and effort. In addition, a nursing facility shall notify the State mental health authority or State mental retardation or developmental disability authority, as applicable, promptly after a significant change in the physical or mental condition of a resident who was mentally ill or mentally retarded.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure pharmacy recommendations were acted upon timely and the recommendations reflected a valid reason a gradual dose reduction (GDR) was not attempted. This finding affected four (Residents #2, #4, #5 and #40) of 11 records reviewed for unnecessary medications. The facility census was 43.Findings include:1. Review of Resident #2 medical record revealed an admission date of 01/09/26 with diagnoses including schizoaffective disorder, anxiety, major depressive disorder and insomnia.Review of Resident #2's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.Review of Resident #2's physician orders revealed an order dated 02/11/26 (discontinued 04/13/26) for Ambien oral tablet 10 milligrams (mg) give one tablet by mouth every 24 hours as needed for sleep.Review of Resident #2's Consultant Pharmacist's Report dated 02/20/26 revealed resident was ordered Zolpidem (Ambien) 10 mg one tablet by mouth at bedtime as needed for sleep without a stop date. Pharmacist recommendation was to discontinue the medication or add a stop date to the current as needed order.Review of Resident #2's Consultant Pharmacist Report dated 03/22/26 revealed the resident had an order for Zolpidem 10 mg one tablet by mouth as needed for sleep without a stop date (started 02/11/26). Please consider either discontinuation or add a duration for use to the current order. The recommendation was addressed by the physician on 04/13/26 and the physician agreed to the recommendation. Resident #2's medical record revealed the first recommendation dated 02/20/26 and second recommendation dated 03/22/26 for the Ambien were not acted upon until 04/13/26.Interview on 05/11/26 at1:51 P.M. with Director of Nursing (DON) confirming above findings.2. Review of Resident #5 medical record revealed an admission date of 05/08/23 with diagnosis that included dementia, schizophrenia, intellectual disabilities, hallucinations and delusional disorder.Review of Resident #5's Quarterly MDS 3.0 assessment dated [DATE] revealed resident exhibited severe cognitive impairment.Review of Resident #5's physician orders revealed an order dated 02/07/25 for Trazodone (antidepressant medication) oral tablet 150 mg with instructions to give 75 mg by mouth take half tab at bedtime for insomnia; an order dated 09/11/25 for Paxil (antidepressant medication) Oral Tablet 10 mg one tablet by mouth one time a day (discontinued date of 04/11/26); and an order dated 04/11/26 for Paxil 10 mg tablet orally one time a day for mood.Review of Resident 5's physician orders revealed an order dated 02/21/25 for Potassium 10 mg one tablet by mouth one time a day for hypokalemia.Review of Resident #5's Pharmacist Recommendation to Provider form dated 07/27/25 and 09/19/25 revealed the resident was ordered Potassium oral tablet with instructions to give 10 mg by mouth one time a day for hypokalemia. Pharmacist's recommendation was to correct the dose to give potassium 10 milliequivalent (mEq) one tablet by mouth once daily. There was no evidence that the pharmacy recommendation was acted upon.Review of Resident #5's Pharmacist Recommendation to Provider form dated 03/22/26 revealed the resident was ordered two or more antidepressants at this time, for different indications, without a recent documented GDR (gradual dose reduction) attempt in the past 6 months. Resident was ordered Paroxetine (Paxil) 10 mg one tablet by mouth once a daily for one tablet by mouth once daily for sexually acting out. Resident was ordered Trazodone 75 mg tablet at bedtime for insomnia. Pharmacist's recommendation was to consider a GDR of one or both of these agents, at this time. Perhaps decreasing Trazodone 50 mg and/or trial without paroxetine, while concurrently monitoring for response or reemergence of symptoms. Otherwise, must indicate rationale for use of two or more psychotropics from same therapeutic class for this resident. The physician response dated 04/15/26 revealed other was marked and will review.Interview on 05/11/2026 at 1:51 P.M. with the DON confirmed the pharmacy recommendations for Potassium were not acted upon and never changed. DON confirmed that the order for Paroxetine was discontinued and reordered for the (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	same dose and Trazodone was not adjusted either without justification to decline pharmacy recommendations.3. Review of Resident #4's medical record revealed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including paraplegia, anxiety disorder and major depressive disorder.Review of Resident #4's Annual MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.Review of Resident #4's physician orders revealed an order dated 09/23/25 for Oxycodone 5 mg give one tablet every six hours as needed for moderate pain; and an order dated 09/23/25 for Oxycodone oral tablet 5 mg give 2 tablets every six hours as needed for pain.Review of Resident #4's Pharmacist Recommendation to Prescriber form dated 11/19/25 revealed the resident had multiple analgesic orders without a clear indication or sequence for administration including Oxycodone 10 mg one tablet by mouth every six hours as needed for body pain; Oxycodone 5 mg one tablet by mouth every six hours as needed for moderate pain; and Oxycodone 5 mg two tablets