STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375230	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leisure Village Health Care Center	2154 South 85th East Avenue Tulsa, OK 74129

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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, interview, facility document and policy review, and U.S. [United States] Food and Drug Administration 2022 Food Code, guidelines, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, daily log documentation was lacking for the dish machine sanitation test strip levels and rinse temperature levels. Additionally, dietary staff did not perform hand hygiene during meal service. Additionally, food was not labeled and dated appropriately in facility refrigerators.These deficiencies had the potential to affect all residents in the facility.Findings included: 1. A facility policy titled, Warewashing, reviewed 08/25/2025, revealed, Nutritional services employees shall ensure food is prepared and served in clean food-safe supplies and maintain compliance with Federal, State, and Local regulations governing food safety. The policy also indicated, Procedure: 1. All tableware, utensils, preparation, and service supplies shall be washed and sanitized in the pot sink and/or through use of a commercially approved dish machine. 2. The dish machine, if low temp [temperature], shall use a detergent, a rinse drying agent, and a sanitizer. If the dish machine is a high temperature machine, a detergent and a rinse drying agent shall be used. The sanitizing temperature for a low temperature machine shall be above 120 degrees or at an appropriate temperature to activate the sanitizer per manufacturer's instructions. The policy continued, 4. Test strips shall be available for the pot sink and low temp [temperature] dish machine sanitizer. Results shall be checked and recorded daily. An undated document titled, [Name of Dish Machine] Operations Guide, revealed, Verify Sanitizer levels regularly. Use test strip to ensure sanitizer level is at least 50 ppm [parts per million] and no more than 200 ppm. A document titled, Low Temperature Dish Machine Log, for the month of May 2026, revealed no documented wash or rinse temperatures for breakfast, lunch, or dinner on 05/30/2026 and 05/31/2026. The column for the recording of the sanitizer had a heading that indicated, Sanitizer 50-100 ppm. The column revealed no recorded sanitizer levels for the entire month of May 2026. The facility's Low Temperature Dish Machine Log, for the month of June 2026, revealed the column for the recording of the sanitizer had a heading that indicated, Sanitizer 50-100 ppm. The column revealed no recorded sanitizer levels for the dates 06/01/2026 through the morning of 06/10/2026. During a tour of the kitchen on 06/08/2026 at 9:56 AM, Dietary Aide (DA) #22 stated they had a high temperature machine, and the temperature should be 180 degrees Fahrenheit (F) and then 120 degrees F for the rinse, and the test strips used for the machine should be at 200 PPMs. During an interview on 06/08/2026 at 10:00 AM, the Dietary Supervisor (DS) stated they had a low temperature machine and the washing temperature should be 180 degrees F. During an interview on 06/10/2026 at 8:50 AM, DA #20 reviewed the June 2026 Low Temperature Dish Machine Log and confirmed he documented the temperatures that morning but did not test the sanitizer. During an interview on 06/10/2026 at 9:00 AM, the DS reviewed the June 2026 Low Temperature Dishwashing Log and confirmed the sanitizer PPMs were not recorded. During a concurrent observation and interview on 06/10/2026 at 9:12 AM, the DS went to do a test strip for the dishwashing machine, and DA #22 stated they did not have the strips since Monday (06/08/2026). During an interview on 06/11/2026 at 2:39 PM, the Registered Dietician (RD) stated the dishwashing machine in the kitchen was a low (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	temperature machine and utilized a sanitizer. The RD stated the dietary staff should have been doing the strips to test the sanitizer levels. The RD stated she audited the May Low Temperature Dish Machine Log on 05/18/2026, and she noted the dishwashing temperatures and sanitizer levels were missing for four days on the log. During an interview on 06/12/2026 at 10:05 AM, the Director of Nursing (DON) stated he expected staff to follow the regulations and at a minimum to determine what was needed related to the dishwasher maintenance. The DON stated they needed another system in place for doing audits and checking in with the DS. During an interview on 06/12/2026 at 10:59 AM, the Administrator (ADM) stated he expected dietary staff to follow the recommendations of the RD, who was the person in charge of training them. The ADM stated he expected dietary staff to follow their established processes. 2. A facility policy titled, Hand Hygiene, reviewed 04/28/2022, revealed, The Facility will provide guidelines to Employees on proper handwashing and Hand Hygiene techniques that will aid in the prevention of the transmission of Infections. An observation of the kitchen on 06/09/2026 at 12:03 PM revealed [NAME] #28 touched her face during the lunch meal tray line when placing plate covers on the plated food for residents, she did not perform hand hygiene, and she continued to assist with placing items on the residents' trays. A concurrent observation revealed Dietary Aide (DA) #20 touched his glasses, sorted diet tickets, and delivered food and beverages to residents without performing hand hygiene. An observation on 06/09/2026 at 12:05 PM revealed [NAME] #28 touched her hair, she did not perform hand hygiene, and she continued to put plates of food into carts. An observation of the kitchen on 06/10/2026 at 8:41 AM, revealed [NAME] #28 touched a tray of dirty dishes, then touched clean plates on the tray line, and then cooked eggs on the stove. The observation revealed [NAME] #28 did not perform hand hygiene during these tasks. During an interview on 06/10/2026 at 8:50 AM, DA #20 stated staff were to perform hand hygiene anytime they touched a dirty plate or anything that could result in cross contamination. DA #20 stated staff were to wash their hands before meal service and if they touched their hair, face, or clothes. During an interview on 06/10/2026 at 8:55 AM, [NAME] #28 stated they were to wash their hands prior to meal service and if they touched their hair. [NAME] #28 stated staff were to use the sanitizer every time they walked into the kitchen. During an interview on 06/10/2026 at 3:05 PM, [NAME] #27 stated hand hygiene should be performed when a staff member came back into the kitchen, and she stated staff had to sanitize when they entered the kitchen. [NAME] #27 stated staff had to wash their hands after they touched dirty dishes before they touched food. During an interview on 06/11/2026 at 2:39 PM, the Registered Dietician (RD) stated hand hygiene should be performed anytime staff went from dirty dishes to a clean area or preparation area and when staff touched their face or glasses. During an interview on 06/12/2026 at 10:59 AM, the Administrator (ADM) stated he expected dietary staff to follow the recommendations of the RD, who was the person in charge of training them. The ADM stated he expected dietary staff to follow their established processes. 3. A facility policy titled, Refrigeration, revised 08/21/2024, indicated, Ensure food storage and safety practices are maintained and monitored and comply with Federal and State regulations governing food storage and safety. The policy continued, Foods shall be stored in an organized manner and shall be maintained in their original containers unless they are considered a leftover. All leftovers shall be labelled and dated with an expiration date of no more than three (3) days unless otherwise indicated by the manufacturer. If food is not deemed potentially hazardous (PHF) then should be discarded after 7 days unless otherwise indicated by USDA [United States Department of Agriculture] recommended Food Storage Guideline. The policy continued, Dating of leftovers shall be as follows: Potentially hazardous foods (PHF) such as cooked eggs, fish and mayonnaise-based products and mixed dishes with multiple ingredients shall be used the same day of preparation then discarded. Other potentially hazardous leftovers shall be labelled with an expiration date of three (3) days. The U.S. [United States] Food and Drug Administration 2022 Food Code, dated 2022, in section 3-501 Temperature and Time Control revealed, Ready-to-Eat, Time/Temperature Control for Safety Food prepared and held in a Food Establishment for more than 24 hours shall be clearly marked to indicate the date or day by (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	kitchen staff were in charge of the refrigerator at the main nurses' station. During an interview on 06/12/2026 at 10:05 AM, the Director of Nursing (DON) stated that he expected the facility staff to follow regulations. During an interview on 06/12/2026 at 10:59 AM, the Administrator stated he expected dietary staff to follow their established processes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on facility policy review, record review, interview, a review of a Centers for Disease Control and Prevention (CDC) and National Institute for Occupational Safety and Health (NIOSH) publication, observation, and a review of a glucometer's manufacturer instructions, the facility failed to develop/implement a comprehensive infection control program when they failed to do the following:- Complete annual fit testing for N95 respirators for staff, which had the potential to affect all residents in the building.