

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375556	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Sherwood Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2416 West 51st South Tulsa, OK 74107	
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 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 observation, record review, interview, facility document and policy review, and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to ensure: 1. Staff donned the appropriate personal protective equipment (PPE) while providing care to a resident on enhanced barrier precautions (EBP) for 1 (Resident #63) of 3 residents reviewed for tube feedings, 2. Staff sanitized the multiuse glucometer between residents for 2 (Resident #2 and Resident #11) of 4 residents observed during medication administration, and 3. To conduct fit testing for N-95 masks which had the potential to affect all residents who resided at the facility. Findings included: 1. A facility policy titled, Enhanced Barrier Precautions, copyrighted 2001, revealed, 2. Enhanced barrier precautions apply when: b. A resident is NOT known to be infected or colonized with any MDRO [multi-drug resistant organism]), has a wound, or indwelling medical device, and does not have secretions or excretions that are unable to be covered or contained. The policy revealed, 5. Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheotomies. The policy revealed, 7. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. The policy revealed, 8. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: c providing hygiene or grooming. An admission Record revealed the facility readmitted Resident #63 on 02/06/2026. According to the admission Record, the resident had a medical history that included diagnoses of Rett's syndrome and functional quadriplegia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/29/2026, revealed Resident #63 had severe impairment in cognitive skills for daily decision-making and had short-term and long-term memory problems per a Staff Assessment of Mental Status (SAMS). The MDS also revealed the resident received 51% or more of their nutritional intake via a feeding tube. Resident #63's Care Plan Report, included a focus area initiated 03/24/2026, that indicated the resident required total assistance for activities of daily living (ADLs), and the resident needed staff to anticipate their needs due to lack of speech. Resident #63's Order Summary Report revealed no orders for enhanced barrier precautions; however, the report included orders for the resident to receive Isosource 1.5 calories at 40 milliliters per hour via a feeding tube. An observation on 07/06/2026 at 10:29 AM revealed Licensed Practical Nurse (LPN) #1 entered Resident #63's room to provide nail care without donning a gown. LPN #1 donned gloves. During the observation, Resident #63 was observed to have feces covering their left hand and attempt to place their hand in their hair. During an interview on 07/07/2026 at 11:25 AM, LPN #1 stated she had entered Resident #63's room to complete nail care for the resident on 07/06/2026. LPN #1 verified Resident #63 was on EBP, and she should have donned a gown and gloves to provide nail care. During an interview on 07/09/2026 at 8:38 AM, the Assistant Director of Nursing (ADON), who was also the Infection Preventionist (IP), stated LPN #1 should have donned a gown and gloves to provide nail care to Resident #63 because the resident was on EBP and nail care (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
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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, and record review, the facility failed to ensure a cognitively impaired resident was provided with privacy while receiving incontinence care for 1 (Resident #63) of 3 residents sampled for feeding tubes. Findings included: An admission Record revealed the facility readmitted Resident #63 on 02/06/2026. According to the admission Record, the resident had a medical history that included diagnoses of Rett's syndrome and functional quadriplegia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/29/2026, revealed Resident #63 had severe impairment in cognitive skills for daily decision-making and had short-term and long-term memory problems per a Staff Assessment of Mental Status (SAMS). The MDS also revealed the resident was non-verbal and was rarely/never understood and rarely/never understood others. Resident #63's Care Plan Report, included a focus area initiated 03/24/2026, that indicated the resident required total assistance for activities of daily living (ADLs), and the resident needed staff to anticipate their needs due to lack of speech. During an observation and concurrent interview on 07/06/2026 at 10:32 AM, Certified Nursing Assistant (CNA) #2 responded to a request for assistance by Licensed Practical Nurse (LPN) #1, who exited Resident #63's room when CNA #2 entered. During the observation, Resident #63 had a bowel movement. CNA #2 assembled supplies and donned a gown and gloves to clean the resident. CNA #2 provided incontinence care and placed a clean brief on the resident. During the observation, CNA #2 was not observed to pull the privacy curtain or shut the room door to provide privacy during the care, which was visible to staff, residents, or visitors who may pass the doorway. During an interview on 07/09/2026 at 8:38 AM, the Assistant Director of Nursing (ADON) stated that LPN #1 should have stayed in the room to assist CNA #2 with Resident #63's incontinence care on 07/06/2026. The ADON stated Resident #63's door should have been shut, the curtain pulled, and the blinds shut by LPN #1 or CNA #2 while the care was provided. The ADON stated that Resident #63 did not receive a dignified experience when incontinence care was provided without privacy. During an interview on 07/09/2026 at 10:02 AM, the Director of Nursing (DON) stated she expected Resident #63's blinds to be closed, the curtain pulled, and the door shut while providing incontinence care in order for the resident to receive care in a dignified manner. During an interview on 07/09/2026 at 10:30 AM, the Administrator (ADM) stated she expected staff to provide incontinence care to Resident #63 in a dignified manner by ensuring the resident's privacy was maintained by pulling the curtain and closing the resident's door.