STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375189	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Wilshire Skilled Nursing and Therapy	505 East Wilshire Blvd Oklahoma City, OK 73105

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on a review of the United States (U.S.) Food and Drug Administration (FDA) Food Code, observation, and interview, the facility failed to ensure waste was properly contained in dumpsters and failed to ensure 2 of 2 dumpsters observed were covered to reduce the potential for harboring insects or rodents. The deficient practice had the potential to affect all the residents in the facility. Findings included: The U.S. FDA Food Code, dated 2022, revealed, Chapter 5. Water, Plumbing, and Waste revealed, 5-501.15 Outside Receptacles, which included, (A) Receptacles and waste handling units for REFUSE, recyclables, and returnable used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers; and (B) Receptacles and waste handling units for REFUSE and recyclables such an on-site compactor shall be installed so that accumulation of debris and insect and rodent attraction and harborage are minimized and effective cleaning is facilitated around and, if the unit is not installed flush with the base pad, under the unit. During an interview on 06/10/2026 at 2:17 PM, the Regional Director of Operations stated that the facility did not have a policy related to keeping the dumpster area clean or keeping the dumpsters' lids closed. An observation on 06/10/2026 at 7:53 AM revealed two roll-off dumpsters located at the rear of the facility and adjacent to the facility's parking lot with both lids open. During an interview on 06/10/2026 at 1:22 PM, the Dietary Supervisor (DS) stated that she and maintenance staff were responsible for keeping the area around the dumpsters free of debris and ensuring the dumpster lids were closed. The DS stated the certified nurse aides (CNAs) and housekeeping staff also utilized the dumpsters and were reminded to close the lid after emptying trash. An observation on 06/10/2026 at 1:30 PM revealed the two roll-off dumpsters located at the rear of the facility and adjacent to the parking lot had their lids open. Broken eggshells, a partially consumed chicken drumstick, and a box resembling a pizza box were observed on the ground next to the dumpsters. During an interview on 06/11/2026 at 11:15 AM, the Director of Nursing (DON) stated that the expectation for the dumpster area was to keep it clean and the lids to be closed. She stated that recent windy conditions had caused the lids to open. She further stated that it was everyone's responsibility to ensure the lids remained closed. During an interview on 06/11/2026 at 11:08 AM, the Administrator (ADM) stated that the expectation for the dumpster area was for the side doors to the dumpsters to remain shut and lids to stay closed.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on facility policy review, facility document review, record review, and interview, the facility failed to ensure 1 (Resident #6) of 3 residents reviewed for beneficiary notification requirements was provided a Notice of Medicare Non-Coverage (NOMNC) and a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) prior to the end of covered Medicare Part A services. Findings included: The facility's undated Resident's Rights and Family Handbook included a document titled, Licensed Nursing Facility's Policy Statement Regarding Residents' Right to Self-Determination, which revealed, 1. It is our policy to follow the directions of our Residents who have the capacity to make decisions to the extent allowed by law. You will be considered to have capacity to make health care decisions unless unconscious, determined to be incompetent by a court of law, or medically determined by your attending physician to be unable to make health care decisions. An admission Record revealed the facility admitted Resident #6 on 02/02/2024. According to the admission Record, the resident had a medical history that included diagnoses of unspecified disorder of adult personality and behavior and mood disorder due to known physiological condition with major depressive-like episode. The admission Record indicated that the resident was their own responsible party for finances. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/25/2026, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. Resident #6's Care Plan Report included a focus area initiated 02/13/2024, that indicated the resident had impaired cognitive function as evidenced by their fluctuating BIMS score. Interventions indicated that the resident's BIMS score was 9, which indicated the resident had moderate cognitive impairment (revised 05/10/2026). Interventions directed staff to engage the resident in simple structured activities that avoided overly demanding tasks (initiated 12/13/2024). Resident #6's Notice of Medicare Non-Coverage, dated 05/22/2026, revealed Medicare coverage of the skilled services would end on 05/24/2026 and financial liability would begin on 05/25/2026. The document revealed that additional information written by Assistant Director of Nursing (ADON)- Licensed Practical Nurse (LPN) #4 indicated that the resident was unable to understand the NOMNC due to a cognitive deficit, indicating that the resident had a BIMS score of 9. The NOMNC further revealed that the Administrator (ADM) was notified via phone. The document revealed the signature section for the resident or their representative acknowledging