STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375276	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Nursing Center	113 East Jones Chouteau, OK 74337

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. On 03/11/26, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to provide supervision to prevent accident hazards related to smoking. On 03/02/26, Resident #26 was smoking in their room while wearing oxygen. The oxygen combusted which caused a facial burn, singed beard, and mustache hair. On 03/11/26 at 2:56 p.m., the Oklahoma State Department of Health verified the existence of an IJ situation. On 03/11/26 at 3:05 p.m., the administrator was notified of the IJ situation. An IJ template was provided to the administrator. On 03/12/26 at 10:47 a.m., an acceptable POR (plan of removal) was received. The POR read in part, Plan of Removal for lJ Amended 3/12/2026 at 0950 [9:50 a.m.]1. Notify Medical Director2. Notify resident # 26 hospice provider of lJ and coordination of care3. New Smoking Assessment for all smokers4. Review/revise smoking policy with resident and resident council with agreement and approval for revision of checking for any smoking material at the end of each smoke break. Update smoking policy to include observation of smoking residents to distinguish and dispose of smoking material ie: cig butts and return lighter at end of smoking times. With a check list to ensure each resident has complied. Staff supervising smoke break(s) will keep the smoking materials container in their passion[sic], with only one lighter available, and will give each resident only one cigarette at a time. All smoking materials brought in by friends/family are to be checked in at nurse's station.5. Post reviewed/revised smoking policy with resident council approval at nurses' station, by exit leading to smoking area.6. Have smoking residents sign revised smoking policy for acknowledging policy7. Administrator to In-Service Staff on revised smoking policy8. Regional supervisor to In-Service Administrator/DON on ODHS [sic] form 283 and completing with adequate supervision of residents and follow-up for accident and incidents related to smoking and charting for interventions and follow up care.9. Up-date care plan for resident # 26.10. Review all smoking residents care plan and revise as needed for adequate supervision/intervention for possible accidents/injury if occurrence happens.11. Move resident # 26 to room closer to nurse's station.12. Educate resident # 26 on hazards of smoking in room and the potential to harm self and other resident due to combustion with oxygen and possible injuries and sign education sheet and upload to resident EHR under resident documents.13. All ODHS [sic] for 283 will be sent to a Regional Supervisor for review for completeness and adequate intervention to prevent reoccurrence and follow-up,14. QAPI for lJ started and monitored for the above intervention for removal of lJ with monitoring implementation. The IJ was lifted, effective 03/12/26 at 10:15 a.m., when all components of the POR were verified. Observation of the room change for Resident #26 was made. Observation of placement of new smoking policy was made to ensure posted in listed areas. Care plans and assessments of smokers were reviewed to ensure updates were completed. The smoking policy was reviewed to ensure it had been updated. Interviews with residents who smoke were conducted to ensure education had been provided. Multiple staff from all shifts were interviewed to verify in-service was completed. The deficient practice remained at an isolated level with actual harm. Based on observation, record review, and interview, the facility failed to provide supervision to prevent accident hazards for 1 (#26) who smoked while wearing oxygen which resulted in facial burns, of 5 sampled residents reviewed who smoked. Regional Nurse #2 identified 5 residents in the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility who smoked. Findings: 1. On 03/10/26 at 8:53 a.m., Resident #26 was observed in the dining room with singed mustache hair above their lip and a wound approximately one inch wide by two inches long to the left of their upper lip. An undated, Smoking policy, read in part, Residents will not be allowed to have cigarettes or paraphernalia's [sic] such as: matches or lighters in their possession or in their rooms. These items will be kept secured at the nurses' station and will be distributed at designated smoking times if applicable.No smoking is permitted in resident rooms or hallways. A care plan, reviewed/revised 02/24/25, showed Resident #26 had a concern for decreased oxygen levels due to a diagnosis of COPD and smoking. The interventions showed to perform smoking assessments quarterly according to facility policy, monitor when smoking to assure resident's safety, and provide smoking policy and rules regarding cigarette and lighter being kept at the desk. An admission assessment, dated 05/14/25, showed Resident #26 had a BIMS of 15, which indicated they were cognitively intact and smoked. A Smoking Assessment, dated 11/12/25, showed Resident #26 had demonstrated ability to safely smoke cigarettes with minimal supervision. A Smoking Assessment, dated 02/12/26, showed Resident #26 was observed to hide a cigarette in their pocket to smoke later. The assessment showed Resident #26 had demonstrated ability to safely smoke cigarettes with minimal supervision. A nurse progress note, dated 02/12/26, showed Resident #26 was observed by the CMA to put a cigarette in their jacket pocket to smoke later. The staff obtained the cigarette and educated the resident on the dangers of smoking while wearing oxygen. A quarterly assessment, dated 02/12/26, showed Resident #26 had a BIMS of 15 and was cognitively intact for daily decision making. The assessment showed diagnoses which included lung cancer of the right lower lobe, anxiety, depression, paranoid schizophrenia, COPD, and respiratory failure. A nurse progress note, dated 03/03/26, showed Resident #26 had smoked in their room the night before while wearing oxygen and the resident's face had been burned. On 03/10/26 at 8:53 a.m., Resident #26 stated they burned themself while smoking and wearing oxygen. They stated the staff have treated the burn with Silvadene (wound ointment) and it had helped. On 03/11/26 at 12:28 p.m., CNA #1 stated residents had set times for smoking, and they were posted all over the building. They stated residents required staff with them at all times while smoking. CNA #1 stated residents were not allowed to keep cigarettes and lighters on them and when staff entered their rooms, they were to use sight and smell to determine if