- Properly utilize a barrier when placing a glucometer and insulin pens on surfaces, ensure staff wore gloves when handling a used glucometer, and failed to properly disinfect a glucometer, which affected 2 (Resident #66 and Resident #83) of 8 residents reviewed for the medication administration task.- Ensure staff did not touch medications with their bare hands during medication administration, which affected 1(Residents #9) of 8 residents reviewed for the medication administration task.Findings included: 1. During an interview on 06/12/2026 at 11:26 AM, Regional Nurse Consultant (RNC) #3 stated that the facility did not have a fit testing policy; the facility followed the guidelines set by the CDC. An undated publication by the CDC and the NIOSH titled, Filtering Out Confusion: Frequently Asked Questions about Respiratory Protection, included How Often Must Fit Testing Be Conducted?, which revealed, In addition to fit testing upon initially selecting a model of respirator, OSHA [Occupational Safety and Health Administration] requires that fit testing be conducted annually, and repeated ?whenever an employee reports, or the employer or the physician or other licensed health care professional makes visual observations of changes in the employee's physical condition that could affect respirator fit.' During an interview on 06/12/2026 at 8:19 AM, Assistant Director of Nursing (ADON) #26/ Infection Preventionist (IP) stated that she started working at the facility on 04/06/202 and she was not sure what the facility's process was for fit testing for N95 respirators. She stated that she was not fit tested at the facility and had not been fit tested within the past year. During an interview on 06/12/2026 at 8:32 AM, Certified Medication Technician (CMT) #10 stated that she had been with the facility for 30 days and had not been fit tested for an N95 respirator. During an interview on 06/12/2026 at 8:38 AM, Certified Nurse Aide (CNA) #12 stated that she started with the facility two months prior. She stated that she had not been fit tested for an N95 respirator. During an interview on 06/12/2026 at 8:39 AM, CMT #13 stated that she started working at the facility a year prior, and she had not been fit tested for an N95 respirator. She stated that there had not been COVID-19 in the building during her time there. During an interview on 06/12/2026 at 8:44 AM, the Rehabilitation Director stated that he had been at the facility for a little over a month and had not been fit tested for an N95 respirator. During an interview on 06/12/2026 at 9:14 AM, RNC #3 stated that as of that moment, they were not fit testing staff for N95 respirators at the facility. RNC #3 stated that the facility had an upcoming skills fair on 06/26/2026, and he planned to implement fit testing. He stated that they did not fit test during the prior annual skills fair. He stated there had been no COVID outbreak since 2022 or 2023.2. A facility policy titled, Hand Hygiene, dated 04/28/2022 revealed, The Facility will provide guidelines to Employees on proper handwashing and Hand Hygiene techniques that will aid in the prevention of the transmission of infections. The policy revealed, Hand Hygiene should be performed following the Clinical indications, which included, Contact with blood, body fluids, or contaminated surfaces; and Before/After applying/removing Gloves/PPE [personal protective equipment]. Manufacturer instructions for the Assure Platinum Blood Glucose Monitoring System, revised 09/2024, included Cleaning and Disinfecting, which specified, Blood glucose meters be cleaned and disinfected after each use on each patient. The instructions revealed, ARKRAY recommends using these wipes to clean and disinfect the Assure Platinum meter, which included Super Sani-Cloth Germicidal Disposable Wipe. The instructions specified, Guidelines for cleaning and disinfecting the Assure Platinum meter included Always wear the appropriate protective gear, including disposable gloves. The instructions included Additional options for cleaning and disinfecting the Assure Platinum meter, which included (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview, record review, facility policy review, the facility failed to notify the physician when ordered medication was not administered for 1 (Resident #41) of 2 residents reviewed for dialysis. Specifically, the facility failed to notify the physician that Resident #41's hydroxyzine (a medication used to treat anxiety) medication was scheduled to be given at a time when the resident was gone for dialysis and was not routinely administered per physician's order for approximately five months.Findings included: A facility policy titled, Medication Administration and General Guidelines, dated 01/2026, revealed, 2. Medications are administered in accordance with written orders of the attending physician. The policy also revealed, 10. Medications are administered within one hour of the scheduled time, unless the physician specifies a specific time then the med [medication] must be given 30 minutes prior to 30 minutes after the specified time (unless facility policy directs otherwise). The policy revealed, 12. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g., resident not in facility at scheduled dose time, initial dose of antibiotic), the space provided on the front of the MAR for that dosage administration is initialed and circled. Per the policy, The physician must be notified when a dose has not been given. If an electronic medical record is being utilized than [sic] the caregiver administering the medication will enter the correct documentation that will then be electronically date/time stamped with their initials. An admission Record revealed the facility admitted Resident #41 on 09/09/2025. According to the admission Record, the resident had a medical history that included diagnoses of end stage renal disease (ESRD) and dependence on renal dialysis. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/29/2026, revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident received antianxiety medication during the seven-day assessment look-back period. Resident #41's Care Plan Report, included a focus area initiated 02/21/2024, that indicated the resident needed hemodialysis on Tuesdays, Thursdays, and Saturdays from 6:50 AM to 10:55 AM. Interventions directed staff to give an anti-anxiety medication before dialysis (initiated 08/30/2024). Resident #41's Care Plan Report, also included a focus area initiated 07/19/2024, that indicated the resident used anti-anxiety medication due to anxiety/ESRD, with instructions to give the medication before dialysis. Interventions also directed staff to administer hydroxyzine per orders before dialysis (initiated 09/17/2025). Resident #41's Order Summary Report contained a physician's order dated 09/11/2025 for hydroxyzine 10 milligrams (mg), 1 tablet by mouth one time a day every Tuesday, Thursday, and Saturday for end stage renal disease, with instructions to give the medication before dialysis. Resident #41's January, February, March, April, May, and June 2025 Medication Administration Record [MAR] revealed that the facility scheduled hydroxyzine administration for the resident for 6:15 AM on Tuesdays, Thursdays, and Saturdays. The resident's MARs revealed the following: - January 2026 MAR revealed staff documented that hydroxyzine was not administered prior to dialysis five times during the month because the resident was out of the facility and one dose of the medication was held. - February 2026 MAR revealed staff documented that hydroxyzine was not administered on eight days because Resident #41 was out of the facility and on one day, the medication was documented as held. - March 2026 MAR revealed staff documented that hydroxyzine was not administered on seven days because Resident #41 was out of the facility and on one day the medication was documented as being held. - April 2026 MAR revealed staff documented that eight doses of hydroxyzine for Resident #41 was not administered because the resident was out of the facility. - May 2026 MAR revealed staff documented that hydroxyzine was not administered to Resident #41 on six days because the resident was out of the facility. - 06/01/2026 to 06/11/2026 MAR revealed staff documented that one dose of hydroxyzine for Resident #41 was held and two instances when staff documented that Resident #41 was out of the facility and hydroxyzine was not (continued on next page)