by mouth every six hours as needed for pain. The form was signed on 12/03/25 by Physician #854 to discontinue both orders for Oxycodone 10 mg and retain the Oxycodone 5 mg as needed orders. (The physician response was 14 days.)Telephone interview on 05/05/26 at 1:52 P.M. with Consultant Pharmacist #857 revealed that Physician #854 ordered Oxycodone narcotics without clear indication of use and he had multiple orders for pain medications. Interview on 05/05/26 at 4:45 P.M. with Regional MDS #855 confirmed Resident #4's pharmacy recommendation dated 11/19/25 to retain the Oxycodone as needed 5 mg and the order had two orders on the same physician order including Oxycodone 5 mg one tablet every six hours as needed for moderate pain and oxycodone 5 mg two tablets every six hours as needed for pain. The two tablets every six hours as needed for pain were not discontinued as indicated on the pharmacy recommendation.4. Review of Resident #40's medical record revealed the resident was admitted on [DATE] with diagnoses including schizoaffective disorder, alcohol dependence with alcohol-induced persisting dementia and Alzheimer's disease.Review of Resident #40's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.Review of Resident #40's physician orders revealed an order dated 02/07/26 (discontinued 03/13/26) for oxycodone 10 mg by mouth three times a day for pain due at 7:00 A.M., 2:00 P.M. and 7:00 P.M.Review of Resident #40's MARS from 02/01/26 to 02/28/26 revealed the resident's medications were administered as ordered and no as needed pain medications were administered.Review of Resident #40's Pharmacist Recommendation to Prescriber form dated 02/19/26 revealed the order for oxycodone was recently increased the oxycodone 5 mg three times a day to oxycodone 10 mg three times a day on 02/07/26. Physician #854 signed the form on 02/27/26 and disagreed with the recommendation but no clinical justification for refusing the GDR was documented on the recommendation.Review of Resident #40's physician orders revealed an order dated 03/12/26 (discontinued 03/27/26) for Dilaudid 4 mg (hydromorphone) give one tablet by mouth three times a day for pain due at 7:00 A.M., 2:00 P.M. and 7:00 P.M.; and an order dated 03/27/26 (discontinued 04/14/26) for Dilaudid 4 mg give one tablet by mouth four times a day for pain due at 7:00 A.M., 11:00 A.M., 3:00 P.M. and 7:00 P.M.Review of Resident #40's Pharmacist Recommendation to Provider form dated 03/22/26 revealed the resident was receiving duplicate opioid therapy with both Dilaudid narcotic pain medication 4 mg three times a day and oxycodone 5 mg twice daily with 10 mg at bedtime. The medications had similar actions and as a result, both may not be necessary. Please discontinue the Dilaudid and adjust the dose of oxycodone for continued pain management. The physician response dated 04/15/26 revealed the oxycodone was discontinued and to continue the Dilaudid. The form was signed on 04/15/26 by the physician which stated the oxycodone was discontinued and continue the Dilaudid. The recommendation did not have a clinical justification for continuing the Dilaudid instead of the oxycodone and the recommendation was not addressed until 23 days after the recommendation was made.Review of Resident #40's MARS from 03/01/26 to 03/31/26 revealed the medications were administered as ordered and one dose of as needed narcotic pain medications was administered and from 04/01/26 to 04/30/26 revealed the medications were administered as ordered. No as needed (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	narcotic pain medications were administered.Interview on 05/04/26 at 5:38 P.M. with the MD revealed Resident #40's family members felt the resident was more confused and on a lot of narcotics. The MD felt the resident was on egregious amounts of hydromorphone narcotic and started weaning the resident.Telephone interview on 05/05/26 at 1:52 P.M. with Consultant Pharmacist #857 confirmed she requested Physician #854 to decrease Resident #40's narcotics on 02/19/26 and again on 03/22/26 and the physician denied the recommendation. She stated she had come to the building to talk to Physician #854 about the usage of narcotics for residents with no clear indication of use at some point in the Fall of 2025 and the physician had asked her who made the rules for narcotics. She stated Physician #854 wanted to know who to talk to about administering narcotics and was told Centers for Medicare and Medicaid (CMS) guidelines. Telephone interview on 05/06/26 at 10:29 A.M. with Physician #863 revealed she was aware Physician #854 was over prescribing narcotics to residents and she counseled the physician on several occasions. Physician #863 indicated she had urged the facility on multiple occasions to discontinue association with Physician #854 and the facility refused. Physician #863 indicated Physician #854 would assess her residents and order narcotics for these residents and then bill for visit when the resident was not his to assess. Physician #863 revealed she parted with the facility in 02/2026.Review of the Unnecessary Medication Policy dated 2025 revealed it was the facility's policy that each resident's entire drug/medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical and psychosocial well-being free from unnecessary drugs.This deficiency represents non-compliance investigated under Complaint Number 2992828.