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, facility document review, and facility policy review, the facility failed to provide an accurate Advance Beneficiary Notice of Non-Coverage (ABN), which included the services that may not be covered and the estimated cost of those services for 2 (Resident #18 and Resident #34) of 3 residents reviewed for beneficiary notification. Findings included: A facility policy titled, Medicare Advance Beneficiary Notice, dated 04/2021, indicated, 1. If the director of admissions or benefits coordinator believes (upon admission or during the resident's stay) that Medicare (Part A of the Fee for Service Medicare Program) will not pay for an otherwise covered skilled service(s), the resident (or representative) is notified in writing why the service(s) may not be covered and of the resident's potential liability for payment of the non-covered service(s). 1. An admission Record indicated the facility admitted Resident #18 on 06/18/2018. According to the admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus, acute and chronic respiratory failure, and adult failure to thrive. A five-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/31/2026, revealed Resident #18 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. A facility document titled, [Name of facility] Census List, dated 07/07/2026, indicated the facility readmitted Resident #18 from the hospital on [DATE]. The census list further indicated that Resident #18 had a payer source change on 05/09/2026. A Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) indicated, The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements. The notice was signed by Resident #18 on 03/24/2026. The notice revealed the reason Medicare may not pay was due to the resident Refusing to Participate, not making progress. The notice did not indicate what care was to be provided or the estimated cost of the care. A Notice of Medicare Non-Coverage indicated Resident #18's Medicare Part A services ended on 05/09/2026. 2. An admission Record indicated the facility admitted Resident #34 on 09/04/2025. According to the admission Record, the resident had a medical history that included diagnoses of chronic atrial fibrillation, congestive heart failure, and chronic obstructive pulmonary disease. A five-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/12/2026, revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. A facility document titled, [Name of facility] Census List, dated 07/07/2026, indicated the facility readmitted Resident #34 from the hospital on [DATE]. The census list indicated Resident #34 had a payer source change on 01/19/2026. A Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) indicated, The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements. The notice was signed by Resident #34 on 01/05/2026. The notice revealed the reason Medicare may not pay was due to the resident Refusing to Participate, not making progress. The notice indicated the care that may not be paid for was Medicare. The notice did not indicate the estimated cost of the care. The notice revealed Resident #34 had checked option one, indicating they wanted the care listed above. A Notice of Medicare Non-Coverage indicated Resident #34's Medicare Part A services ended on 01/19/2026. During an interview on 07/07/2026 at 10:54 AM, the Social Services (SS) Coordinator stated that when a new resident was admitted to the facility on Medicare Part A services, the ABN form was included in the admission paperwork for them to sign. The SS Coordinator further stated that if a current facility resident was readmitted from the hospital with Medicare Part A, she would have the (continued on next page)		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident sign an ABN form when the resident returned from the hospital. During an interview on 07/08/2026 at 12:44 PM, the SS Coordinator stated that the ABN form had to be signed anytime a resident was on skilled Medicare services. The SS Coordinator stated the purpose of the ABN form was to give the facility permission to bill Medicare. The SS Coordinator stated the service being provided was skilled services and the estimated cost was left blank because she had no way of knowing what the estimated cost for the services would be. The SS Coordinator confirmed that Resident #18 had checked the option that they wanted to receive the services, but that it was just difficult to see it on the copy. The SS Coordinator stated she always had residents sign option one because that gave the facility permission to bill Medicare; otherwise, the resident would be indicating they did not want the facility to bill Medicare. She stated there was a meeting with the therapy department every Tuesday to discuss what residents were getting ready to be discharged from therapy, and that was when they would provide the resident with the Notice of Medicare Non-Coverage form. During an interview on 07/09/2026 at 9:50 AM with the Director of Nursing (DON) and the Administrator (ADM), the DON stated she was not involved with the ABNs. The ADM stated that the facility always started discharge planning upon admission and worked with their residents to ensure they received the length of therapy that was needed. The ADM stated they would be reviewing the process for providing ABNs to residents.		