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	375230	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered (06/06/2026 and 06/11/2026). During an interview on 06/08/2026 at 11:40 AM, Resident #41 stated that they had anxiety and stress and did not believe their medication had been given as ordered. During a follow-up interview on 06/10/2026 at 4:00 PM, Resident #41 stated that they did not think that they received any medication prior to going to dialysis because they left the facility at 4:00 AM. Resident #41 stated that they were not aware of a current physician order for hydroxyzine to be administered prior to going to dialysis. During an interview on 06/11/2026 at 10:00 AM, Resident #41 stated that they had just returned from dialysis. Per Resident #41, they did not receive any medication prior to leaving for dialysis that morning. During an interview on 06/11/2026 at 11:22 AM, Transportation Specialist (TS) #23 stated that he routinely transported residents to appointments and on that date he had transported Resident #41 to dialysis. He stated he usually picked up Resident #41 to go to dialysis at 5:20 AM, as the resident was scheduled to arrive for their dialysis appointments at 5:45 AM. During an interview on 06/11/2026 at 9:08 AM, Certified Medication Technician (CMT) #10 stated that Resident #41 was typically gone to dialysis by the time her shift started (6:00 AM). CMT #10 stated that the hydroxyzine should have been given on Tuesdays, Thursdays, and Saturdays before Resident #41 left for dialysis, which was a task for the night shift nurse. During an interview on 06/11/2026 at 11:37 AM, CMT #13 stated that she has typically worked the 6:00 AM to 2:00 PM shift and had not worked the overnight shift. She stated that she had never administered medication to Resident #41 prior to dialysis. She stated that usually Resident #41 was already gone to dialysis when she arrived at work. CMT #13 stated that typically she documented in Resident #41's MAR that the resident was out of the facility. During an interview on 06/11/2026 at 11:46 AM, Licensed Practical Nurse (LPN) #8 stated that if medication was scheduled to be given at 6:15 AM then the 6:00 AM to 2:00 PM shift staff should have administered the medication. Per LPN #8, if the physician's order was for the medication to be given before dialysis and the resident's dialysis chair time was 6:00 AM or before, staff should administer the medication prior to the resident leaving for dialysis. According to LPN #8, Resident #41's chair time was 6:00 AM, and the night shift staff was responsible for ensuring the medication was given. LPN #8 stated if there was a pattern of a resident not receiving their medications, staff should have let the nurse know so that changes could have been made to the order. She stated that she expected the resident to receive their medication before dialysis. During an interview on 06/11/2026 at 4:02 PM, LPN #16 stated that she was a charge nurse and worked the night shift. LPN #16 stated that she had not administered any morning medications to residents before they left for dialysis. She stated if there were residents who required medication prior to going to dialysis in the morning, it would have been up to her to administer the medications. LPN #16 stated that Resident #41 typically was out of the facility to dialysis by 5:30 AM. She stated that she had never administered anti-anxiety medication to Resident #41. She stated that if a physician order directed staff to give medication before dialysis, the medication should be administered when Resident #41 was awakened before the resident left for dialysis. During an interview on 06/12/2026 at 10:35 AM with Director of Nursing (DON) and Regional Nurse Consultant (RNC) #3, RNC #3 stated that documentation would be completed in the residents' electronic charts each day to make sure medication had been documented as given. The DON stated his expectation was that an adjustment should be made to ensure that medications were given as ordered. The DON stated that in general, if there was a reoccurring situation that a resident was not getting their medication, management should have been alerted so that the problem could be fixed. During an interview on 06/12/2026 at 10:16 AM, the Administrator stated that the process for administering medication was that once the physician order was put into the electronic record, the CMTs were responsible for administrating the medication. Depending on medication, the nurse may have been responsible for administering the medication. The Administrator stated that his expectation was that the residents receive their medication exactly as the doctor had ordered. He stated that if staff noticed a trend where a resident was not receiving their medication, it should have been communicated to the supervisor. During an interview on 06/12/2026 at 1:10 PM, the Medical Director (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on interview and facility document and policy review, the facility failed to ensure nutritional nighttime snacks were provided to the residents on 1 (South Hall) of 3 facility halls.Findings included: A facility policy titled, Meals & Snacks, reviewed 09/12/2025, revealed, Meal service shall be provided to residents on a regularly scheduled basis according to facility established times. Nutritional Services shall be responsible for all food preparation including snacks and shall deliver meals [with assigned assistance] to the residents or to the nursing units. Snacks shall be delivered to the nursing units by nutritional services personnel. Nursing shall be responsible for distributing snacks to the residents. The policy also indicated, Procedure: 3. An evening snack shall be provided by Nutritional Services and offered to the residents by Nursing. Additional snacks shall be provided between meals as ordered by the Physician, Registered Dietician, per facility's determination of resident preferences and/or per resident request. The policy also indicated, Procedure: 5. Nutritional Services shall deliver nourishment to the nursing units. Nursing shall be responsible for offering and/or distributing snacks. An untitled and undated facility document with information about meal times revealed, Hydration Station and snacks are available throughout the day. An untitled facility snack delivery log, beginning 05/18/2026 through 05/29/2026 and 06/01/2026 through 06/09/2026, revealed, Snacks are to go out every night between 6:30 PM and 7PM for nightly snacks. This includes ([nutritionally dense frozen snack] cups, health shakes, and PBJS [peanut butter and jelly sandwiches]) [Dietary Supervisor (DS)]. The facility snack delivery log revealed snacks were delivered to the North Station and Main Station, including signatures indicating dietary staff had prepared and delivered resident snack trays. An admission Record revealed the facility admitted Resident #80 on 10/31/2024. According to the admission Record, the resident had a medical history that included diagnoses of iron deficiency anemia and a history of peptic ulcer disease. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/13/2026, revealed Resident #80 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident required supervision or touching assistance with eating. The MDS revealed the resident did not require a mechanically altered or therapeutic diet. The MDS revealed the resident was able to walk with supervision and required no mobility devices. During an interview on 06/08/2026 at 12:21 PM, Resident #80, who resided on the South Hall, stated the facility did not make or provide enough snacks for everyone. Resident #80 stated the snacks were placed at the main nurses' station and the residents had to snatch and grab them in order to get one. Resident #80 stated there were not enough snacks if you did not get to the nurses' station early. Resident #80 stated the snacks were just placed at the nurses' station and not passed out to residents. An admission Record revealed the facility admitted Resident #77 on 04/07/2026. According to the admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus and mild protein-calorie malnutrition. An admission MDS, with an ARD of 04/14/2026, revealed Resident #77 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognition. The MDS revealed the resident required partial to moderate assistance with eating. The MDS revealed the resident required a mechanically altered diet. The MDS revealed the resident required the use of a walker or wheelchair. During an interview on 06/12/2026 at 9:31 AM, Resident #77, who resided on the South Hall, stated they did not get nighttime snacks. Resident #77 stated the snacks were at the main nurses' station, and the snacks were picked over by the time Resident #77 got there, and usually there were no snacks left. Resident #77 stated the residents got the snacks themselves. During an interview on 06/10/2026 at 3:27 PM, Certified Nurse Aide (CNA) #17 stated snacks were delivered by the kitchen and put at the main nurses' station between the East Hall and South Hall. CNA #17 stated an aide or nurse signed off that the snacks (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were received from the kitchen. CNA #17 stated the East Hall residents got snacks before the South Hall residents and before the staff on the South Hall even knew the snacks were delivered. CNA #17 stated staff on the South Hall were not notified when the snacks were delivered. During an interview on 06/10/2026 at 3:32 PM, CNA #18 stated she worked the South Hall and the residents did not receive nighttime snacks. CNA #18 stated the kitchen took snack trays to the main nurses' station. CNA #18 stated the kitchen staff used to deliver two bowls of snacks, one for the East Hall and one for the South Hall, and the nursing care staff would then deliver snacks to the residents, or the residents would come to staff and ask for one. CNA #18 stated that now kitchen staff just brought trays to the main nurses' station, and that started about three months prior. CNA #18 stated residents had complained, and she told the Dietary Supervisor, nurses, and management. CNA #18 stated it would change for one or two nights and then it would happen again. During an interview on 06/10/2026 at 3:41 PM, Licensed Practical Nurse (LPN) #19 stated the kitchen brought the residents' snacks to the main nurses' station and residents would get their snacks. LPN #19 stated sometimes the residents would ask the CNAs to get the snacks for them. LPN #19 stated any staff could sign off that the kitchen delivered the snacks.During a phone interview on 06/11/2026 at 6:24 AM, LPN #16 stated for months the residents on the South Hall had no snacks provided by the facility. LPN #16 stated the provision of snacks for the residents on the South Hall did not always happen. During a follow-up interview on 06/11/2026 at 8:26 AM, Resident #80 stated that the previous night was the first night in months that the residents had snacks (on the South Hall). Resident #80 stated the snacks were delivered to the main nurses' station by the North Hall. Resident #80 stated residents on the South Hall usually did not get snacks at night, but they used to get them. During an interview on 06/11/2026 at 8:36 AM, the Dietary Supervisor (DS) stated snacks were delivered at 7:00 PM every night and there were three trays, one for each hall (North, East, and South). The DS stated the kitchen delivered snack trays to the main nurses' station and nursing staff signed off that the trays were received. The DS stated it was the responsibility of nursing staff to deliver the snacks to each hall. The DS stated her job was to get the snack trays to the nurses. The DS stated that when nursing signed off on receiving the snacks, she did not know when the snacks were delivered to the halls because nursing did that part. During an interview on 06/11/2026 at 2:39 PM, the Registered Dietician (RD) stated that recently the facility started the process where dietary staff would put the snacks on trays and there was a log where the nurses and dietary signed off on the delivery to show the hand-off. The RD stated the number of snacks provided should be based off the census and allow, at minimum, one snack per person. The RD stated that once dietary staff handed off the snacks, it was nursing's responsibility to distribute them to the residents. During an interview on 06/11/2026 at 4:28 PM, LPN #19 stated she would sign off on the snacks for the South Hall and leave the snacks at the main nurses' station, and sometimes the CNAs would come to the nurses' station for the residents from the South Hall to get them a snack. During an interview on 06/12/2026 at 9:47 AM, the Assistant Director of Nursing (ADON) #26 stated the DS brought out the resident nighttime snacks on a tray. ADON #26 stated a nurse signed off on snacks for the North Hall and Main Nurses' station that they received the snacks. ADON #26 stated she was not sure how the nurse for the South Hall would know when the snacks were delivered; she just knew nurses were to sign off when the snacks were delivered. ADON #26 stated residents who could ambulate came to the Main Nurses' station, and CNAs would distribute the snacks for the residents who could not ambulate. During an interview on 06/12/2026 at 10:42 AM, the Administrator (ADM) stated his expectation was that staff were following the established process.

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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. Based on interview, record review, and facility policy review, the facility failed to ensure that 3 (Residents #7, #44, and #77) of 5 sampled residents reviewed for immunizations were offered the pneumococcal vaccination.Findings included: A facility policy titled, Pneumococcal Vaccine, reviewed 12/05/2024, indicated, The opportunity to receive the Pneumococcal Vaccine will be extended to all Residents. The Facility will provide pertinent information regarding the Risks/ Benefits of receiving the vaccine. The policy continued, Residents; Document Immunizations in the Medical Record: Vaccine Name, Date, Education, Time, Route, Amount, Location, Manufacturer Name, Expiration Date, Lot Number, Person Administering. 1. An admission Record revealed the facility admitted Resident #7 on 05/20/2026. According to the admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease without exacerbation, emphysema, and acute respiratory failure with hypoxia. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/27/2026, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident's pneumococcal vaccine was not up to date and that the resident had not received the pneumococcal vaccine because it was not offered. Resident #7's Immunizations section in their Electric Medical Record (EMR) did not reflect that the resident was offered a pneumococcal vaccination or that the resident had refused the vaccine. The Immunizations section in the resident's EMR was blank. During an interview on 06/12/2026 at 12:57 PM, Resident #7 said they had not been offered a pneumococcal immunization at the facility, and they would not have been interested. 2. An admission Record revealed the facility admitted Resident #44 on 02/15/2026. According to the admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease and cerebral palsy. A quarterly MDS, with an ARD of 06/03/2026, revealed Resident #44 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS indicated the resident's pneumococcal vaccine was not up to date and that the resident had not received the pneumococcal vaccine because it was not offered. Resident #44's Immunizations section in their EMR did not reflect that the resident was offered a pneumococcal vaccination or that the resident had refused the vaccine. The Immunizations section in the resident's EMR was blank. During an interview on 06/12/2026 at 12:16 PM, Resident #44 stated they had not been offered a pneumococcal immunization at the facility, and they would have liked to have been offered. 3. An admission Record revealed the facility admitted Resident #77 on 04/07/2026. According to the admission Record, the resident had a medical history that included diagnoses of heart failure and type two diabetes mellitus. An admission MDS, with an ARD of 04/14/2026, revealed Resident #77 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident's pneumococcal vaccine was not up to date and that the resident had not received the pneumococcal vaccine because it was not offered. Resident #77's Immunizations section in their EMR did not reflect that the resident was offered a pneumococcal vaccination or that the resident had refused the vaccine. The Immunizations section in the resident's EMR was blank. During an interview on 06/12/2026 at 12:19 PM, Resident #77 stated they had not been offered a pneumococcal immunization at the facility, and they would have liked to have been offered. During an interview on 06/12/2026 at 8:19 AM, the Assistant Director of Nursing (ADON) #26 /Infection Preventionist (IP) stated she started working as the infection preventionist two to three weeks prior. She said she had not looked at the pneumococcal vaccinations. During an interview on 06/12/2026 at 9:14 AM, Regional Nurse Consultant (RNC) #3 stated that when a resident entered the facility, the Social Services Supervisor inquired if the resident wanted immunizations. Declinations were verbal and not documented, though the facility might put it in a progress note. RNC #3 said they were unable to find any documentation that indicated Residents #7, #44, and #77 had declined or received their pneumococcal vaccinations. During an interview on 06/12/2026 at 11:01 AM, with the Director of (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing (DON) and RNC #3, the DON did not comment on immunizations. RNC #3 said that pneumococcal immunizations should be offered annually, and that the facility would begin doing that going forward. During an interview on 06/12/2026 at 11:36 AM, the Administrator stated the facility followed the regulations regarding immunizations for residents. During an interview on 06/12/2026 at 1:05 PM, the Medical Director stated he expected the facility to offer pneumonia vaccinations.