a resident had been smoking in their room. They stated they were to report to the nurse if there were signs of smoking. On 03/11/26 at 12:34 p.m., CMA #1 stated residents could smoke in designated areas and must be evaluated for safe smoking. They stated the smoking hours were posted. CMA #1 stated cigarette (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	butts must be put in the receptacle, and someone must supervise residents while they smoked. CMA #1 stated they had observed cigarette ash around the toilet of Resident #26 in the past and thought they had reported it to a charge nurse. On 03/11/26 at 12:48 p.m., the DON stated residents were able to sign themselves out and go smoke out front at the end of the sidewalk. They stated in the past housekeeping had found ashes on the toilet seat of Resident #26. The DON stated since the incident on 03/02/26, the facility did not allow residents to have smoking materials in their possession; staff provided direct supervision and lit their cigarettes for them. They stated staff supervised residents while they smoked. The DON stated they completed smoking assessments quarterly. The DON stated they could not be sure they obtained all the lighters from Resident #26 and stated, I can't legally go through their stuff. On 03/11/26 at 1:03 p.m., the administrator stated residents had regular smoke times and the CMA would hold the lighter and light the resident's cigarettes. The administrator stated in the past housekeeping had reported ashes on the toilet seat of Resident #26. They stated the last time this was reported was a couple months ago. They stated they asked Resident #26 if they had been smoking in their room and the resident stated they had smoked in their room but would not do it anymore. The administrator stated they had confiscated the smoking materials from Resident #26. The administrator stated on 03/03/26, the day after the incident, the maintenance director had found a lighter under the bed of Resident #26. The administrator stated it had been reported to them Resident #26 had been smoking in their room six times from 01/02/26 to 03/03/26. They stated there was no guarantee residents did not have lighters or cigarettes in their room.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure nurse staffing was posted.The administrator identified 34 residents who resided in the facility. Findings: On 03/12/26 at 1:30 p.m., nurse staffing information was not observed posted in the facility. On 03/13/26 at 9:28 a.m., a dry erase board was observed by the nurse's station that contained the date, staff name with titles, census, and how many residents were in the hospital. An undated policy titled, Staffing Requirement Policy, read in part, Daily staffing reports will be posted for residents and visitors to view. On 03/13/26 at 9:28 a.m., LPN #2 stated they posted nurse staffing information on the dry erase board by the nurse's station. On 03/13/26 at 9:41 a.m., the DON stated nurse staffing information was documented on the dry erase board for visitors and residents. They stated they had a book at the nurse's station for daily assignments for the staff but those were not available for visitors and residents. On 03/13/26 at 9:51 a.m., the administrator stated they posted nurse staffing information in the past, but the ball has been dropped on that.

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, record review, and interview, the facility failed to have effective administration who utilized its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility administration failed to:a. report allegations of abuse to OSDH,b. investigate allegations of abuse,c. develop/implement comprehensive care plans, d. review and revise care plans, ande. provide supervision to prevent accident hazards related to smoking. The administrator identified 34 residents who resided at the facility.Findings: a. Based on record review and interview, the facility failed to ensure allegations of abuse were reported to OSDH for 1 (#4) of 1 sampled residents who were reviewed for abuse. On 03/12/26 at 3:56 p.m., the administrator stated they had not reported the allegations of abuse made by Resident #4 on 02/22/26 or 02/28/26 to OSDH because the abuse had not occurred per a skin assessment and the police officer's investigation. b. Based on record review and interview, the facility failed to ensure allegations of abuse were investigated for 1 (#4) of 1 sampled residents who were reviewed for abuse. On 03/12/26 at 3:56 p.m., the administrator stated the DON, MDS coordinator, or themself would investigate allegations of abuse. The administrator stated they had not investigated the allegation made on 02/28/26 because the police had unsubstantiated the allegation. The administrator stated they had not investigated the allegation on 02/22/26 because they had asked the shower aide on 02/23/26 to check for bruises during the shower and no bruising was observed. They stated when they asked Resident #4 they had denied being abused. The administrator stated, Then what is there to investigate? The administrator stated they had never had to conduct an abuse investigation and had not documented the conversation with Resident #4. c. Based on observation, record review, and interview, the facility failed to ensure comprehensive care plans were completed for 2 (#4 and #20) of 12 sampled residents reviewed for care plans. On 03/16/26 at 1:05 p.m., the DON stated they were responsible to oversee the MDS coordinator to ensure comprehensive care plans had been developed. The DON stated the MDS coordinator was on vacation. They reviewed the care plan for Resident #4 and stated the resident had smoked since admission and they did not know why a care plan for smoking had not been developed. On 03/16/26 at 1:11 p.m., the DON stated the smoking care plan was implemented and added to the care plan for Resident #20 on 03/12/26. They stated care plans were reviewed and updated quarterly, and care plan meetings were supposed to be quarterly as well. On 03/17/26 at 10:52 a.m., Regional Nurse #2 stated the smoking care plan was probably implemented on 03/12/26 and should not have been dated 12/15/25. They stated they did not know why the care plan did not include smoking on the original care plan. d. Based on record review and interview, the facility failed to ensure care plans were updated quarterly for 5 (#4, 28, 1, 37, and #26) of 12 sampled residents whose care plans were reviewed. On 03/16/26 at 1:23 p.m., the DON stated care plans were to be updated quarterly. On 03/16/26 at 1:49 p.m., the DON stated they had reviewed the care plan for Resident #26. They stated care plans had not been reviewed/revised