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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, record review, and facility policy review, the facility failed to ensure a wheelchair was maintained in safe operating condition for 1 (Resident #33) of 2 residents reviewed for environment. Findings included: A facility policy titled, Homelike Environment, revised 2021, indicated, Residents are provided with a safe, clean, and Home like environment. An admission Record indicated the facility admitted Resident #33 on 04/04/2024. According to the admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominate side and muscle weakness. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/15/2026, revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated that the resident used a wheelchair for mobility daily during the assessment's seven-day lookback period. Resident #33's Care Plan Report, included a focus area initiated 04/09/2024, that indicated the resident was a fall risk related to a neuro-cognitive disorder, gait/balance instability, impulsiveness, and poor safety awareness. During an observation on 07/06/2026 at 11:33 AM, Resident #33 was observed in their wheelchair. The wheelchair did not have an armrest on the right side of the wheelchair; it was bare metal. The armrest on the left side of the wheelchair had the plastic part peeling off. A facility document titled, Maintenance Work Log, for the timeframe from 04/26/2026 through 07/07/2026 revealed there was no report of Resident #33's wheelchair needing repairs, missing parts, or needing maintenance. On 07/07/2026 at 1:50 PM, Certified Nursing Assistant (CNA) #11 stated that staff put maintenance concerns in the maintenance book. She stated she would notify a nurse and the Director of Nursing (DON) if there was a maintenance concern with a resident's wheelchair. During a concurrent observation, CNA #11 observed the resident's wheelchair while the resident was sitting in therapy. She stated the wheelchair had a missing arm piece on the right side of the wheelchair. She stated the left side was also peeling. She stated the wheelchair condition was something that should be reported to maintenance. She reviewed the maintenance log and stated there had not been a report made about Resident #33's wheelchair. On 07/07/2026 at 1:55 PM, the Maintenance Supervisor stated staff told him about issues as he was going down the hall, or the staff reported it in the maintenance book. He stated if a resident did not have an arm rest or it was torn, it should be replaced. He stated he had not had anything reported to him about Resident #33's wheelchair. He reviewed the maintenance log and stated there was nothing reported related to Resident #33's wheelchair in May or June (2026). He stated he did not know the arm rests were broken and peeling. He stated he would have expected staff to inform him of the broken chair, and he would have fixed it. On 07/07/2026 at 2:06 PM, Licensed Practical Nurse (LPN) #6 stated that when resident equipment was broken, there was a maintenance logbook in which staff wrote down the issue to notify maintenance to fix. She stated she had never seen Resident #33 in their wheelchair. She stated she had not noticed the resident's wheelchair was missing an arm rest. She stated that if the resident's wheelchair were missing an arm rest, the staff should notify her so she could report the issue to maintenance. On 07/08/2026 at 8:19 AM, the DON stated the staff should report broken equipment in the maintenance log. She stated the staff had a stand-up meeting daily, and they all discussed what was in the book for the maintenance staff to repair. She stated she would expect staff to identify the broken wheelchair and report the broken wheelchair to maintenance staff for repair. On 07/08/2026 at 12:54 PM, the Administrator stated she expected staff to report immediately if there was broken resident equipment. She stated it (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview, record review, and CMS (Centers for Medicare and Medicaid) guidelines, the facility failed to ensure current Minimum Data Set (MDS) assessments were accurately coded for 3 (Residents #1, #9, and #29) of 16 sampled residents reviewed for accurate assessments. Specifically, Resident #1 and Resident #29 were incorrectly coded for insulin instead of injections, and Resident #9 was incorrectly coded for antipsychotics and anticonvulsants in the Medications sections of the MDSs. Findings included: The CMS Long-Term Care Facility [LTC] Resident