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents were provided education on influenza and pneumococcal vaccinations and the vaccinations were offered and/or administered as ordered. This finding affected four (Residents #2, #3, #23 and #31) of five residents reviewed for immunizations. The facility census was 43.Findings include:1.Review of Resident #2's medical record revealed the resident was admitted on [DATE] with diagnoses including schizoaffective disorder, generalized anxiety disorder and major depressive disorder.Review of Resident #2's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.Review of Resident #2's electronic health record (EHR) revealed immunizations including influenza and pneumococcal vaccines were not listed as given.Interview on 05/11/26 at 12:09 P.M. with Registered Nurse (RN) Travel Director of Nursing (DON) #861 confirmed Residents #2's medical record did not have evidence the resident was educated on vaccine use, consent for vaccines was obtained and vaccines were offered and/or administered as required.2. Review of Resident #3's medical record revealed the resident was admitted on [DATE] with diagnoses including malignant neoplasm of the border of the tongue, alcohol abuse and adult failure to thrive.Review of Resident #3's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.Review of Resident #3's immunization tab in the EHR revealed pneumococcal and influenza vaccines were not listed as given.Interview on 05/11/26 at 12:09 P.M. with RN Travel DON #861 confirmed Residents #3's medical record did not have evidence the resident was educated on vaccine use, consent for vaccines was obtained and vaccines were offered and/or administered as required.3. Review of Resident #23's medical record revealed the resident was admitted on [DATE] with diagnoses including schizoaffective disorder bipolar type, diabetes and dependence on renal dialysis.Review of Resident #23's admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.Review of Resident #23's immunization tab in the EHR revealed pneumococcal and influenza vaccines were not listed as given.Interview on 05/11/26 at 12:09 P.M. with RN Travel DON #861 confirmed Residents #23's medical record did not have evidence the resident was educated on vaccine use, consent for vaccines was obtained and vaccines were offered and/or administered as required.4. Review of Resident #31's medical record revealed the resident was admitted on [DATE] with diagnoses including cellulitis of the left lower limb, bipolar disorder and heart failure.Review of Resident #31's admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.Review of Resident #31's immunization tab in the EHR revealed pneumococcal and influenza vaccines were not listed as given.Interview on 05/11/26 at 12:09 P.M. with RN Travel DON #861 confirmed Residents #31's medical record did not have evidence the resident was educated on vaccine use, consent for vaccines was obtained and vaccines were offered and/or administered as required.Review of the Influenza Vaccine policy revised 03/2022 revealed all residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. The facility shall provide pertinent information about the significant risks and benefits of vaccines to staff and residents or residents' legal representatives.Review of the Pneumococcal Vaccine policy revised 10/2023 revealed all residents were offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents were provided education on COVID-19 vaccinations and the vaccinations were offered and/or administered as ordered. This finding affected four (Residents #2, #3, #23 and #31) of five residents reviewed for immunizations. The facility census was 43.Findings include:1.Review of Resident #2's medical record revealed the resident was admitted on [DATE] with diagnoses including schizoaffective disorder, generalized anxiety disorder and major depressive disorder.Review of Resident #2's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.Review of Resident #2's electronic health record (EHR) revealed the COVID-19 vaccination was not listed as given. Interview on 05/11/26 at 12:09 P.M. with Registered Nurse (RN) Travel Director of Nursing (DON) #861 confirmed Residents #2's medical records did not have the evidence the resident was educated on COVID-19 vaccine use, consents for COVID-19 vaccines were obtained and evidence vaccines were offered and/or administered.2. Review of Resident #3's medical record revealed the resident was admitted on [DATE] with diagnoses including malignant neoplasm of the border of the tongue, alcohol abuse and adult failure to thrive.Review of Resident #3's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.Review of Resident #3's immunization tab in the EHR revealed the COVID-19 vaccination was not listed as given. Interview on 05/11/26 at 12:09 P.M. with RN Travel DON #861 confirmed Residents #3's medical records did not have the evidence the resident was educated on COVID-19 vaccine use, consents for COVID-19 vaccines were obtained and evidence vaccines were offered and/or administered.3. Review of Resident #23's medical record revealed the resident was admitted on [DATE] with diagnoses including schizoaffective disorder bipolar type, diabetes and dependence on renal dialysis.Review of Resident #23's admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.Review of Resident #23's immunization tab in the EHR revealed the COVID-19 vaccination was not listed as given. Interview on 05/11/26 at 12:09 P.M. with RN Travel DON #861 confirmed Residents #23's medical records did not have the evidence the resident was educated on COVID-19 vaccine use, consents for COVID-19 vaccines were obtained and evidence vaccines were offered and/or administered.4. Review of Resident #31's medical record revealed the