quarterly and as needed. On 03/16/26 at 1:05 p.m., the DON stated they were responsible to oversee the MDS coordinator to ensure care plans had been reviewed/revised quarterly and as needed. The DON stated the MDS coordinator was on vacation. They stated they did not know why the care plan had not been revised. On 03/16/26 at 1:07 p.m., the DON stated Resident #28 had received hospice services for less than one year. The DON stated they did not know why the care plan for Resident #28 had not been reviewed/revised since 01/31/25 to include hospice services. On 03/16/26 at 1:49 p.m., the DON reviewed the care plan for Resident #1 and stated they did not know why the care plan had not been revised to reflect the resident's current status. They stated the care plan should have been revised to exclude fluid restriction that was currently reflected on the care plan and include nutrition/weight loss and the interventions they had in place. They stated they did not know why the care plan had not been updated. e. Based on observation, record review, and interview, the facility failed to provide supervision to prevent accident hazards for 1 (#26) of 5 sampled residents reviewed (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	for smoking. On 03/11/26 at 1:03 p.m., the administrator stated residents had regular smoke times and the CMA would hold the lighter and light the resident's cigarettes. The administrator stated in the past housekeeping had reported ashes on the toilet seat of Resident #26. They stated the last time this was reported was a couple months ago. They stated they asked Resident #26 if they had been smoking in their room and the resident stated they had smoked in their room but would not do it anymore. The administrator stated they had confiscated the smoking materials from Resident #26. The administrator stated on 03/03/26, the day after the incident, the maintenance director had found a lighter under the bed of Resident #26. The administrator stated it had been reported to them Resident #26 had been smoking in their room six times from 01/02/26 to 03/03/26. They stated there was no guarantee residents did not have lighters or cigarettes in their room. On 03/17/26 at 1:28 p.m., regional nurse #1 with Regional Nurse #2 present, stated the regional nurses, regional administrator, and Chief Operating Officer were involved with the governing body. They stated they provided training and offered any support the facility administration would allow to be provided. Regional Nurse #1 stated there were a lot of personalities in the building, when some support was provided, they did not want to listen. They stated they knew coming in to this there would be systemic failures. Regional Nurse #1 stated there was a strong personality in the building and they tried to take control over things. They stated the system failure was every time help was offered, it was refused.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on observation, record review, and interview, the facility failed to maintain an effective Quality Assessment and Performance Improvement (QAPI), as evidenced by failure to demonstrate systematic identification, reporting, investigation, analysis, and prevention of adverse events and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities. The facility had systematic problems with identification of abuse allegations, reporting abuse allegations to OSDH, development of comprehensive care plans/revision of care plans, and adequate supervision to prevent accident hazards related to smoking.The administrator identified 34 residents who resided in the facility.Findings: Please refer to CMS form 2567 with exit date 03/17/26, F609, F610, F656, F657, and F689 for evidence details. A policy titled Quality Assessment and Assurance Program dated 06/27/13, read in part, 4. Each department or services will submit to the Quality Assessment and Assurance Committee a quarterly report of its own monitoring systems. 5. Reports will be evaluated to determine problems, plan solutions, implement actions, and ensure follow-up as well as consistent monitoring of results over a specified time frame. On 03/17/26 at 11:51 a.m., the administrator stated the QAPI committee met at least quarterly. They stated they completed a process improvement project (PIP) annually with the most recent regarding urinary catheters. They stated during QAPI meetings, they reviewed what the facility had concerns with, and the head of that department would monitor to ensure goals had been met. On 03/17/26 at 1:49 p.m., the administrator stated system failures identified during the survey, including accident hazards regarding smoking, failure to report and investigate abuse allegations, and comprehensive care plan development/revision had not been identified by the QAPI committee because things had been hectic.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interview, the facility failed to ensure residents and/or resident representatives had been informed of medication changes for 3 (#4, 15, and #37) of 5 sampled residents who were reviewed for unnecessary medications. LPN #1 identified 34 residents who received medications in the facility.Findings: 1. A policy titled, Notification of Changes Policy, read in part, It is the policy of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative . A physician order, dated 12/17/25, showed Resident #4 was ordered clozapine (an antipsychotic medication) 50mg at bedtime. Nurse progress notes, dated 12/17/25 through 12/22/25, did not show the resident had been made aware of the new medication order or the risks/benefits of the change in their medication treatment regimen. A quarterly assessment, dated 01/16/26, showed Resident #4 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, received antipsychotic medications, and had a diagnosis of schizophrenia. A physician order, dated 01/28/26, showed Resident #4 was ordered haloperidol (an antipsychotic medication) 5mg twice daily. Nurse progress notes, dated 01/28/26 through 01/31/26, did not show the resident had been informed of the new medication order or the risks/benefits of the change in their medication treatment regimen. On 03/11/26 at 11:52 a.m., Resident #4 stated they received medication for mental health diagnoses and they were adjusted at times. They stated they were not sure they were notified of the haloperidol or clozapine orders but could tell when they needed an adjustment to their medication regimen. On 03/13/26 at 11:48 a.m., LPN #2 stated the charge nurse who received the physician order for a new medication was responsible to notify the resident and/or resident representative of the change to the medication regimen. They stated they did not discuss the risks/benefits of the treatment but did discuss possible side effects of the new medication. They stated they documented the notification in the progress notes. On 03/13/26 at 11:50 a.m., the DON stated the charge nurses were to document in the progress notes when they had notified the resident and/or resident representatives of changes to the medication regimen, but it was not a common practice. They stated they had discussed the risks/benefits a couple of times with residents but had not discussed them with Resident #4 or with their representative. Findings: 2.A physician order, dated 09/21/25, showed to administer Rexulti (antipsychotic) 3 mg daily. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order, dated 09/21/25, showed to administer tramadol (opioid analgesic) 50 mg TID. An admission assessment, dated 09/28/25, showed Resident #15 had a BIMS of 15 which indicated they were cognitively intact for daily decision making. The assessment showed diagnoses which included depression and schizoaffective disorder. The assessment showed Resident #15 took antipsychotic, antianxiety, antidepressant, and opioid medications during the seven-day look back period. The assessment showed an indication was provided for each medication. A physician order, dated 10/21/25, showed to administer trazodone (antidepressant) 50 mg at bedtime. A care plan, revised 01/06/26, showed a category of mood state with increased risk for behaviors, loneliness, sleep disturbance, depression, anxiety and schizoaffective bipolar type with a potential to be physically aggressive. The care plan showed an approach to administer medication as ordered and to monitor for side effects and effectiveness. A physician order, dated 01/28/26, showed to administer buspirone (anti-anxiety) 7.5 mg TID. Review of progress notes, dated 09/15/25 to 03/12/26, did not show the resident or representative had been notified of the risks and benefits of medications. On 03/17/26 at 11:05 a.m., the DON stated information regarding risk and benefit of medications were provided to the resident/representative before the medication was given and was provided by the physician. The stated it was documented in the physician's progress note. 3. A significant change assessment, dated 01/12/26, showed a BIMS of 08, which indicated Resident #37 was moderately impaired in cognition for daily decision making. The assessment showed diagnoses which included emphysema, heart failure, hypertension, and depression. A care plan, revised 01/31/25, showed concern for mood state with medications. A physician order, dated 03/09/26, showed to administer Lantus (insulin) Solostar 15 units daily. A physician order, dated 03/09/26, showed to administer Lantus Solostar 5 units daily. A physician order, dated 03/09/26, showed to administer Levofloxacin (antibiotic) 750 mg on 03/10/26 and 03/12/26 for bacterial pneumonia. Review of progress notes dated 03/09/26 did not show the facility had discussed with the resident or representative the benefits and side effects of medications. On 03/13/26 at 11:50 a.m., the DON stated the charge nurses were to document in the progress notes when they had notified the resident and/or resident representatives of changes to the medication regimen, but it was not a common practice. They stated they had discussed the risks/benefits a couple of times with residents but had not discussed them with Resident #37 or with their representatives as applicable.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review and interview, the facility failed to provide residents assistance to develop an advance directive for 1 (#15) of 3 sampled residents reviewed for advance directives. The administrator identified 34 residents who resided at the facility.Findings: An Advance Directive Policy and Record form, dated 09/21/25, for Resident #15 read in part, Documents were not received, Facility informed of Document. The form showed a POA was in place, with initials from the responsible party for Resident #15. An admission assessment, dated 09/28/25, showed Resident #15 had a BIMS of 15 which indicated they were cognitively intact for daily decision making. The assessment showed diagnoses which included dementia. On 03/13/26 at 3:30 p.m., the DON stated the business office manager typically went through the admission packet with all new admissions. The DON stated the resident was not offered/declined/accepted assistance to formulate an advance directive.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure comprehensive care plans were completed for 2 (#4 and #20) of 12 sampled residents reviewed for care plans. The administrator identified 34 residents who resided at the facility. Findings: 1. On 03/09/26 at 3:35 p.m., Resident #20 stated they required someone to stay with them when they smoked. They stated they could not push their wheelchair because it was a transport chair. An admission assessment, dated 12/08/25, showed Resident #20 was a smoker. A care plan, dated 12/13/25, saved on 03/11/26 by the surveyor, showed no concern for smoking for Resident #20. A care plan, revised 12/15/25, saved on 03/12/26 by the surveyor, showed a concern for smoking with interventions. A Quarterly Smoking Assessment, dated 03/10/26, showed Resident #20 was safe for smoking with minimal supervision. A Quarterly Smoking Assessment, dated 03/11/26, showed Resident #20 was safe for smoking with minimal supervision. No other smoking assessments were located in the clinical record. On 03/16/26 at 1:11 p.m., the DON stated the smoking care plan was implemented and added to the care plan for Resident #20 on 03/12/26. They stated care plans were reviewed and updated quarterly, and care plan meetings were supposed to be quarterly as well. On 03/17/26 at 10:52 a.m., Regional Nurse #2 stated the smoking care plan was probably implemented on 03/12/26 and should not have been dated 12/15/25. They stated they did not know why the care plan did not include smoking on the original care plan. 2. On 03/09/26 at 1:06 p.m., Resident #4 was observed to be outside smoking with other residents and staff. A policy titled Smoking and Vaping Policy, showed Resident #4 had signed the smoking policy on 10/24/24. The care plan, revised 01/31/25, did not show the resident smoked. A Quarterly Smoking assessment dated [DATE], showed Resident #4 was able to smoke with minimal supervision. On 03/16/26 at 1:05 p.m., the DON stated they were responsible to oversee the MDS coordinator to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ensure comprehensive care plans had been developed. The DON stated the MDS coordinator was on vacation. They reviewed the