Assessment Instrument [RAI] 3.0 User's Manual, dated 10/2025, revealed Section N: Medications - Intent: The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and/or select medications were received by the resident. The LTC RAI 3.0 User's Manual also indicated, N0350: Insulin, Coding Instructions for N0350A, and Enter in item N0350A, the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that insulin injections were received. The LTC RAI 3.0 User's Manual also indicated, N0415: High-Risk Drug Classes and Coding Instructions - Code all high-risk drug class medications according to their pharmacological classification, not how they are being used. - Column 1: Check if the resident is taking any medications by pharmacological classification during the 7-day observation period (or since admission/entry or reentry if less than 7 days). - Column 2: If Column 1 is checked, check if there is an indication noted for all medications in the drug class. N0415A1. Antipsychotic: Check if an antipsychotic medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days), and N0415K1. Anticonvulsant: Check if an anticonvulsant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). 1. An admission Record revealed the facility admitted Resident #1 on 01/06/2026. According to the admission Record, the resident had a medical history that included a diagnosis of heart failure. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/09/2026, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. In section N0350 the MDS indicated Resident #1 received one day of insulin during the last seven days. Resident #1's Care Plan included a focus area, initiated 01/07/2026, that indicated the resident was on a regular mechanical soft diet and on medication for weight control. Interventions directed staff to administer Mounjaro (a dual GIP, glucose-dependent insulinotropic polypeptide, and glucagon-like peptide-1, GLP-1, receptor agonist, medication to promote weight loss) as ordered by the physician. Resident #1's Order Summary Report, with active orders as of 07/08/2026, contained an order, dated 04/16/2026, for Mounjaro Subcutaneous Solution Auto-Injector 10 milligrams (mg)/0.5 milliliters (ml), 10 mg injected subcutaneously one time a day, every Thursday, for weight control. Resident #1's Order Summary Report did not contain an order for insulin. During an interview on 07/09/2026 at 8:37 AM, the Minimum Data Set Coordinator (MDS Coordinator) stated it was their process to complete the MDS and review it for accuracy. The MDS coordinator stated they referred to the resident's order summary to know what injections the resident was on. The MDS coordinator stated they had reviewed Resident #1's medications, and Mounjaro was not an insulin. The MDS Coordinator stated it was their expectation for Mounjaro to be coded as an injection and not as an insulin. During an interview on 07/09/2026 at 10:02 AM, The Director of Nursing (DON) stated it was their expectation for the MDS coordinator to go to each department and gather information on each resident for the MDS sections to be coded correctly. The DON stated it was their expectation for staff to verify the medications (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375556	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Sherwood Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2416 West 51st South Tulsa, OK 74107	
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was on to code correctly in section N of the MDS. During an interview on 07/09/2026 at 10:02 AM, the Administrator (ADM) stated it was their expectation for the MDS coordinator to go to each department and gather information on each resident for the MDS sections to be coded correctly. The ADM stated it was their expectation for staff to verify the medications Resident #1 was on and to code section N correctly. 2. An admission Record revealed the facility admitted Resident #9 on 01/17/2025. According to the admission Record, the resident had a medical history that included a diagnosis of Parkinson's disease with dyskinesia with fluctuations. A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/10/2026, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Section N0415 of Resident #9's MDS indicated the resident was taking an antipsychotic and the resident was not taking an anticonvulsant. Resident #9's Care Plan included a focus area, initiated 10/28/2025, that indicated the resident was on anti-convulsant/seizure medication for depression management. Interventions directed staff to administer medication