receiving and understanding the notice was left blank. Resident #6's undated Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage revealed that beginning on 05/25/2026, the resident may have to pay out of pocket for care provided at the facility if the resident did not have other insurance that may cover the costs. The document indicated that Option 3 was selected and reflected that the resident did not want the care and understood that they were not responsible for paying and would forgo the appeal process to see if Medicare would pay. The document revealed that additional information was handwritten and signed by ADON-LPN #4 that the resident was unable to understand the form due to a cognitive deficit, and that the ADM was notified via phone on 05/22/2026. The document revealed the signature area at the bottom of the page for patient or authorized representative acknowledging receiving and understanding the notice was left blank. During an interview on 06/10/2026 at 3:08 PM, ADON-LPN #4 stated that she completed Resident #6's NOMNC and ABN notices. She stated that if a resident was cognitively able, they signed the forms. She stated that if the resident had a cognitive deficit and had an assigned representative, the representative was contacted, and the form was explained. She stated that if the resident had a cognitive deficit, did not understand the form, and had no representative, she explained the case to the ADM, who would become the resident's representative, and the resident would become a trust patient. During the interview with ADON-LPN #4, the Regional Nurse Consultant stated that the Director of Skilled Services and Clinical Reimbursement (DSSCR) was responsible for the trust designation and process. During a phone interview on 06/10/2026 at 4:00 PM, the DSSCR stated that (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if a resident had a cognitive deficit, did not have family, and was not an Adult Protective Services (APS) case, the resident was designated as a trust patient, which was handled by the ADM and/or the Business Manager. She stated that she did not know the process of becoming a trust patient. During an interview on 06/10/2026 at 4:11 PM, the ADM revealed that if a resident could not make decisions and did not have family or another representative, then he assigned himself as the decision maker and was responsible for signing forms on the resident's behalf. The ADM stated that the only resident he was assigned as decision maker at the time of the survey was Resident #6. The ADM stated that he was not officially the resident's representative and not legally capable of making decisions to consent to treatment, such as surgery. He stated that due to the resident's designation as a trust patient, he was responsible for Resident #6's managing monthly stipends related to the facility trust fund accounts. Per the ADM, Regarding the NOMNC and ABN notice, therapy staff deemed the resident met their maximum potential, and he did not feel it was ethical to continue therapy services and bill Medicare for services that were of no benefit to the resident. He stated that ADON-LPN #4 notified him by phone because Resident #6 was coming off skilled nursing services, and he only needed to be made aware of the situation and did not need approval or a signature for the form. He stated that the resident did not fully understand the NOMNC or ABN notice and/or the three options for Medicare billing for care, room, and board. The ADM stated that he did not make a decision for Resident #6's Medicare billing and did not sign the NOMC on behalf of the resident. During an interview on 06/11/2026 at 9:23 AM, the ADM stated that he was not the legal representative for Resident #6. The ADM stated that if a resident could not understand a form and had no representative, the resident's physician would be required to make the resident's decisions. The ADM stated that ADON-LPN #4 notified him by phone because Resident #6 was coming off skilled services and LPN #4 was only to provide notification and there was no need to sign anything.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on facility policy review, record review, and interview, the facility failed to ensure that prompt efforts were made to resolve grievances with regard to missing property, which affected 1 (Resident #27) of 2 residents reviewed for personal property concerns. Findings included: A facility policy titled, Resident/Family Grievances, revised 03/03/2020, revealed, The facility promotes an atmosphere in which the resident/family has a right to voice grievances without discrimination or reprisal. Resident/Family grievances could include treatment, funds, lost items or violation of rights. The facility will attempt to work with resident/family to resolve grievances promptly. The policy revealed, Any grievance from resident/family should be recorded on a Grievance Log (NRSG-O02-G). Grievance Log should be updated and reviewed in the Q2 meeting and a designee will be assigned to call or follow-up on the grievance using the To Do List (NRSG-062-H). The Designee will document any follow-up contact on the Grievance Log and discuss any resolution in the Q2 meeting. Resident/Records/Care Plans will be updated if needed with any contact or changes. During an interview on 06/10/2026 at 2:05 PM, the Regional Director of Operations (RDO) stated that the facility did not have a policy for personal property or missing property. An admission Record revealed the facility admitted Resident #27 on 05/13/2025. According to the admission Record, the resident had a medical history that included diagnoses of stage 3A chronic kidney disease and morbid (severe) obesity due to excess calories. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/08/2026, revealed Resident #27 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated that the resident did not experience hallucinations (perceptual experiences in the absence of real external sensory stimuli) or delusions (misconceptions or beliefs that are firmly held, contrary to reality). Resident #27's Care Plan Report, included a focus area revised 10/22/2025, that indicated the resident had the potential for poor activity involvement related to a decrease in interest. Interventions directed staff that Resident #27 preferred self-directed activities such as watching movies and television shows and talking on the phone (revised 05/24/2026). During an interview on 06/08/2026 at 10:45 AM, Resident #27 stated that two Mondays prior, they (Resident #27) left a phone charging and when they returned from a shower, the phone was missing. During an interview on 06/10/2026 at 11:06 AM, Certified Nurse Aide (CNA) #10 stated that a couple of weeks prior, Resident #27 told her that their phone went missing, so she reported it to a nurse. During an interview on 06/10/2026 at 11:16 AM, CNA #7 stated Resident #27 told her a few weeks ago that the resident's phone was missing. She stated she reported it to the Director of Nursing (DON). During an interview on 06/10/2026 at 11:30 AM, the DON stated that staff had not reported to her that Resident #27 was missing a phone. During an interview on 06/10/2026 at 11:46 AM, the DON stated that her expectation was that staff report missing property as soon as possible to the charge nurse or the Abuse Coordinator. During an interview on 06/11/2026 at 12:14 PM, the Administrator stated that Resident #27's phone had been found. He stated it had been in the medication room because the staff did not know who the phone belonged to. He stated that he did not know who found the phone. During an interview on 06/11/2026 at 4:27 PM, Resident #27 stated the Administrator brought their cell phone to them that day (06/11/2026). The resident stated that they (Resident #27) did not know when it had been found. During an interview on 06/10/2026 at 11:33 AM, the Administrator stated that he was the Abuse Coordinator. He stated that a missing phone for Resident #27 had not been reported to him. He stated that his expectation was that staff search for the missing item and if not found, then report immediately to him.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's nails were kept clean and trimmed for 1 (Resident #3) of 1 resident reviewed for activities of daily living (ADLs) care. Findings included: A facility policy titled, Nursing Skills Guideline, revised 03/2025, indicated, Assistance with activities of daily living will be provided in a manner that prioritizes the resident's comfort, safety, and personal preferences. An admission Record revealed the facility admitted Resident #3 on 01/09/2026. According to the admission Record, the resident had a medical history that included diagnoses of legal blindness and sequelae of cerebral infarction (long-term condition or complications as a result of a stroke). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/08/2026, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated that Resident #3 required substantial/maximal assistance with personal hygiene. Resident #3's Care Plan Report, included a focus area initiated 01/26/2026, that indicated the resident had an ADL self-care deficit related to limited mobility, impaired cognition, and incontinence. An undated intervention directed staff to check the resident's nail length on bath days and report concerns to the nurse. Resident #3's nail care record for the timeframe, from 05/12/2026 through 06/10/2026, indicated that staff documented that Resident #3 received nail care 61 times. The record did not indicate what Nail care was provided. During a concurrent observation and interview on 06/08/2026 at 1:30 PM, Resident #3's nails on both hands were noted to be untrimmed and dirty underneath. Resident #3 stated they asked staff to cut their nails, but staff did not do it. The resident stated they did not like their nails being long in length. During a concurrent observation and interview on 06/10/2026 at 8:55 AM, Resident #3's nails were observed to still be long. Resident #3 stated their nails had not been trimmed and that they still wanted them trimmed. During an interview on 06/10/2026 at 11:26 AM, Certified Nurse Aide (CNA) #7 stated that she was aware of Resident #3's nail length and had not reported it to the nurse. She stated that she had cleaned the resident's nails on 06/08/2026 but did not trim them. During an interview on 06/10/2026 at 1:45 PM, CNA #7 stated that when she documented in Resident #3's nail care task record that the task had been completed, it indicated she had only cleaned the nails. She stated that she did not trim the nails. During an interview on 06/10/2026 at 1:39 PM, Licensed Practical Nurse (LPN) #2 observed Resident #3's nails and stated that the nails should have been filed at the length they were at. She stated the resident's left thumb nail was broken and chipped. During an interview on 06/10/2026 at 1:49 PM, the Director of Nursing (DON) measured Resident #3's nails. She stated that the longest nail on the right hand was the thumb at 0.5 centimeters (cm) and the longest nail on the left hand was the ring finger at 0.4 cm. She stated that a couple of the nails were broken and the nails were long. She stated her expectation was that nails be trimmed during showers when nails were softened. She stated that it was the resident's right to have the nails shorter if the resident wanted shorter nails. During an interview on 06/11/2026 at 10:21 AM, the Administrator stated his expectation for nail care was that it be provided if needed. He stated his expectation was that Resident #3 should have had nails trimmed with the resident's showers, and the nails should have been neat and clean.