resident was admitted on [DATE] with diagnoses including cellulitis of the left lower limb, bipolar disorder and heart failure.Review of Resident #31's admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.Review of Resident #31's immunization tab in the EHR revealed the COVID-19 vaccination was not listed as given. Interview on 05/11/26 at 12:09 P.M. with RN Travel DON #861 confirmed Residents #31's medical records did not have the evidence the resident was educated on COVID-19 vaccine use, consents for COVID-19 vaccines were obtained and evidence vaccines were offered and/or administered.Review of the Coronavirus (COVID-19) Policy revised 05/10/23 revealed for the protection of the residents and staff which was the top priority. The facility had developed a proactive plan designed to minimize the impact of COVID-19 within the facility.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure individualized interventions were developed and implemented to prevent resident-to-resident physical abuse between Resident #2 and Resident #24. This finding affected two (Residents #2 and #24) of three residents reviewed for abuse. The facility census was 43.Findings include: Review of Resident #2's medical record revealed the resident was admitted on [DATE] with diagnoses including schizoaffective disorder, major depressive disorder and essential hypertension.Review of Resident #2's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition.Review of Resident #24's medical record revealed the resident was originally admitted on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, bipolar disorder and alcohol dependence.Review of Resident #24's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.Review of facility submitted physical abuse Self-Reported Incident (SRI) form, tracking #271735 dated 03/04/26 revealed Resident #24 struck Resident #2 because he felt as though he cut him in line. The residents were immediately separated, and Resident #24 was placed on 15-minute checks for increased monitoring. Skin assessments were conducted for both residents with no injuries. Resident #24 was his own person but Resident #2's guardian and the physician were made aware. The following interventions were completed post-altercation including separating both residents immediately, placing Resident #24 on fifteen-minute checks, notifying the Medical Director of the altercation, obtaining skin assessments for Residents #2 and #24, obtaining staff statements, obtaining resident questionnaires with no negative findings and abuse education with facility staff. The SRI was unsubstantiated for physical abuse. Review of Resident #2's witness statement dated 03/04/26 revealed the resident was in the smoke line first but left the line. The resident had then attempted to cut the line and one of the other residents became upset and told him not to cut in line. The resident then proceeded to tell Resident #24 to be quiet and that he would punch him. Resident #24 punched first.Review of Resident #24's witness statement dated 03/04/26 revealed the resident hit Resident #2 because the resident threatened to hit him.Review of Resident #2 and Resident #24's medical record revealed no additional individualized interventions were implemented other than 15 minute checks ending on 03/07/26 to prevent physical abuse between the residents. Review of the facility submitted physical abuse SRI tracking #273847 dated 04/27/26 revealed Resident #24 struck Resident #2 in the face because he felt that he was going too slow down the hallway. The residents were immediately separated and no injuries were noted. The interventions completed post-altercation included separating both residents, placing both residents on fifteen-minute checks, completing neurological checks, notifying the Medical Director and the emergency contacts, completing skin assessments, obtaining staff statements and resident questionnaires and completing staff abuse education. The SRI was unsubstantiated for physical abuse.Review of Resident #24's witness statement dated 04/28/26 revealed the resident was on the way to a smoke break and Resident #2 blocked the hallway. Resident #24 asked Resident #2 to move and the resident replied negatively. Resident #2 hit Resident #24 in the face near the resident's eye with a closed fist and broke the resident's glasses.Interview on 05/07/26 at 12:16 P.M. with Registered Nurse (RN) Travel Director of Nursing (DON) #861 and the Administrator confirmed the facility was aware the two separate resident-to-resident altercations occurred between Residents #2 and #24. The Administrator stated she felt the residents in the facility had behaviors and 15-minute checks were completed following both altercations. The Administrator also indicated the facility staff tried to keep the two residents separated and one resident was moved to another hall following the second altercation. Interview on 05/07/26 at 12:16 P.M. with the Administrator and Travel DON #861 revealed the staff were aware the resident-to-resident incidents occurred and the facility did initiate (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the 15-minute checks post incident to ensure resident safety. The Administrator revealed one incident occurred in the hall and another in the smoking area. She stated a new policy was implemented for the smoking area to ensure resident safety.Review of the Abuse and Neglect Clinical Protocol policy revised 03/2018 revealed abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.This deficiency represents non-compliance investigated under Complaint Number 2990964.