as ordered and to refer to physician orders for current details (initiated 10/28/2025). Resident #9's Order Summary Report, with active orders as of 07/07/2026, included an order, for divalproex sodium (an anticonvulsant) extended release (ER) 500 mg (milligrams), one tablet by mouth at bedtime for depression, dated 03/05/2026. Resident #9's Order Summary Report did not contain an order for an antipsychotic. During an interview on 07/09/2026 at 8:37 AM, the Minimum Data Set Coordinator (MDS Coordinator) stated Resident #9 was not taking an antipsychotic and that section of the MDS was not coded correctly. The MDS coordinator stated it was their expectation for the medications to be coded correctly and reflect what the resident was taking. During an interview on 07/09/2026 at 10:02 AM, the Director of Nursing (DON) stated it was their expectation for the MDS coordinator to go to each department and gather information on each resident for the MDS sections to be coded correctly. The DON stated they were not sure if Resident #9 was on an antipsychotic or an anticonvulsant, but they would expect staff to review the resident's medications and code them by the correct class. The DON stated MDS accuracy was important not only for care, but it was how the facility would be paid. During an interview on 07/09/2026 at 10:02 AM, the Administrator (ADM) stated it was their expectation for the MDS coordinator to review the resident's medications and code them by their correct drug class. 3. An admission Record revealed the facility admitted Resident #29 on 05/29/2020. According to the admission Record, the resident had a medical history that included type 2 diabetes mellitus without complications. An annual Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 06/04/2026, revealed Resident #29 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. In section N0350 the MDS indicated Resident #29 received one day of insulin during the last seven days. Resident #29's Order Summary Report, dated 07/07/2026, did not include an active order for insulin. Resident #29's Order Summary Report included an order for Ozempic (a GLP-1, glucagon-like peptide-1, medication to help lower blood sugar levels). Resident #29's order indicated Ozempic subcutaneous solution pen-injector 2 mg/mL (milligram/milliliter), 1 mg injected subcutaneously one time a day, every Friday, related to type 2 diabetes mellitus without complications, started 03/06/2026. During an interview on 07/07/2026 at 2:48 PM, the Minimum Data Set Coordinator (MDS Coordinator) stated she had been coding Ozempic as insulin if the resident's order indicated the use was for diabetes. The MDS Coordinator stated she knew Ozempic was a GLP-1 medication but thought it was used to treat diabetes and could be counted on the MDS assessment as insulin. The MDS Coordinator stated she should not have coded Resident #29's Ozempic as insulin on the MDS. During an interview on 07/09/2026 at 10:02 AM, the Director of Nursing (DON) stated she expected MDS assessments to be complete and accurate. During (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Sherwood Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2416 West 51st South Tulsa, OK 74107	
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview on 07/09/2026 at 10:30 AM, the Administrator (ADM) stated she expected the MDS assessments to be completed accurately.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident received nutritional feeding via a percutaneous endoscopic gastrostomy (PEG) tube according to physician's orders for 1 (Resident #63) of 3 residents reviewed for tube feedings. Findings included: A facility policy titled, Enteral Nutrition, revised 11/2018, revealed, 4. Enteral nutrition is ordered by the provider based on the recommendations of the dietician. An admission Record revealed the facility readmitted Resident #63 on 02/06/2026. According to the admission Record, the resident had a medical history that included diagnoses of Rett's syndrome and functional quadriplegia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/29/2026, revealed Resident #63 had severe impairment in cognitive skills for daily decision-making and had short-term and long-term memory problems per a Staff Assessment of Mental Status (SAMS). The MDS also revealed the resident received 51% or more of their nutritional intake via a PEG tube. Resident #63's Care Plan Report, included a focus area initiated 11/02/2023, that indicated the resident had a PEG tube in place for hydration and nutrition needs related