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview, record review, and facility policy review, the facility failed to ensure staff followed physician orders with regard to laboratory testing, dressing changes, and application of ice packs, which affected 1 (Resident #50) of 14 sampled residents. Findings included: A facility policy titled, Skin and Wound Care Guidelines Skin Integrity/Wound Care, revised 07/2024, indicated, 4. Current Treatment, which specified, Medical treatments will be ordered by a physician or their designee. The policy revealed, 7. The nurse who identifies areas of skin breakdown should complete the following, which included Notify the attending provider; and Obtain a treatment and initiate. The policy further indicated, 11. A multidisciplinary plan of care will be implemented that reflects intervention strategies designed to alleviate, reduce, or minimize the negative effects of each resident's identified risk factors, and manage and treat existing pressure ulcers. Care plan to be implemented by the charge or staff nurse, *Document appropriate interventions on falling stars. An admission Record revealed the facility admitted Resident #50 on 02/28/2025. According to the admission Record, the resident had a medical history that included a diagnosis of aftercare following joint replacement surgery. The admission Record indicated that the facility discharged the resident on 03/02/2025. A five-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/02/2025, revealed that Resident #50 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. During a phone interview on 06/10/2026 at 1:24 PM, Resident #50 stated the facility staff did not draw ordered laboratory tests, change the surgical dressing, or provide ice packs as ordered during their stay at the facility. Resident #50 stated that they abruptly left the facility due to concerns about safety and lack of care. Resident #50's Order Summary Report, with active orders as of 03/02/2025 contained the following orders:- Laboratory testing, including a complete blood count (CBC), comprehensive metabolic panel (CMP), and prealbumin, to be completed upon admission, with an order date of 02/28/2025.- Clean the resident's surgical incision twice daily with peroxide and change dressing daily and as needed (PRN), with an order date of 02/28/2025.- Apply ice packs every four hours and PRN for pain, with an order date of 03/01/2025. Resident #50's clinical record and facility documentation revealed no evidence of completion of the ordered laboratory tests, dressing changes, or application of ice packs. During an interview on 06/12/2026 at 2:20 PM, the Director of Nursing (DON) stated staff were expected to follow provider orders. The DON reviewed Resident #50's clinical record and stated that there was no documented evidence that the orders were completed. She stated that the expectation was that laboratory orders upon admission were to be completed within 72 hours. During an interview on 06/12/2026 at 12:15 PM, the Administrator stated staff were expected to carry out physician orders or notify the provider if unable to do so. The Administrator stated that failure to carry out ordered treatments represented a failure in care and may have contributed to the resident's decision to leave the facility.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. Based on facility document review, observation, interview, and record review, the facility failed to ensure resident shared bedrooms were designed and equipped to maintain full visual privacy for residents in them, which affected 4 (Residents #43, #35, #24, and #14) 4 residents identified with privacy curtain concerns. Findings included: During an interview on 06/10/2026 at 11:15 AM, the Regional Director of Operations (RDO) stated that the facility did not have a policy related to resident privacy. The facility's undated Resident's Right's and Family Handbook revealed Federal Resident Rights, which included You have the right to privacy, as well as private telephone calls, meetings and mail. 1. A quarterly Minimum Data Screening Assessment (MDS), with an Assessment Reference Date (ARD) of 04/24/2026, indicated that the facility admitted Resident #43 on 02/16/1999. The MDS revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. Per the MDS, the resident had active diagnoses that included anxiety disorder and depression. A quarterly MDS, with an ARD of 04/24/2026, indicated that the facility admitted Resident #35 on 06/19/2013. The MDS revealed that the resident had a BIMS score of 15, which indicated the resident had intact cognition. Per the MDS, the resident had active diagnoses that included anxiety disorder and depression. An observation of Resident #43's and Resident #35's shared bedroom on 06/09/2026 at 10:13 AM revealed the room had a partial privacy curtain. The