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure Resident #48 was provided a notification in writing the reason for the discharge to the hospital in a language the resident understands and a bed hold policy indicating the bed hold days remaining and the process for returning to the facility. This finding affected one (Resident #48) of two residents reviewed for hospitalization. The facility census was 43.Findings include:Review of Resident #48's closed medical record revealed the resident was admitted on [DATE], readmitted on [DATE] and discharged to the hospital on [DATE] with diagnoses including unspecified dementia, hyperlipidemia and essential hypertension. Resident #48 did not return to the facility.Review of Resident #48's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.Review of Resident #48's progress note dated 02/24/26 at 5:24 A.M. revealed during morning care, the resident had an episode of coffee ground emesis. The emesis was reported to the physician, and orders were obtained to send the resident to the hospital.Review of Resident #48's medical record did not reveal evidence the resident and/or representative were provided a notice for the reason for the discharge to the hospital in a language the resident understands or a bed hold policy with rates and bed hold days.Interview on 05/12/26 at 3:30 P.M. with Social Service Designee (SSD) #839 confirmed Resident #48's medical record did not have evidence the resident was provided with the reason for discharge to the hospital in a language the resident understands or the bed hold policy listing the rate and bed hold days.Review of the Resident Transfer and Discharge Policy and Procedure dated 2026 revealed once residents were admitted , the residents have a right to remain in the facility. Discharging a resident was a violation of this right unless the facility demonstrated that the conditions that allow for transfer or discharge were met.

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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 record review and interview, the facility failed to ensure Resident #31 was provided timely incontinence care. This finding affected one resident (#31) of three residents reviewed for incontinence care. The facility census was 43. Findings include:Record review of Resident #43 revealed he was admitted on [DATE] with diagnoses included cerebral infarction, heart failure, acute respiratory failure with hypoxia, tobacco use, alcohol abuse, hypertension, chronic obstructive pulmonary disease with acute exacerbation, generalized anxiety disorder, shortness of breath, asthma and personal history of pulmonary embolism.Record review of Resident #43's care plan dated 03/05/26 revealed he was resistive to care related to refusing to shower, refusing to change clothes, refusing incontinence care, refusing wound care and refusing to sleep in his bed. Interventions were to allow the resident to make decisions about treatment regime to provide a sense of control, encourage as much participation/interaction by the resident as possible curing care activities, give clear explanation of all care activities prior to and as they occur during each contact and praise the resident when behavior is appropriate. Provide consistency in care to promote comfort with activities of daily living skills (ADLs). Maintain consistency in timing of ADLs, care givers and routine as much as possible and provide resident with opportunities for choice during care provision. Record review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #43 required partial to moderate assist for toileting hygiene and substantial to maximum assist from staff for shower/bathing self. He was not on a urinary or bowel toileting program and was occasionally incontinent of urine and bowel.Review of a nursing note dated 05/03/26 at 11:38 P.M. revealed an aide made this nurse aware Resident #43 fell out of his wheelchair and onto the floor. Vital signs were taken. No pain was noted but having difficulty breathing while being on the floor. He urinated on himself and it was blood and urine mixed. 911 was called because this nurse and staff were not able to get him off the floor. Resident #43 would be transported to the hospital.Review of Resident #43's medical record revealed no evidence Resident #43 refused to get cleaned up after being incontinent when he fell on the floor or interventions implemented due to refusing ADL care.Review of Resident #43's Prehospital Care Report Summary dated 05/03/26 at 5:00 A.M. revealed the resident was lying on the floor supine and pants were saturated with urine, feces, and blood. The resident did not know how long he had been on the floor. One nurse stated the resident had been on the floor for two minutes, another nurse stated the resident had been on the floor for ten minutes. By the condition of the resident's clothes, EMS estimated the resident had been lying on the floor for a longer period of time.Review of a confidential concern submitted to the State Agency revealed on 05/03/26 Resident #43 arrived at the hospital with a saturated depends with concerns of possible neglect at the nursing home.Interview with Licensed Practical Nurse (LPN) #878 on 05/12/26 at 1:55 P.M. revealed Resident #43 was found on the floor and he had urinated on himself. She stated he refused toileting and hygiene care therefore did present at the hospital incontinent of urine. He did not wear briefs; he used the urinal or commode for bowel and bladder needs.This deficiency represents non-compliance investigated under Complaint Number 3004505 and 2721208.