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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. Based on interview, record review, and facility policy review, the facility failed to ensure that 3 (Residents #7, #14, and #44) of 5 sampled residents reviewed for immunizations were offered the Coronovirus-19 (COVID-19) vaccination.Findings included: A facility policy titled, COVID Vaccine, revised 09/04/2024, indicated, The Facility will offer the COVID Vaccine to Employees/Residents to assist in mitigating the spreads of COVID-19. The policy continued, The Facility shall maintain documentation for all Residents and Employees on COVID-19 Vaccination. 1. An admission Record revealed the facility admitted Resident #7 on 05/20/2026. According to the admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease without exacerbation, emphysema, and acute respiratory failure with hypoxia. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/27/2026, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident's COVID-19 vaccination was not up to date. Resident #7's Immunizations section in their Electric Medical Record (EMR) did not reflect that the resident was offered a COVID-19 vaccination or that the resident had refused the vaccine. The Immunizations section in the resident's EMR was blank. During an interview on 06/12/2026 at 12:57 PM, Resident #7 said they had not been offered a COVID-19 immunization at the facility, and they would not have been interested. 2. An admission Record revealed the facility admitted Resident #14 on 12/11/2025. According to the admission Record, the resident had a medical history that included diagnoses of chronic systolic congestive heart failure and chronic obstructive pulmonary disease. A quarterly MDS, with an ARD of 06/03/2026, revealed Resident #14 had a BIMS score of 14, which indicated the resident had intact cognition. The MDS indicated the resident's COVID-19 vaccination was not up to date. Resident #14's Immunizations section in their EMR did not reflect that the resident was offered a COVID-19 vaccination or that the resident had refused the vaccine. During an interview on 06/12/2026 at 1:03 PM, Resident #14 stated they could not remember if they had been offered vaccinations. They did not believe they had and would not have minded being offered. 3. An admission Record revealed the facility admitted Resident #44 on 02/15/2026. According to the admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease and cerebral palsy. A quarterly MDS, with an ARD of 06/03/2026, revealed Resident #44 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS indicated the resident's COVID-19 vaccination was not up to date. Resident #44's Immunizations section in their EMR did not reflect that the resident was offered a COVID-19 vaccination or that the resident had refused the vaccine. The Immunizations section in their EMR was blank. During an interview on 06/12/2026 at 12:16 PM, Resident #44 stated they had not been offered a COVID-19 immunization at the facility, and they would have liked to have been offered. During an interview on 06/12/2026 at 8:19 AM, the Assistant Director of Nursing (ADON) #26 /Infection Preventionist (IP) stated she started working as the infection preventionist two to three weeks prior. She said she had not reviewed the COVID-19 vaccinations. During an interview on 06/12/2026 at 9:14 AM, Regional Nurse Consultant (RNC) #3 stated that when a resident entered the facility, the Social Services Supervisor inquired if the resident wanted immunizations. Declinations were verbal and not documented, though the facility might put it in a progress note. RNC #3 said they were unable to find any documentation that indicated Residents #7, #14, and #44, had declined or received their COVID-19 vaccinations. During an interview on 06/12/2026 at 11:36 AM, the Administrator stated the facility followed the regulations regarding immunizations for residents. During an interview on 06/12/2026 at 1:05 PM, the Medical Director stated he expected the facility to offer COVID-19 vaccinations.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a dignified dining experience for 3 (Residents #80, #13, and #77) sampled residents during 2 of 2 meal observations. Specifically, on 06/08/2026, 23 minutes after being served, Resident #13 had finished their meal and Resident #77 and Resident #80, who were seated at the same table, had not been served their meal. On 06/11/2026, the residents were seated at the same table again and staff had not served Resident #13 and Resident #77's meals when Resident #80 had consumed 75% of their meal.Findings included: A facility policy titled, Resident Rights, revised 01/28/2026, revealed, The facility shall treat Residents with kindness, respect, and dignity and ensure Resident Rights are being followed. An admission Record revealed the facility admitted Resident #80 on 10/31/2024. According to the admission Record, the resident had a medical history that included diagnoses of iron deficiency anemia and a history of peptic ulcer disease. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/13/2026, revealed Resident #80 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed that the resident required supervision or touching assistance with eating. The MDS also revealed the resident did not require a mechanically altered or therapeutic diet. An admission Record revealed the facility admitted Resident #77 on 04/07/2026. According to the admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus and mild protein-calorie malnutrition. An admission MDS, with an ARD of 04/14/2026, revealed Resident #77 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident required partial to moderate assistance with eating. The MDS also revealed the resident required a mechanically altered diet. An admission Record revealed the facility admitted Resident #13 on 05/20/2025. According to the admission Record, the resident had a medical history that included diagnoses of protein calorie malnutrition, anxiety, and depression. A quarterly MDS, with an ARD of 05/27/2026, revealed Resident #13 had a BIMS score of 8, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident required partial to moderate assistance with eating and required a mechanically altered diet. During an observation of the lunch meal service on 06/08/2026 at 12:30 PM in the main dining room, Resident #13 was seated at a table with Resident #80 and Resident #77. Resident #13 was eating their meal, and staff had not served Resident #80 and Resident #77 their lunch meal. At 12:47 PM on 06/08/2026, staff served Resident #80's lunch. At 12:53 PM, Resident #13 finished their lunch and left the table, and Resident #77 still had not received their lunch. At that time, Resident #77 stated the resident was eating lunch today, but had not received their food yet. During a concurrent observation and interview on 06/11/2026 at 8:22 AM, Residents #77, #13, and #80 were sitting at the same table for breakfast meal service in the main dining room. Resident #77 had their meal at that time, and Resident #13 and Resident #80 did not. Resident #80 stated they received their meal when their meal ticket came up, and it was random. Resident #80 stated that the delivery of meals was sporadic, and they did not get their meals at the same time when sitting together at a table. At that time, Resident #77, who was eating the meal that was delivered, stated it bothered them when the others were eating, and the resident did not have their meal. During the interview, Resident #13 stated it bothered them a little when the others had their meal, and Resident #13 did not, especially when the others were finished eating, and they still had not received a meal. An observation at 8:34 AM on 06/11/2026, revealed Resident #77 had eaten 75 percent (%) of their meal, and Resident #80 and Resident #13 did not have their meals. During a concurrent observation and interview on 06/11/2026 at 8:36 AM, the Dietary Supervisor (DS) observed Resident #80 and Resident #13 without a meal and Resident #77 eating their meal. The DM stated the staff were to serve the whole table at the same time. She stated they should organize the meal tickets by table when doing the beverage service then give the tickets to the cook. During an (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 06/09/2026 at 11:39 AM, Dietary Aide (DA) #20 stated they were to serve everyone at the table at the same time, but he followed the cook's flow when delivering meals. During an interview on 06/12/2026 at 9:47 AM, the Assistant Director of Nursing (ADON) #26 stated that residents should be served at the same time. ADON #26 stated it would not be fair for a person to watch another person eat a meal in front of them. During an interview on 06/12/2026 at 9:55 AM, the Director of Nursing stated his expectation would be to produce a better system for choosing how meal tickets were planned. He stated they had a monitoring system in place for dining service, but they were not monitoring to ensure residents were served at the same time when sitting at the same table. During an interview on 06/12/2026 at 10:42 AM, the Administrator stated the expectation was to serve table by table and follow the orders on meal tickets; however, he stated that meal service at the facility was not the same as a restaurant. He stated that the expectation was for dietary staff to serve meals based on diet orders. He stated he could not say what may have been going on in the main dining room at the time of the observations.