care plan for Resident #4 and stated the resident had smoked since admission and they did not know why a care plan for smoking had not been developed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to ensure care plans were updated quarterly for 5 (#4, 28, 1, 37, and #26) of 12 sampled residents whose care plans were reviewed.The administrator identified 34 residents who resided at the facility. Findings: 1.A Care Planning-Interdisciplinary Team policy, revised 09/2013, read in part, Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.The interdisciplinary team must review and update the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. A care plan for Resident #4 showed it was last reviewed/revised on 01/31/25. A quarterly assessment, dated 01/16/26, showed Resident #4 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, and had diagnoses which included schizophrenia. On 03/16/26 at 1:05 p.m., the DON stated they were responsible to oversee the MDS coordinator to ensure care plans had been reviewed/revised quarterly and as needed. The DON stated the MDS coordinator was on vacation. They stated they did not know why the care plan had not been revised. 2. A physician order, dated 08/07/25, showed Resident #28 was admitted to hospice services for senile degeneration of the brain. A care plan showed it was last reviewed/revised on 01/31/25 and did not show a concern regarding hospice services. A quarterly assessment, dated 02/10/26, showed Resident #28 had a BIMS score of four, which indicated the resident was severely impaired in cognition for daily decision making, and a had chronic disease or condition that may result in a life expectancy of less than six months. On 03/16/26 at 1:07 p.m., the DON stated Resident #28 had received hospice services for less than one year. The DON stated they did not know why the care plan for Resident #28 had not been reviewed/revised since 01/31/25 to include hospice services. 3. A care plan for Resident #1 showed it was last reviewed/revised on 10/14/25. The care plan did not show a concern regarding nutrition. A dietician note, dated 10/10/25, showed Resident #1 had poor meal intake, a weight loss of 9.5% in six months, received a supplement, and the dietician would consult with the physician to determine if the resident was a candidate for an appetite stimulant. A dietician note, dated 12/10/25, showed Resident #1 had a weight loss of 5% in 1 month, to offer high calorie snacks twice daily, and periactin (an antihistimine medication used for appetite). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly assessment, dated 01/11/26, showed Resident #1 had a BIMS score of nine which indicated the resident was moderately impaired in cognition for daily decision making, and had experienced a weight loss. On 03/16/26 at 1:49 p.m., the DON reviewed the care plan for Resident #1 and stated they did not know why the care plan had not been revised to reflect the resident's current status. They stated the care plan should have been revised to exclude fluid restriction that was currently reflected on the care plan and include nutrition/weight loss and the interventions they had in place. They stated they did not know why the care plan had not been updated. 4. An annual assessment, dated 10/23/25, showed Resident #37 had a BIMS of 15 and was cognitively intact for daily decision making. The assessment showed diagnoses which included emphysema and COPD. A care plan for Resident #37, reviewed/revised on 01/31/25 did not show a concern for hospice services. A physician's order, dated 03/09/26, showed Resident #37 was admitted to Hospice services with a diagnosis of COPD. On 03/16/26 at 1:23 p.m., the DON stated care plans were to be updated quarterly. 5. A care plan for Resident #26 showed it was last reviewed/revised on 02/24/25. A re-admission assessment, dated 05/14/25, showed Resident #26 had hospice services. The assessment showed Resident #26 had a prognosis of less than six months. A nurse progress note, dated 02/12/26, showed Resident #26 was observed by a CMA to put a cigarette in their pocket and the charge nurse had to obtain it. This was not included in the care plan. A nurse progress note, dated 03/03/26, showed Resident #26 had lit a cigarette in their room while wearing oxygen and it ignited. This was not included in the care plan. On 03/10/26 at 8:53 a.m., Resident #26 stated they burned themself while smoking and wearing oxygen. They stated the staff had treated the burn with Silvadene (ointment for burns) and it had helped. On 03/16/26 at 1:23 p.m., the DON stated care plans were to be updated quarterly. On 03/16/26 at 1:49 p.m., the DON stated they had reviewed the care plan for Resident #26. They stated care plans had not been reviewed/revised quarterly and as needed.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on record review and interview, the facility failed to ensure staff competencies were completed for 4 (CNA#2, 3, 4, and CNA #5) of 4 employee files reviewed who were hired in the past 4 months.The administrator identified 11 CNAs who were hired in the past 4 months.Findings:An undated policy titled New Hire Process, read in part, All other functions turned over to the DON or other department head for scheduling and training .Employees are subject to TB test, employee physical, competencies, and three [3] days of training on the floor at the DON's discretion and schedule.The employee file for CNA #3 showed they were hired on 11/22/25. The employee file did not show a staff competency had been completed.The employee file for CNA #4 showed they were hired on 01/28/26. The employee file did not show a staff competency had been completed.The employee file for CNA #5 showed they were hired on 01/08/26. The employee file did not show a staff competency had been completed.The employee file for CNA #2 showed they were hired on 02/05/26. The employee file did not show a staff competency had been completed.On 03/13/26 at 9:39 a.m., the DON stated newly hired CNAs were trained by another CNA. They stated they were to document the check off of the CNAs competencies on a form. The DON stated they had not documented staff competencies due to the staff turnover they recently had. The DON stated, It slipped through the cracks.