privacy curtain separated Bed A from Bed B and ran from the wall between the two heads of the beds to the end of both residents' beds, stopping approximately 4 feet before reaching the opposite wall. The approximate 4-foot gap between the end of the curtain and the wall closest to the foot of the beds allowed each resident's sleeping area to be visible from inside the room. A mirror approximately 3 feet high by 3.5 feet wide was adhered to the opposite wall of both residents' beds, which allowed a view of each residents' sleeping area. There was no wrap around capability of the privacy curtain that was in the room for either bed. During an interview on 06/09/2026 at 10:17 AM, Resident #43 stated that they resided in a shared bedroom on the 200 Hall and that they were assigned the bed nearest to the window (Bed B). Resident #43 stated that when they left their bedroom and passed their roommate's bed (Bed A), they lowered their head and looked at their wheelchair wheels, so they did not look at their roommate. Resident #35 was not available for interview during the survey. 2. An annual Minimum Data Screening Assessment (MDS) with an Assessment Reference Date (ARD) of 04/03/2026, revealed the facility admitted Resident #24 on 04/12/2025. The MDS revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Per the MDS, the resident had active diagnoses that included schizophrenia. A quarterly MDS, with an ARD of 04/02/2026, revealed the facility admitted Resident #14 on 12/29/2006. The MDS revealed the resident had a BIMS score of 8, which indicated the resident had moderate cognitive impairment. Per the MDS, the resident had active diagnoses that included anxiety, depression, and schizophrenia. An observation of Resident #24's and Resident #14's shared bedroom on 06/08/2026 at 10:59 AM revealed the room had a partial privacy curtain. The privacy curtain separated Bed A from Bed B and ran from the wall between the two heads of the beds to the end of both residents' beds, stopping approximately 4 feet before reaching the opposite wall. The approximate 4-foot gap between the end of the curtain and the wall closest to the foot of the beds allowed each resident's sleeping area to be visible from inside the room. A mirror approximately 3 feet high by 3.5 feet wide was adhered to the opposite wall of both residents' beds, which allowed a view of each residents' sleep area. There was no wrap around capability of the privacy curtain that was in the room for either bed. During an observation and concurrent interview on 06/09/2026 at 10:20 AM, Resident #24, who was assigned to Bed A, exited the shared bathroom and walked past Bed B's bedroom area while returning to their bedroom area. Resident #24 stated that they could see their roommate's bedroom area whenever they entered or exited the shared bathroom. Resident #14 was not interviewed due to their level of cognition. During an interview on 06/10/2026 (continued on next page)

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 8:56 AM, Certified Nurse Aide (CNA) #7 stated that she was usually assigned to the 200 Hall and was familiar with the needs of the residents residing in that hall. CNA #7 stated that the process to ensure residents were provided privacy included pulling the privacy curtain. CNA #7 stated that it was impossible to provide privacy to Residents #43, #35, #24, and #14 due to the lack of a full wrap around curtain and the mirror placement on the wall in their rooms. During an interview on 06/10/2026 at 9:17 AM, Certified Medication Aide (CMA) #8 stated that she worked both 100 Hall and 200 Hall and was familiar with resident care needs. CMA #8 stated that if either resident in a shared bedroom had a visitor, the staff asked the visitor to leave the room while they administered medication. CMA #8 further stated that if the resident assigned to Bed A needed to use the shared bathroom, the resident in Bed A would have a view of Bed B's sleeping area while crossing the room to enter or exit the bathroom. CMA #8 stated that the large mirror placement also provided residents and/or visitors in the room with a full view of each resident's sleep area. During an interview on 06/10/2026 at 9:36 AM, the Director of Nursing (DON) stated that the expectation for providing residents' privacy was to pull the curtain across the room. She stated that depending on the direction of placement of the head and foot of the beds, residents of a shared room had the capability of viewing their roommate's area. The DON stated that the resident assigned to Bed B could not take a nap without being seen by their roommate and/or their visitors. The DON stated that it would be impossible to provide privacy to both residents while they received care. The DON further stated that all resident bedrooms were structured the same way with the mirror placement, curtain length, and placement. During an interview on 06/10/2026 at 10:00 AM, the Administrator (ADM) stated that the expectation for providing residents' privacy was that privacy curtains in resident rooms should be used. The ADM stated that the process of providing residents with privacy included knocking on the door and pulling the privacy curtain. The ADM stated that the privacy curtain divided the room by running across the middle of the room between the two beds. The ADM also stated that if the resident assigned to Bed A wanted to use the shared bathroom, they would have to cross Bed B's area, which would allow a full view of the resident assigned to Bed B.