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to maintain a sanitary, orderly, and comfortable environment for 1 (Resident #88) of 2 residents who utilized a wheelchair. Specifically, observation revealed Resident #88 had damaged wheelchair armrests, and there was no documented evidence that efforts to repair the damage had been made, despite the Maintenance Director being aware of the issue.Findings included: During an interview on 06/11/2026 at 8:41 AM, the Administrator stated there was no policy regarding maintenance or maintaining resident care equipment. An admission Record revealed the facility admitted Resident #88 on 06/24/2025. According to the admission Record, the resident had a medical history that included diagnoses of dementia, muscle weakness, unsteadiness on feet, and a history of falling. A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/03/2026, revealed Resident #88 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. According to the MDS, Resident #88 used a wheelchair for mobility. During an observation on 06/08/2026 at 12:30 PM, Resident #88's wheelchair had a cracked armrest on the left side with an area of exposed foam that was approximately 3 inches wide by 1 inch long, and the foam was projecting outwards onto the armrest. The armrest on the right side of the resident's wheelchair revealed the lining was torn from an area that was approximately five square inches. During an interview on 06/10/2026 at 2:15 PM, Certified Medication Technician (CMT) #7 stated they reported damaged or torn equipment to the charge nurse. When she observed the torn armrests to Resident #88's wheelchair, she stated she should have noticed it and brought it to someone's attention. During an interview on 06/10/2026 at 2:15 PM, the Maintenance Supervisor stated staff reported damaged equipment via the building's maintenance management system. He stated he was familiar with the issue with Resident #88's chair and had not fixed it yet. He stated that he believed the issue had already been documented. During an interview on 06/12/2026 at 11:01 AM, the Director of Nursing (DON) stated that if nursing staff noticed damaged equipment, they notified maintenance staff to repair the equipment. Per the DON, if the equipment was no longer safe to use, they immediately removed it. During an interview on 06/10/2026 at 4:04 PM, the Administrator stated that he was first notified about Resident #88's armrests that day (06/10/2026) and reviewed the building's maintenance management system on 06/10/2026 at 2:22 PM. Per the Administrator, there were no prior system entries regarding Resident #88's wheelchair. The Administrator stated that if staff noticed damaged resident care equipment, they should enter the concern into the building's maintenance management system, which would produce a ticket indicating the facility was addressing the issue.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and facility policy review, the facility failed to provide respiratory care consistent with professional standards of practice for 1 (Resident #14) of 3 residents reviewed for respiratory care. Specifically, Resident #14 received oxygen therapy without a physician's order, the resident's nebulizer mask was observed stored improperly, and a physician ordered oxygen humidifier bottle was not provided for the resident.Findings included: A facility policy titled, Oxygen Administration and Storage, dated 01/01/2014, revealed, Purpose: To ensure staff follow safety guidelines and regulation for storage and use of oxygen. The policy also revealed, Concentrator: Residents are to be provided with an oxygen concentrator whenever possible for the purpose of maximizing mobility and overall consistency in regulation of oxygen administration. A facility policy titled, Medication Administration and General Guidelines, dated 01/2026, revealed, Medications are administered as prescribed, in accordance with State Regulations using good nursing principles and practices and only by persons legally authorized to do so. An admission Record revealed the facility readmitted Resident #14 on 12/11/2025. According to the admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD), encephalopathy, and chronic systolic heart failure. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/03/2026, revealed Resident #14 had a Brief Interview for Mental Status (BIMS) of 14, which indicated the resident had intact cognition. The MDS revealed the resident had active diagnoses of COPD and shortness of breath (SOB). The MDS did not indicate that Resident #14 received oxygen therapy. Resident #14's Care Plan Report included a focus area, initiated 12/23/2025, that indicated the resident had altered respiratory status/difficulty breathing related to COPD, wheezing, and SOB. Interventions directed staff to: administer medication for SOB and wheezing as ordered and monitor for side effects and effectiveness; change and date the humidifier bottle and oxygen tubing weekly every Wednesday night; change the nebulizer mask and tubing every Wednesday night if in use and document Y if changed and N if not in use ; change nebulizer tubing and mask per orders; monitor for signs and symptoms of respiratory distress and report to the physician as needed; and to provide oxygen per orders as/if needed. Resident #14's Order Summary Report, with active orders as of 06/08/2026, did not include orders for supplemental oxygen administration. The Order Summary Report included orders:- to change the nebulizer tubing and mask weekly on the night shift every seven days, dated 05/14/2026;- to change the humidifier bottle on the oxygen concentrator, the tubing, the mouthpiece, the mask, and the water in the oxygen humidifier every night shift every seven days, dated 05/14/2026; and- for albuterol sulfate (a bronchodilator) inhalation nebulization solution 1.25 milligrams (MG)/3 milliliters (ML), one application to be inhaled orally four times a day for SOB, 12/19/2025. Resident #14's Medication Administration Records (MARs), dated 05/2026 and 06/2026, did not indicate the resident received supplemental oxygen treatment. An observation on 06/08/2026 at 10:43 AM revealed Resident #14 in bed receiving supplemental oxygen via a nasal cannula (a thin flexible tube to deliver oxygen through the nose). The observation revealed Resident #14's oxygen concentrator was set at a rate of 3.5 liters per minute (LPM). The observation revealed a nebulizer mouthpiece and tubing were observed on Resident #14's nightstand uncovered and not stored in a bag. An observation on 06/08/2026 at 2:18 PM revealed Resident #14 in bed receiving supplemental oxygen via a nasal cannula, the oxygen concentrator was set at 3.5 LPM, and a nebulizer mouthpiece and tubing were observed on the resident's nightstand uncovered and not stored in a bag. An observation on 06/09/2026 at 10:56 AM revealed Resident #14 in bed receiving supplemental oxygen via a nasal cannula, the oxygen concentrator was set at 3.5 liters per LPM, and there was no humidifier bottle. The observation revealed a nebulizer mouthpiece and tubing on Resident #14's nightstand uncovered and not stored in a bag. An observation on 06/10/2026 at 9:55 AM revealed Resident #14 in bed receiving supplemental oxygen via a nasal cannula, the oxygen concentrator was