to Rett's syndrome and was at risk for complications related to having a PEG tube in place. Interventions directed staff to administer tube feedings as ordered by the physician and refer to physician orders for details (initiated 02/02/2023). Resident #63's Order Summary Report, dated 07/07/2026, revealed an order dated 10/28/2025 for Isosource 1.5 cal (calories) at 40 milliliters (mL) per hour via PEG tube. Further review revealed the order indicated that the resident's feeding may be off for up to four hours daily. Resident #63's Treatment Administration Record [TAR] for 07/2026 revealed staff documented that the resident's Isosource 1.5 was infusing at a rate of 40 mL per hour via PEG tube on 07/05/2026 and 07/06/2026. An observation on 07/06/2026 at 10:24 AM revealed Resident #63 was lying in bed with their tube feeding attached and running via a kangaroo infusion pump, which was located beside the resident's bed with a pillowcase draped over the intravenous (IV) pole. The nutritional supplement infusing was pre-labeled as Nutren 1.5 and contained a handwritten date of 07/06/2026 at 12:12 AM and the initials of Licensed Practical Nurse (LPN) #4. During an observation and concurrent interview on 07/06/2026 at 10:32 AM, CNA #2 observed Resident #63's tube feeding and confirmed that the tube feeding was labeled Nutren 1.5. During an interview on 07/07/2026 at 11:25 AM, LPN #1 stated she worked with Resident #63, and although she provided PEG tube care and administered medication to the resident via the PEG tube, she did not verify the type of nutritional supplement that was infusing. LPN #1 stated she should have verified that the resident was receiving the ordered nutritional supplement via PEG tube. During an interview on 07/07/2026 at 11:42 AM, LPN #3 stated he worked on the night of 07/06/2026 and noticed Resident #63 had the incorrect nutritional supplemental feeding running between 10:00 PM and 11:00 PM. He stated that at the time he sent a text message to the Assistant Director of Nursing (ADON) to notify her and obtain directions. LPN #3 stated that when he did not receive a return call after midnight, he changed the resident's tube feeding formula to Isosource 1.5 as ordered. He stated he had been taught to check the tube feeding formula to the resident's physician's orders, but he did not notify the provider or the dietician for further directions at the time. He stated he also could not verify how much of the incorrect nutritional supplement had been infused via PEG tube but stated it was most of the bag because it was time for the tube feeding to be changed when he realized it. An attempt was made to contact LPN #4 on 07/07/2026 at 11:33 AM, 07/08/2026 at 9:18 AM, and 07/08/2026 at 6:45 PM and were unsuccessful. During an interview on 07/08/2026 at 10:28 AM, the Registered Dietician (RD) stated that she had minor concerns with (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #63 receiving Nutren 1.5 instead of Isosource 1.5 due to the fiber content. She stated that although it was not a significant amount, the resident did not receive the same amount of fiber content that would have been provided with the ordered Isosource 1.5 feedings. During an interview on 07/09/2026 at 8:38 AM, the ADON stated each nurse on duty should have checked Resident #63's nutritional formula to verify the correct formula and rate were infusing and should have notified the Director of Nursing (DON) and the Medical Director (MD) immediately if it was incorrect. The ADON stated that the incorrect nutritional formula should have been stopped, and the correct nutritional formula should have been initiated. During an interview on 07/09/2026 at 10:02 AM, the DON stated that she expected nurses to compare the physician's order to the formula prior to initiation, and each nurse following the initiation of the nutritional formula should verify the correct formula was being infused. During an interview on 07/09/2026 at 10:30 AM, the Administrator stated she expected nurses to verify the correct nutritional formula that was infusing each shift. During an interview on 07/09/2026 at 10:45 AM, the MD stated he was made aware that Resident #63 received the incorrect nutritional formula via PEG tube. He stated although he expected nurses to verify residents were receiving the correct nutritional formula, he did not have any significant concern that Resident #63 received the incorrect nutritional formula as the only difference between the ordered formula and the infused formula was the fiber content.		