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on observation, record review, and interview, the facility failed to ensure performance reviews were completed every 12 months for 1 (CMA #1) of 1 employee file reviewed who had been employed by the facility for 12 months or more.The administrator identified 34 residents who resided in the facility.Findings: On 03/11/26 at 9:41 a.m., CMA #1 was observed to administer Resident #1 zinc 50mg by mouth. A physician order, dated 03/03/26, showed an order for Resident #1 for zinc 30mg every day. The employee file for CMA #1 showed they were hired on 11/19/24. The employee file did not show a performance review had been completed since they were hired. On 03/13/26 at 9:39 a.m., the DON stated they did not have a system in place to ensure CNA/CMAs had performance reviews completed at least every 12 months. The DON confirmed they could not locate documentation to show CMA #1 had a performance review since being hired.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to:a. ensure medications were secured for 1 (nurse treatment cart) of 3 medication/treatment carts observed for secured medications;b. ensure medications were dated when opened and not expired for 1 (nurse treatment cart) of 3 medication/treatment carts observed for medication storage; andc. ensure discontinued narcotics were stored in a separately locked, permanently affixed compartment for 1 (DON medication/treatment cart) of 3 medication/treatment carts observed for medication storage.RN #1 identified three medication/treatment carts in the facility and one medication/treatment cart for discontinued narcotic storage.Findings:1.On 03/09/26 at 11:16 a.m., the nurse treatment cart was observed to be unlocked and unattended by the nurse's station. On 03/09/26 at 11:18 a.m., RN #1 was observed to lock the nurse treatment cart.On 03/13/26 at 1:13 p.m., the nurse treatment cart was observed to be unlocked and unattended at the nurse's station. On 03/13/26 at 1:16 p.m., the administrator was observed to walk by the nurse treatment cart. On 03/13/26 at 1:20 p.m., a visitor was observed to walk by the unlocked and unattended nurse treatment cart. On 03/13/26 at 1:21 p.m., LPN #2 was observed to approach the nurse treatment cart and open the top drawer. On 03/09/26 at 11:16 a.m., RN #1 stated the nurse treatment cart was to be kept locked because it contained medications. On 03/13/26 at 1:21 p.m., LPN #2 stated they thought they had locked the nurse treatment cart before leaving it unattended. On 03/16/26 at 1:21 p.m., the DON stated medication/treatment carts were to be kept locked when unattended. 2. On 03/16/26 at 1:31 p.m., the nurse treatment cart was observed to contain the following:a. one bottle of glucometer check strips that were opened and not dated;b. one albuterol inhaler with an expiration date of 10/31/25 for Resident #40;c. one bottle of nystatin powder with an expiration date of 04/04/25 for Resident #11;d. one bottle of nystatin powder with an expiration date of 08/18/25 for Resident #8;e. one lantus insulin pen for Resident #4 was opened and not dated;f. one lantus insulin pen for Resident #27 was opened and not dated;g. one lantus insulin pen and one novolog insulin pen were opened and not dated for Resident #22;h. one novolog insulin pen opened and not dated for Resident #40;i. one lantus insulin pen and one lispro insulin pen were opened and not dated for Resident #11;j. one lantus insulin pen opened and not dated for Resident #3; andk. one lantus insulin pen and one novolog insulin pen opened and not dated for Resident #5. On 03/16/26 at 1:31 p.m., RN #1 stated they did not know how often the nurse treatment cart was monitored for expired medications. On 03/16/26 at 1:32 p.m., LPN #2 stated the pharmacist monitored the nurse treatment cart monthly for expired medications. On 03/16/26 at 1:39 p.m., RN #1 stated they did not know how long the insulin pens listed above had been opened since they were not dated. On 03/16/26 at 1:45 p.m., the DON stated the nurses were to date insulin pens when they were opened and placed on the nurse treatment cart for use. They stated LPN #1 was responsible to monitor the nurse treatment cart to ensure opened medications were labeled and medications were not expired. The DON stated they did not monitor to ensure LPN #1 had audited the nurse medication cart to ensure opened medications were dated and expired medications had been removed. 3. On 03/16/26 at 2:32 p.m., the discontinued narcotics were observed in the DON's office. The discontinued narcotics were observed to be kept in a drawer in a locked medication/treatment cart. On 03/16/26 at 2:33 p.m., the DON stated the discontinued narcotics were behind two locks, their office door and the lock on the medication/treatment cart. The DON stated they did not have a key to the locked compartment inside the medication/treatment cart, so it was not able to be locked. They stated the medication/treatment cart, which stored the discontinued narcotics, was not permanently affixed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure eggs, served over easy, were pasteurized for 1 (breakfast meal) of 2 meals observed and failed to ensure left over foods were labeled and dated in the refrigerator for 1 of 1 refrigerators in the kitchen. The dietary manager identified 8 residents who ate eggs over easy and 34 residents who ate food from the kitchen. Findings: On 03/09/26 at 11:29 a.m., the cold storage refrigerator was observed to have sliced cheese in an unlabeled open zip close bag that was dated 02/26/26. An undated, unlabeled clear plastic container with a lid was observed in the refrigerator. The container was observed to have an unknown liquid. Two flats of unpasteurized eggs were observed in the refrigerator. No other eggs were observed. On 03/10/26 at 8:26 a.m., three residents in the dining room were observed to eat eggs over easy. No policy for storage of food or the use of pasteurized/unpasteurized eggs was provided by the end of the survey. On 03/09/26 at 11:30 a.m., the DM stated the cheese should have been zipped closed. They stated the clear plastic container was the lunch of an employee. The DM stated staff had a separate refrigerator for their food. They stated the unpasteurized eggs were used for scrambled, over easy, and fried eggs every morning. The DM stated they used the eggs that morning for over easy eggs and fried eggs. They stated they did not know if the eggs were pasteurized or not. On 03/17/26 at 12:04 p.m., the administrator stated they were not aware the eggs ordered from the supplier were not pasteurized. They stated they assumed the supplier would provide what was required for a nursing facility. The administrator stated their representative should have known they required pasteurized eggs.