set at 3.5 LPM, and there was no humidifier bottle. The (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observation revealed a nebulizer mouthpiece and tubing on Resident #14's nightstand uncovered and not stored in a bag. During a concurrent interview, Resident #14 stated they took the nebulizer treatment four times a day every day. During an interview on 06/10/2026 at 10:10 AM, Certified Medication Technician (CMT) #10 stated nurses managed residents' oxygen and inhalers, and the nebulizer mouthpiece and tubing should be stored in a plastic bag, labeled and dated. Immediately following the interview, on 06/10/2026 at 10:14 AM, CMT #10 observed the nebulizer mouthpiece and tubing on Resident #14's nightstand and confirmed it was not stored correctly. During an interview on 06/10/2026 at 1:24 PM, Licensed Practical Nurse (LPN) #8 confirmed Resident #14 utilized oxygen, and she stated the resident was on continuous oxygen. LPN #8 reviewed Resident #14's electronic medical record and stated she did not see a physician's order for use of supplemental oxygen. During concurrent interviews in Resident #14's room on 06/10/2026 at 2:01 PM, LPN #8 acknowledged Resident #14's oxygen concentrator was at 3.5 LPM, and there was no oxygen humidifier. Concurrently, Resident #14 stated staff never put the water bottle on the oxygen concentrator. Resident #14 stated the resident had received oxygen at 3.5 LPM for a long time. Resident #14 stated staff did not put the nebulizer mouthpiece or tubing in a bag until that day. During a phone interview on 06/11/2026 at 6:24 AM, LPN #16 stated Resident #14 had been on oxygen since the resident arrived at the facility. During an interview on 06/11/2026 at 10:27 AM, LPN #15 stated Resident #14 received oxygen and breathing treatments. LPN #15 stated she did not notice that there was no physician's order for Resident #14's oxygen, and if she had she would have contacted the doctor for an order. During an interview on 06/12/2026 at 3:08 PM, LPN #19 stated Resident #14 received supplemental oxygen, and she was unaware Resident #14 had no physician's order for supplemental oxygen. During an interview on 06/12/2026 at 10:14 AM, the Director of Nursing (DON) stated if a resident had no oxygen order and was receiving oxygen, he expected staff to make sure the physician's orders for supplemental oxygen were in the electronic medical record and the nurses were following the orders. The DON stated he expected the nursing team to ensure the nebulizer mask, mouthpiece, and tubing were stored correctly.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure that dialysis services were consistent with professional standards of practice for 1 (Resident #58) of 2 residents reviewed for dialysis. Specifically, the facility failed to ensure Resident #58 had a physician order and care plan for dialysis treatment and for care/monitoring of the resident's hemodialysis (a process in which blood is pulled from a dialysis access, such as a catheter, circulated outside the body through a dialysis machine, then pumped back into the blood stream) catheter/catheter site. The facility also failed to ensure staff completed an ongoing assessment of the resident's condition and monitored for complications after hemodialysis treatments.Findings included: A facility policy titled, Care of Hemodialysis Resident, issued 01/01/2014, revealed the purpose was, To ensure the needs of the resident receiving hemodialysis are met by both the facility and the dialysis center. Residents receiving hemodialysis are transported routinely out of the facility. Communication is essential for the continuity of care. The policy revealed Post Dialysis care included, Review communication documents for any pertinent information. Take vital signs per physician order. The policy revealed care of External Catheters [a hemodialysis catheter is a flexible tube inserted into a large vein to provide immediate access to the bloodstream for dialysis] included, Care should be taken so the external catheter is not pinched poked, bent or pulled. A smooth clamp should be kept at the bedside for emergency situations. Avoid getting catheter wet during bathing. You may cover the plastic wrap during bathing. Replace the dressing if it comes off or becomes wet. Cleanse the area with cleanser such as Betadine swab or Hibiclens and apply new sterile dressing. An admission Record revealed the facility readmitted Resident #58 on 02/28/2026. According to the admission Record, the resident had a medical history that included diagnoses of acute kidney failure and type 2 diabetes mellitus with diabetic chronic kidney disease. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/27/2026, revealed Resident #58 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident had an active diagnosis of renal insufficiency and renal failure. The MDS did not indicate that the resident received dialysis. A hospital After Visit Summary revealed Resident #58's was hospitalized from [DATE] through 05/11/2026. The After Visit Summary indicated that Resident #58 was started on dialysis and was to continue as a dialysis outpatient beginning 05/12/2026. The summary revealed that the location of the dialysis center was listed and indicated that dialysis was scheduled every Tuesday, Thursday, and Saturday at 11:00 AM. A hospital Discharge Summary revealed Resident #58's was hospitalized again from 05/19/2026 through 05/22/2026. The Discharge Summary indicated discharge diagnoses included end stage renal disease on hemodialysis (HD). The Discharge Summary revealed Resident #58 was admitted on [DATE] for altered mental status and somnolence noted at the dialysis center, which precluded the resident's scheduled dialysis session. Per the Discharge Summary, follow up instructions included ensuring the resident followed up with regularly scheduled HD. Resident #58's Progress Note, created by Licensed Practical Nurse (LPN) #15 on 05/22/2026, revealed the resident returned to the facility from the hospital and had a new HD catheter located on the right side of the resident's chest and the dressing to the area was clean, dry, and intact. Resident #58's Care Plan Report included a focus area, initiated on 10/13/2023, that indicated the resident had acute renal failure related to Stage 2 chronic kidney disease. There was no documented evidence that the facility developed a care plan for dialysis with interventions that directed staff how to care for the resident who was receiving dialysis or assessment/monitoring/treatment of the resident's HD catheter. Resident #58's Order Summary Report, with active orders as of 06/08/2026, revealed no documented evidence that the resident had orders for dialysis services, or for care of the resident's HD catheter. Resident #58's Medication Administration Records [MARs] and Treatment Administration Records [TARs] for May 2026 and for (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/01/2026 through 06/08/2026 (printed 06/08/2026 at 4:53 PM Central Daylight Time) revealed no documented evidence that the resident received dialysis services, that staff were monitoring the HD catheter site for signs and symptoms of bleeding or infection, or that staff were providing treatment to the HD catheter site. Resident #58's Dialysis Communication Transfer Form revealed the resident had dialysis at an offsite hemodialysis center on 05/12/2026, 05/14/2026, 05/16/2026, 05/23/2026, 05/30/2026, 06/06/2026 and 06/09/2026. The Dialysis Communication Transfer Form revealed that upon return to the facility, staff were required to assess the resident's vital signs and cognition status, monitor the access site dressing, document whether or not the physician was notified of any concerns, and sign and date the bottom of the form. Per the Dialysis Communication Transfer Forms, with the exception of 05/14/2026 when staff documented the resident's vital signs, cognition status, and that the access site dressing was changed, there was no documented evidence that staff assessed Resident #58 upon return from dialysis on the aforementioned dates. Resident #58's Progress Notes for the timeframe from 05/12/2026 through 06/10/2026 also revealed no documented evidence that staff monitored/assessed the resident after dialysis or assessed/monitored/treated the resident's HD catheter site/dressing. During an interview on 06/10/2026 at 3:52 PM, Resident #58 stated the hospital put a shunt (HD