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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, facility policy review, and review of manufacturers' instructions, the facility failed to ensure the medication error rate was 5 percent (%) or less. The facility had 3 medication errors out of 31 opportunities affecting 2 (Resident #2 and Resident #11) of 4 residents reviewed during the medication administration task, resulting in a medication error rate of 9.68%. Findings included: A facility policy titled, Administering Medication, revised April 2019, revealed, 4. Medications are administered in accordance with prescriber orders, including any required time frame. Manufacturer's instructions titled, How to use your Lantus [device brand name of a prefilled disposable long-acting insulin injection pen] pen, dated 2022, indicated: Step 3: Perform A Safety Test - Dial a test dose of 2 Units.- Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle.- Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test.- If no insulin comes out, repeat the test 2 more times. If there is still no insulin coming out, use a new needle and do the safety test again. Always perform the safety test before each injection. An admission Record revealed the facility admitted Resident #2 on 06/05/2024. According to the admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus with diabetic neuropathy. A quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 06/17/2026, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 3 which indicated the resident had severe cognitive impairment. The MDS indicated the resident was diabetic and received seven days of insulin during the last seven days. Resident #2's Order Summary Report, with active orders as of 07/07/2026, revealed an order for Lantus (device brand name) Subcutaneous Solution Pen-Injector 100 units/milliliter (mL) 10 units injected subcutaneously one time a day related to type 2 diabetes mellitus with diabetic neuropathy, started 01/14/2026. An observation on 07/08/2026 at 6:49 AM revealed Licensed Practical Nurse (LPN) #1 administered 10 units of Lantus insulin to Resident #2. During the observation, LPN #1 was not observed to perform the safety test of priming the insulin pen. During an interview on 07/08/2026 at 8:55 AM, the Pharmacist stated insulin pens should be primed with 2 units of insulin before each administration to remove the air and ensure the resident did not miss 1 to 2 units of insulin. During an interview on 07/08/2026 at 9:28 AM, LPN #1 stated she had no knowledge of how to prime an insulin pen and did not understand the importance of completing that step. During an interview on 07/08/2026 at 9:45 AM, the Director of Nursing (DON) stated she expected LPN #1 to prime the insulin pen prior to administering each dose of insulin. 2. Manufacturer's instructions titled, How to use your Lantus [device brand name of a prefilled disposable long-acting insulin injection pen] pen, dated 2022, indicated: Step 3: Perform A Safety Test - Dial a test dose of 2 Units.- Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle.- Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test.- If no insulin comes out, repeat the test 2 more times. If there is still no insulin coming out, use a new needle and do the safety test again. Always perform the safety test before each injection. Manufacturer's instructions titled, How to use your NovoLog [device name of a prefilled disposable fast-acting insulin injection pen], revised 02/2023, indicated: Step 2: Do an air shot (Prime the needle)1. Dial 2 units.2. Hold the syringe with needle pointing up and tap reservoir gently to move air bubbles to top of needle.3. Press the push button on your syringe as far as it will go until a drop of insulin appears. An admission Record revealed the facility admitted Resident #11 on 01/25/2024. According to the admission Record, the (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had a medical history that included diagnoses of type 2 diabetes mellitus without complications. A quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 04/21/2026, revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident was diabetic and received seven days of insulin during the last seven days. Resident #11's Order Summary Report, with active orders as of 07/07/2026, revealed an order for Lantus (device name) Subcutaneous Solution Pen-Injector 100 units/milliliter (mL), 120 units injected subcutaneously in the morning for diabetes, hold if finger stick blood sugar is less than 150 mg/dL (milligrams per deciliter), started 04/10/2026 and Novolog Injection Solution 10 units injected subcutaneously three times a day related to type 2 diabetes mellitus without complications, with meals, give with sliding scale, and hold for glucose 110 mg/dL and below, started 03/23/2026. An observation on 07/08/2026 at 7:04 AM revealed Licensed Practical Nurse (LPN) #1 administered 120 units of Lantus insulin and 10 units of Novolog insulin to Resident #11. During the observation, LPN #1 was not observed to perform the safety test of priming the insulin pens before administration. During an interview on 07/08/2026 at 8:55 AM, the Pharmacist stated insulin pens should be primed with 2 units of insulin before each administration to remove the air and ensure the resident did not miss 1 to 2 units of insulin. During an interview on 07/08/2026 at 9:28 AM, LPN #1 stated she had no knowledge of how to prime an insulin pen and did not understand the importance of completing that step. During an interview on 07/08/2026 at 9:45 AM, the Director of Nursing (DON) stated she expected LPN #1 to prime the insulin pen prior to administering each dose of insulin.		