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to ensure allegations of abuse were reported to OSDH for 1 (#4) of 1 sampled residents who were reviewed for abuse.The administrator identified 34 residents who resided at the facility. Findings:The undated policy titled Abuse Prohibition Procedure, read in part, PURPOSE: To assure that any or all suspected abuse is reported, investigated and that the residents of this facility are kept in a safe environment at all times .If any person(s) see or suspects abuse to a resident or group of residents or Finds any unexplained injury this should be reported immediately to the charge nurse, DON, or Administrator.The Administrator or designees will immediately initiate an investigation And notify the OSDH.A quarterly assessment, dated 01/16/26, showed Resident #4 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, and had a diagnosis of schizophrenia. A progress note, dated 02/22/26 at 11:42 p.m., read in part, Resident telling other residents during smoke break today that [they had] been getting beaten and has bruises on [their] arms and back. The progress note was signed by LPN #3.A progress note, dated 02/28/26 at 4:56 p.m., read in part, Resident called 911 from resident phone in living area. Police officer showed up stating resident called stating staff were beating [them] with whips and chains. Full body assessment completed with this nurse and police officer, no bruising noted to body. The progress note was signed by LPN #4. On 03/12/26 at 2:31 p.m., LPN #4 stated Resident #4 had called the police department and reported to them staff were beating them with whips and chains. They stated when the police officer arrived, they had observed the resident and had not identified any marks on the resident's body. They stated after the police officer left the facility they had notified the DON of the allegation of abuse. On 03/12/26 at 3:19 p.m., LPN #3 stated after Resident #4 had made an allegation of abuse on 02/22/26 they had notified the administrator and the DON of the allegation. On 03/12/26 at 3:28 p.m., the DON stated allegations of abuse were immediately investigated by the MDS coordinator, the administrator, or themself. The DON stated they were not sure they had been notified of the allegation of abuse on 02/22/26. The DON stated they had been made aware of the allegation of abuse on 02/28/26. The DON stated they had investigated the allegation but had not reported it to OSDH since the police had looked into it and had not substantiated the allegation. On 03/12/26 at 3:56 p.m., the administrator stated they had not reported the allegations of abuse made by Resident #4 on 02/22/26 or 02/28/26 to OSDH, because the abuse had not occurred per a skin assessment, and the police officer's investigation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to ensure allegations of abuse were investigated for 1 (#4) of 1 sampled residents who were reviewed for abuse.The administrator identified 34 residents who resided in the facility.Findings:An untitled and undated policy, read in part, Purpose: To assure that any or all suspected abuse is reported, investigated and that the residents of this facility are kept in a safe environment at all times.The Administrator or designees will immediately initiate an investigation and notify the OSDH.A quarterly assessment, dated 01/16/26, showed Resident #4 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, and had a diagnosis of schizophrenia. A progress note, dated 02/22/26 at 11:42 p.m., read in part, Resident telling other residents during smoke break today that [they had] been getting beaten and has bruises on [their] arms and back. The progress note was signed by LPN #3.A progress note, dated 02/28/26 at 4:56 p.m., read in part, Resident called 911 from resident phone in living area. Police officer showed up stating resident called stating staff were beating [them] with whips and chains. Full body assessment completed with this nurse and police officer, no bruising noted to body. The progress note was signed by LPN #4. On 03/12/26 at 2:31 p.m., LPN #4 stated Resident #4 had called the police department and reported to them staff were beating them with whips and chains. They stated when the police officer arrived, they had observed the resident and had not identified any marks on the resident's body. They stated after the police officer left the facility they had notified the DON of the allegation of abuse. On 03/12/26 at 3:19 p.m., LPN #3 stated after Resident #4 had made an allegation of abuse on 02/22/26 they had notified the administrator and the DON of the allegation. On 03/12/26 at 3:28 p.m., the DON stated allegations of abuse were immediately investigated by the MDS coordinator, the administrator, or themself. The DON stated they had not investigated the allegations of abuse for Resident #4 but would look to see if the MDS coordinator or the administrator had completed an investigation. On 03/12/26 at 3:53 p.m., the DON stated they had no evidence the allegation of abuse for Resident #4 on 02/22/26 or 02/28/26 had been investigated. On 03/12/26 at 3:56 p.m., the administrator stated the DON, MDS coordinator, or themself would investigate allegations of abuse. The administrator stated they had not investigated the allegation made on 02/28/26 because the police had unsubstantiated the allegation. The administrator stated they had not investigated the allegation on 02/22/26 because they had asked the shower aide on 02/23/26 to check for bruises during the shower and no bruising was observed. They stated when they asked Resident #4 they had denied being abused. The administrator stated, Then what is there to investigate? The administrator stated they had never had to conduct an abuse investigation and had not documented the conversation with Resident #4.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the clinical record contained documentation for a discharge for 1 (#36) of 1 sampled residents who were reviewed for discharge.Regional nurse #2 identified 13 residents who had discharged from the facility in the past 3 months. Findings: A discharge return-not anticipated assessment, dated 12/29/25, showed Resident #36 was admitted to the facility on [DATE], and discharged from the facility to home on [DATE]. Review of the clinical record, dated 12/23/25 through 12/29/25, did not show the reason for the discharge, the status of the resident upon discharge, a physician order for discharge, or what resources were required/provided upon discharge. On 03/16/26 at 9:37 a.m., LPN #2 stated Resident #36 had returned to their apartment upon discharge from the facility with hospice services and left with medication and personal belongings. On 03/16/26 at 9:39 a.m., the DON stated the physician had provided an order that Resident #36 could be discharged to home. On 03/16/26 at 9:46 a.m., the DON stated they had reviewed the clinical record but it had not shown a physician order for discharge, documentation of the resident's status upon discharge, or what resources were required/provided upon discharge. On 03/16/26 at 10:22 a.m., the administrator stated Resident #36 had discharged from the facility to return to their apartment as a planned discharge and that the resident had improved. They stated at times the resident discussed staying at the facility long term but had decided to discharge back to their apartment. The administrator stated the resident left with their personal belongings and medications with instructions. The administrator stated they did not know why the information had not been documented in the clinical record for the discharge of Resident #36. On 03/16/26 at 10:36 a.m., family member #1 for Resident #36 stated the resident had decided to return to their apartment and left with medications and hospice services.