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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 record review and interview, the facility failed to ensure scheduled narcotics for pain were administered as ordered and quarterly pain assessments were completed for residents on narcotic pain medications. This finding affected three (Residents #10, #31 and #40) of eleven residents reviewed for unnecessary medications. The facility census was 43.Findings include:1. Review of Resident #10's medical record revealed the resident was admitted on [DATE] with diagnoses including unspecified dementia, anxiety disorder and essential hypertension.Review of Resident #10's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment. Review of Resident #10's quarterly pain assessments (admit date [DATE]) revealed a pain assessment dated [DATE]. The resident's record did not have a pain assessment for 02/2026.Review of Resident #10's pain care plans revised 04/06/26 revealed to administer analgesia as per orders, anticipate the resident's need for pain relief, identify and record previous pain history, monitor/document for probably cause of each pain episode, monitor/document side effects of pain medication/ and monitor/record/report to nurse any signs or symptoms of non-verbal pain. Interview on 05/06/26 at 12:10 P.M. with Regional Director of Clinical Services #860 confirmed Resident #10 was missing the quarterly pain assessment for 02/2026.Review of the Pain policy dated 2001 revealed the nursing staff would assess each individual for pain upon admission to the facility, at the quarterly review, whenever there was a significant change in condition, and when there was onset of new pain or worsening of existing pain. The assessment and recognition of pain included reviewing known diagnoses and conditions that commonly cause pain, including a review for any treatments the resident is currently receiving for pain, including complementary and non-pharmacological treatments. The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. The staff and provider will identify the characteristics of pain such as location, intensity, frequency, pattern, and severity. The nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated, for example, wound care, ambulation, or repositioning. The staff and provider will evaluate how pain is affecting mood, activities of daily living, sleep, and the resident's quality of life, as well as how pain may be contributing to complications such as gait disturbances, social isolation, and falls.2. Review of Resident #31's medical record revealed the resident was admitted on [DATE] with diagnoses including unspecified complications of an amputation stump, chronic obstructive pulmonary disease and bipolar disorder.Review of Resident #31's admission MDS dated [DATE] revealed the resident exhibited intact cognition.Review of Resident #31's physician orders revealed an order dated 03/27/26 (discontinued 04/06/26) for Lidocaine external gel 4% apply to skin topically one time a day for pain; an order dated 04/11/26 to document pain every shift; an order dated 03/26/26 for Gabapentin 300 mg one tablet by mouth three times a day for pain; an order dated 04/10/26 for Hydrocodone-Acetaminophen 7.5-325 mg give one tablet every six hours as needed for pain; an order dated 04/06/26 (discontinued 04/10/26) for Oxycodone 5 mg one tablet by mouth every six hours as needed for pain; an order dated 04/11/26 for Acetaminophen 325 mg give one tablet every six hours as needed for pain; and an order dated 04/14/26 for Hydrocodone-Acetaminophen 7.5-325 mg give one tablet every 8 hours as needed for pain related to cellulitis of the left lower limb.Review of Resident #31's progress note dated 05/06/26 at 1:30 A.M. revealed the resident requested the midnight narcotic for pain and the medication as not available due to reorder. The facility was waiting for the delivery from the pharmacy. The resident became visibly upset, throwing items from the bedside table and pushing the tablet across the room. The resident then lowered herself to the floor and was observed lying on the floor yelling into the hallway. The nurse and two aides approached the resident and initially aided return to bed and the resident refused. The Director of Nursing (DON) was notified (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the physician was notified.Review of Resident #31's MARS and TARS from 04/01/26 to 05/07/26 revealed the scheduled Hydrocodone-Acetaminophen 7.5-325 mg tablets were due every six hours at 12:00 A.M., 6:00 A.M., 12:00 P.M. and 6:00 P.M. The MARS confirmed Resident #31 did not receive the scheduled narcotics on 05/06/26 at 12:00 A.M., 6:00 A.M. and 12:00 P.M.Interview on 05/11/26 at 7:10 A.M. with Registered Nurse (RN) Regional Director of Clinical Services #860 confirmed the nurses could pull narcotics from the pyxis and she was not sure why Resident #31 did not receive her narcotic pain medications for three doses on 05/06/26.Interview on 05/11/26 at 7:35 A.M. with Director of Nursing (DON) revealed the staff had to have an authorization to pull narcotics before they could remove Resident #31's scheduled narcotics from the pyxis medication system and she had ordered