catheter) in the right side of the resident's chest for dialysis. The resident confirmed they went to dialysis on Tuesdays, Thursdays, and Saturdays. Resident #58 stated the nurses checked the HD catheter a couple of times a week but did not usually check the resident's vital signs or the HD catheter access site when the resident returned from dialysis. During an interview on 06/09/2026 at 5:02 PM, Certified Medication Technician (CMT) #5 stated that when Resident #58 came back from dialysis, she checked the resident's vital signs and administered the resident's medications. Per CMT #5, she had not seen the resident yet that day and did not know whether the resident had returned from dialysis. During an interview on 06/09/2026 at 5:02 PM, LPN #6 also stated that she did not know whether Resident #58 had returned from the dialysis center. She stated that when the resident returned, CMT #5 would take the resident's vital signs, and she (LPN #6) would check the resident's blood sugar. Per LPN #6, she did not do anything else when the resident returned from dialysis unless the resident had a complaint. According to LPN #6, she never saw Resident #58's paperwork from dialysis. She stated she worked on Tuesdays, and per LPN #6, the paperwork was processed at the main nurses' station. During a concurrent observation and interview on 06/09/2026 at 5:18 PM, Resident #58 was in the main dining room waiting for dinner. The resident stated that they returned to the facility from the dialysis center a little after 4:00 PM on 06/09/2026. There was no documented evidence at that time (over an hour after returning from dialysis) that staff had assessed the resident. During an interview on 06/09/2026 at 10:48 AM, LPN #15 stated that staff obtained vital signs before leaving for dialysis and when the resident returned. Per LPN #15, a resident's electronic TAR prompted the nurse to obtain and document a resident's vital signs. However, LPN #15 reviewed Resident #58's MAR and TAR for June 2026 and stated the resident did not have a physician's order for pre and post dialysis vital signs. She also stated she did not see a physician's order for dialysis treatment for Resident #58. During a follow-up interview on 06/10/2026 at 9:31 AM, LPN #15 stated that she reviewed Resident #58's electronic medical record and stated she did not see a physician's order for monitoring or assessing the resident HD catheter access site. During an interview on 06/10/2026 at 1:39 PM, LPN #8 stated that when a resident returned from dialysis, the nurse was supposed to obtain the resident's vital signs if there was a physician's order and the nurse should also check and make sure the HD access site was not bleeding. She stated that if a resident was receiving dialysis, there should be a physician's order and there should also be an order to monitor the access site and make sure it was clean and dry. She reviewed Resident #58's electronic medical record and stated there was no physician order for dialysis or monitoring and assessing the access site. During an interview on 06/12/2026 at 11:41 AM, the Nurse Practitioner (NP) stated that the facility providers typically did not provide orders for dialysis. She stated that dialysis orders were determined prior to the resident being discharged from (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the hospital. However, the NP stated that she expected there to be an order for dialysis, and the facility dropped the ball. During an interview on 06/12/2026 at 9:43 AM, Assistant Director of Nursing (ADON) #26 stated nurses should obtain a resident's vital signs after dialysis and, depending on each resident, they needed to monitor the HD catheter dressing to make sure it was clean and dry and follow up if necessary. ADON #26 stated that staff should monitor residents when they came back from HD, and they should document the assessment on the Dialysis Transfer Communication forms. Per ADON #26, if staff did not see a physician's order for HD, they should get an order from the physician. During an interview on 06/12/2026 at 10:19 AM, with the Director of Nursing (DON) and Regional Nurse Consultant (RNC) #4, the DON stated his expectation was for nurses to make sure post dialysis care was completed and documented on the Dialysis Transfer Communication form. RNC #4 stated that the monitoring should be completed and documented on the resident's TAR, and the Dialysis Transfer Communication Form should be uploaded into the electronic medical record. During an interview on 06/12/2026 at 10:58 AM, the Administrator stated his expectation was that doctor's orders were to be followed.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, record review, and facility document and policy review, the facility failed to ensure their medication rate was below 5% for 1 (Resident #83) of 8 residents observed for medication administration. Specifically, staff did not perform an insulin pen safety check before insulin administration which resulted in 2 medication errors of 27 opportunities. The facility's overall medication error rate was 7.41%.Findings included: A facility policy titled, Medication Administration and General Guidelines, revised 01/2026, indicated, Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. An undated facility document titled, Standardized Priming (Safety Test) Instructions, indicated, Priming is essential before every injection to remove air bubbles from the needle and cartridge, and to ensure the device is functioning correctly. The policy also indicated, 2. The Priming Step (Safety Test) 1. Dial the dose: Turn the dose selector to 2 units. 2. Position the pen: Hold the pen with the needle pointing straight upward. 3. Tap the cartridge: Gently tap the insulin reservoir (cartridge) with your finger to help any air bubbles rise toward the needle. 4. Inject the prime: Press the injection button all the way in. Check the dose window to ensure it returns to 0. 5. Verify: Look for a drop or stream of insulin at the tip of the needle. If you see a drop: The pen is primed and ready to dial the required dose. Findings included: An admission Record revealed the facility admitted Resident #83 on 03/24/2021. According to the admission Record, the resident had a medical history that included a diagnosis of type 2 diabetes mellitus. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/29/2026, revealed Resident #83 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 received insulin injections. Resident #83's Care Plan included a problem statement, initiated 07/19/2024, that indicated the resident had Type II diabetes mellitus. Interventions directed the staff to administer insulin as ordered. Resident #83's Order Summary Report, with active orders as of 03/05/2026, revealed an order dated 03/06/2026 for 25 units of glargine (Lantus, a long-acting insulin) injected subcutaneously via pen-injector one time a day for diabetes and 5 units of NovoLog (a fast-acting insulin) injected subcutaneously via pen-injector with meals for diabetes. During a concurrent observation of medication administration and an interview on 06/10/2026 at 7:55 AM, Licensed Practical Nurse (LPN) #8 removed one NovoLog insulin pen and one Lantus insulin pen. The observation revealed LPN #8 dialed up 5 units of insulin on the NovoLog pen and 25 units of insulin on the Lantus insulin pen and then started toward Resident #83's room. LPN #8 stated she was ready to give the doses unless she needed to add more based on the blood glucose reading. LPN #8 stated she had not primed the insulin pens with two units of insulin and stated that she was not shown how to prime the insulin pens. LPN #8 left with the insulin pens and came back after she stated she went to the Director of Nursing (DON) for education on priming the insulin pens. During an interview on 06/11/2026 at 1:37 PM, Assistant Director of Nursing/Infection Preventionist (ADON/IP #26) stated her expectation would be to prime the insulin pen with 2 units of insulin before dialing up the ordered dose.During a phone interview on 06/12/2026 at 11:01 AM, the Pharmacy Consultant stated the nurses should prime the insulin pens prior to use.During an interview on 06/12/2026 at 11:58 AM, the DON stated he expected staff to prime the insulin pens per manufacturer's instructions.During a phone interview on 06/12/2026 at 1:02 PM, the Medical Director stated he expected insulin dosage to be accurate each time.