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a discharge summary was completed and the State Ombudsman office was notified of discharge for 1 (#36) of 1 sampled resident reviewed for discharge.Regional nurse #2 identified 13 residents who had been discharged in the past 3 months. Findings: A discharge return-not anticipated assessment, dated 12/29/25, showed Resident #36 was admitted to the facility on [DATE] and discharged from the facility to home on [DATE]. Review of the clinical record, dated 12/23/25 through 12/29/25, did not show a discharge summary had been completed or the State Ombudsman office had been notified of the discharge for Resident #36. On 03/16/26 at 9:37 a.m., LPN #2 stated Resident #36 had returned to their apartment upon discharge from the facility with hospice services and left with medication and personal belongings. On 03/16/26 at 9:39 a.m., the DON stated discharge summaries were completed by the MDS coordinator and placed in the clinical record under the 'observations' section. On 03/16/26 at 9:46 a.m., the DON stated they had reviewed the clinical record but it had not shown a discharge summary. On 03/16/26 at 10:22 a.m., the administrator stated they were responsible to notify the State Ombudsman of discharges. They stated they had not notified the State Ombudsman office for Resident #36. They stated they only notified them if the discharge was involuntary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375276	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 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. Based on record review and interview, the facility failed to ensure pre and post dialysis assessments were completed for 1 (#10) of 1 sampled residents who were reviewed for dialysis.Regional nurse #2 identified two residents who received dialysis at the facility.Findings: An admission assessment, dated 12/15/25, showed Resident #10 had a BIMS score of 11, which indicated the resident was moderately impaired in cognition for daily decision making, and received dialysis. A physician order, dated 02/20/26, showed Resident #10 received dialysis weekly on Monday, Wednesday, and Friday. A care plan, dated 03/05/26, showed Resident #10 had a diagnosis of end stage renal disease and received dialysis. Dialysis Communication forms and progress notes, dated 03/02/26 through 03/13/26, did not show nurses had conducted a pre or post dialysis assessment on 03/02/26 or 03/09/26. On 03/13/26 at 4:32 p.m., LPN #2 stated pre and post dialysis assessments were documented on Dialysis Communication forms or in the progress notes. On 03/16/26 at 1:17 p.m., the DON stated they could not locate documentation Resident #10 had received a pre or post dialysis assessment on 03/02/26 or 03/09/26. The DON stated they did not know why the assessments had not been completed and did not know what monitoring was in place to ensure pre and post dialysis assessments were completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review, the facility failed to ensure assessments were conducted for bedrails for 1 (#1) of 1 sampled residents who were reviewed for bedrails.CNA #1 identified six residents who had bedrails.Findings: On 03/10/26 at 8:44 a.m., Resident #1 was observed in bed. An enabler style bedrail was observed on the right side of the bed, in the up position. A physician order, dated 12/22/25, showed Resident #10 may use an enabler style bedrail to assist with positioning. A care plan, revised 12/27/25, read in part, 12/22/2025-Transfer bar evaluation with demonstration completed for safety of repositioning while in bed and transferring in and out of bed safely. Review of the observation section and the progress notes, dated 12/25/25 through 03/13/26, did not show the resident had been assessed for safety with the use of the bedrail. On 03/10/26 at 8:44 a.m., Resident #1 stated they used the enabler style bedrail to assist them in getting out of bed. On 03/13/26 at 3:33 p.m., the DON stated residents with bedrails were to be assessed when bedrails were ordered and then quarterly. The DON stated they were not aware Resident #1 had a bedrail. On 03/13/26 at 3:38 p.m., the DON stated they did not have any documentation the resident had been assessed for safety for use of the bedrail.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure TB testing, Flu, and Pneumonia immunizations were performed annually for 2 (#16 and #26) of 5 sampled residents reviewed for immunizations. The administrator identified 34 residents resided at the facility.Findings: 1. An admission assessment, dated 09/28/25, showed Resident #15 had a BIMS of 15 which indicated they were cognitively intact for daily decision making. The assessment showed diagnoses which included dementia. The assessment showed Resident #15 admitted to the facility 09/21/25. Review of the immunization record for Resident #16 showed they had not received their TB test on admission or their flu and pneumonia vaccinations annually. 2. A quarterly assessment, dated 02/12/26, showed Resident #26 had a BIMS of 15 and was cognitively intact for daily decision making. The assessment showed diagnoses which included lung cancer of the right lower lobe. The assessment showed Resident #26 re-admitted to the facility on [DATE]. Review of the immunization record for Resident #26 showed they had not received their TB test upon admission to the facility. On 03/16/26 at 3:55 p.m., the DON was provided a list of residents for TB tests and vaccinations. They stated it should be in the electronic health record. On 03/16/26 at 4:22 p.m., the DON stated the TB and vaccination documentation were in the administration office. On 03/17/26 at 11:07 a.m., the DON stated TB tests were to be completed on admission. Immunization and TB tests documentation for Residents #15 and #26 were not provided by the end of the survey.