the narcotic pain medications the next day when she found out the resident did not have more narcotics for resident use.3. Review of Resident #40's medical record revealed the resident was admitted on [DATE] with diagnoses including schizoaffective disorder, alcohol dependence with alcohol-induced persisting dementia and Alzheimer's disease.Review of Resident #40's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.Review of Resident #40's Quarterly pain assessments revealed an assessment dated [DATE]. The resident was missing quarterly pain assessments for 05/2025,11/2025 and 02/2026.Review of Resident #40's pain care plan dated 07/22/24 revealed interventions including administering analgesics as ordered; anticipate the resident's need for pain relief and respond immediately; monitor/document for probably cause of each pain episode, monitor/document side effects of pain/ monitor/record/report to nurse any signs or symptoms of non-verbal pain. Interview on 05/06/26 at 12:10 P.M. with Regional Director of Clinical Services #860 confirmed Resident #40 was missing the quarterly pain assessments for three of the four quarters.Review of the Pain policy dated 2001 revealed the nursing staff would assess each individual for pain upon admission to the facility, at the quarterly review, whenever there was a significant change in condition, and when there was onset of new pain or worsening of existing pain. The assessment and recognition of pain included reviewing known diagnoses and conditions that commonly cause pain, including a review for any treatments the resident is currently receiving for pain, including complementary and non-pharmacological treatments. The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. The staff and provider will identify the characteristics of pain such as location, intensity, frequency, pattern, and severity. The nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated, for example, wound care, ambulation, or repositioning. The staff and provider will evaluate how pain is affecting mood, activities of daily living, sleep, and the resident's quality of life, as well as how pain may be contributing to complications such as gait disturbances, social isolation, and falls.This deficiency represents non-compliance investigated under Complaint Number 2721208.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure residents were served meals to meet their individual needs. This finding affected two residents (Residents #24 and #35) of four residents reviewed for food. The facility census was 43.Findings include:1. Review of Resident #24's medical record revealed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, bipolar disorder and alcohol dependence.Review of Resident #24's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.Review of Resident #24's physician orders revealed an order dated 04/26/24 for a regular diet, regular texture with a regular consistency and double portions for meals.Review of Resident #24's meal ticket dated 05/06/26 revealed the resident wanted juice and hot cereal with no pasta and double portions for all meals.Interview on 05/04/26 at 12:13 P.M. with Resident #24 revealed he did not routinely get double portions even though it was on the meal ticket.Observation on 05/06/26 at 12:20 P.M. revealed Resident #24's lunch meal tray consisted of an Italian sausage link, scalloped potatoes and lima beans. The meal tray did not have double portions.A second interview on 05/06/26 at 12:22 P.M. with Resident #24 revealed he never received double portions.Interview on 05/06/26 at 12:25 P.M. with the Director of Nursing (DON) confirmed Resident #24 did not receive double portions for the lunch meal.2. Review of Resident #35's medical record revealed the resident was admitted on [DATE] with diagnoses including bipolar disorder, essential hypertension and diabetes.Review of Resident #35's MDS 3.0 assessment dated [DATE] revealed the resident's memory was okay.Review of Resident #35's physician orders revealed an order dated 03/30/26 for a regular diet, regular texture with thin liquids consistency and double portions.Observation on 05/04/26 at 12:13 P.M. with Resident #35 revealed the facility did not provide double portions and the food was a big thing.Observation on 05/04/26 at 12:45 P.M. revealed Resident #35's lunch meal tray consisted of a hamburger, potato salad, peas/carrots and pudding. The resident did not receive double portions as indicated on the meal ticket.Interview on 05/04/26 at 12:50 P.M. with Certified Nursing Assistant (CNA) #848 confirmed Resident #35 did not receive double portions per the meal ticket.Review of Resident #35's lunch meal ticket dated 05/06/26 revealed the resident did not want fish, hot dogs or kielbasa. The lunch ticket listed double portions.Observation on 05/06/26 at 12:40 P.M. revealed Resident #35's lunch meal tray consisted of one piece of Italian sausage link, scalloped potatoes and lima beans. The resident's meal tray did not have double portions.Interview on 05/06/26 at 12:45 P.M. with the DON confirmed the above findings.Review of the Food and Nutrition Services policy revised 10/2017 revealed each resident was provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.

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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. Based on observation, record review and interview, the facility failed to maintain proper infection control practices during wound care for Resident #31. This affected one resident (Resident #31) of one resident observed for wound care. The census was 43.Findings include:Record review revealed Resident #31 was admitted to the facility 03/19/26 with diagnoses including but not limited to acquired absence of left leg below-knee amputation (BKA).Record review revealed Resident #31 had an order to cleanse the left stump with soap and water, pat dry, apply Santyl and an abdominal pad and cover with kerlix. Observation of the wound care and dressing change with the Director of Nursing (DON) on 05/06/26 at 1:31 P.M. revealed the bedside table was visibly dirty and not cleaned/wiped down with an antiseptic cloth prior to the DON putting two paper towels from Resident #31's bathroom on it, as a barrier. The DON stated she forgot her marker and scissors so started removing the old dressing by removing what tape she could get ahold of with gloves on, from the top of the dressing closest to resident's knee, then pulled the rest of it off Resident #31's stump. The old dressing was then put in the trash can. The DON then grabbed the wound cleaner, sprayed the wound and started cleaning the wound with four-by-four gauze without removing the old gloves and washing her hands. The gauze used to clean the surgical site was thrown away along with the gloves. DON washed her hands and applied new gloves, but the gloves that were applied were lying half on the barrier paper while the fingers were off the barrier resting on a dirty remote-control device. DON confirmed the observation after the dressing change.Review of the facility policy, Wound Care, dated 10/2010 revealed the facility would gather equipment necessary ie: scissors and a writing utensil. Staff would pull gloves over dressing and discard and staff would ensure all clean items were on a clean field. This deficiency represents non-compliance investigated under Complaint Number 2721208.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations, interviews and facility policy the facility failed to ensure residents call lights were in working order. This affected three residents (Residents #6, #9, and #41) of 56 residents reviewed for call light function. The facility census was 43. Findings include: Interview on 05/06/26 at 3:02 P.M. with Resident Council members Resident #16, Resident #11 and Resident #36 revealed call light response times at night are very long and response times are sometimes over two hours.Interview on 05/07/26 at 3:45 P.M. with Resident #41 revealed he needed a new call light and his had not worked for three weeks. The bedside call cord was pulled revealing the bedside station light was activated but the corridor dome light outside the room did not light up. Interview and observation on 05/07/26 at 3:48 P.M. with Resident #6 revealed the resident tested bedside call cord revealed the bedside station light was activated but the corridor dome light outside the room did not light up and the light was missing the cover. Interview on 05/07/26 at 3:55 P.M. with Director of Clinical Services #860 confirmed the above observations.Interview on 05/11/26 at 4:22 P.M. with Resident #9 revealed he did not have a functioning call light. Interview with Regional Traveling Administrator (RTA) #876 at the time who said he would have maintenance get resident a bedside call cord.Review of facility policy titled, Answering the Call Light with a revised date of March 2021 under General Guidelines revealed be sure that the call light is plugged in and functioning at all times and report all defective call lights to the nurse supervisor promptly.

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F 0803 Level of Harm - Potential for minimal harm Residents Affected - Many	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 observation and interviews the facility failed to follow the weekly menu and maintain a substitution log. This had the potential to affect 43 out of 43 residents who ate meals in the facility's kitchen. The facility census was 43.Findings include:Review of weekly menu for 05/03/26 to 05/09/26 revealed on 05/06/26 the supper entree options on the menu were jerk chicken sandwich on a hamburger bun or grilled ham and cheese sandwich on sandwich bread. The side items were buttered carrots and dessert was a frosted spice cake. Observation and interview 05/06/26 at 4:47 P.M. of dinner tray line with Kitchen Director #875 and Regional Kitchen Director #865 revealed the entree was a hamburger with shredded lettuce and a tomato. The side item was french fries and the dessert was chocolate frosted spice cake. The RKD #865 revealed they substituted the buttered carrots for French fries because the lettuce and tomato on the hamburger was the vegetable. He said the hamburger was an option on the spreadsheet menu. Interview on 05/07/26 at 9:11 A.M. with Registered Dietitian #871 revealed lettuce and tomato can be a vegetable but it depends on the portion size. Review of weekly menu for 05/03/26 to 05/09/26 for 05/07/26 revealed lunch was entree option of either turkey meatloaf or a BBQ rib patty. The side items were mashed potatoes, poultry gravy, brussels sprouts, fruit mix and cornbread with margarine.Interview and observation on 05/07/26 at 10:35 A.M. with KD #875 and RKD #865 revealed lunch was going to be BBQ rib patty, stuffing, mashed potatoes, mixed vegetables, fruit mix and a sugar cookie. When asked why certain items were being substituted KD #875 revealed he had to make many substitutions due to the freezer being broken and not being able to store certain items. RKD #865 revealed he could not find the substitution log but would look for it.Interview and observation on 05/07/26 at 12:09 P.M. with KD #875 and RKD #865 of lunch tray line revealed lunch was BBQ rib patty, mashed potatoes, poultry gravy, mixed vegetables and fruit. RKD #865 revealed he was unable to find the substitution log but would start a new one.Review of weekly menu for 05/03/26 to 05/09/26 for 05/07/26 revealed supper entree options as Italian parmesan breaded pork cutlet, rotini pasta, parmesan bread or a tuna melt sandwich on sandwich bread. A side item of garlic broccoli and dessert was a peanut butter bar. Observation on 05/07/26 at 4:55 P.M. of dinner revealed residents received a cheese and ham sandwich, stuffing, green beans and corn and a sugar cookie. Interview and observation on 05/07/26 at 04:55 P.M. with KD #875 and Regional Kitchen Director #865 revealed dinner was ham and cheese sandwiches. When asked about not serving the pork KD #875 revealed he did not have a freezer to store the pork and that the residents do not like pork.