STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375582	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Healthcare and Rehab	1530 NE Grand Blvd Oklahoma City, OK 73117

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure:a. care plan interventions were implemented to prevent skin breakdown, andb. a resident with wounds received appropriate treatment for 1 (#26) of 3 sampled residents reviewed for pressure ulcers and skin conditions.The wound care nurse identified 12 residents had wounds in the facility. Findings:On 02/12/26 at 10:40 a.m., Resident #26 was observed with three open areas to their coccyx and buttocks during an incontinent care observation.On 02/12/26 at 10:48 a.m., CNA #1 was observed to apply vitamin A&D ointment to Resident #26's wounds.On 02/13/26 at 11:11 a.m., Resident #26 was observed lying on their back on a regular mattress.On 02/17/26 at 9:39 a.m., Resident #26 was observed lying in bed. They had a navy-blue pressure relieving mattress on their bed.An undated facility SKIN MANAGEMENT POLICY, read in part, Any resident with pressure sores will receive the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing based upon the resident's clinical condition .The CNA staff will monitor skin daily of all resident's during care .and alert their Charge Nurse of any skin change.A physician order for Resident #26, dated 01/23/26, showed weekly skin assessment every Thursday evening night shift.An admission assessment for Resident #26, dated 01/29/26, showed the resident had diagnoses which included unspecified fracture of sacrum and abnormalities of gait and mobility. The assessment showed the resident was at risk for developing pressure ulcers. The assessment showed the resident required supervision or touching assistance with rolling left to right and required substantial or maximal assistance with perineal hygiene. The assessment showed the resident's cognition was intact with a BIMS score of 15.A care plan for skin breakdown for Resident #26, initiated 02/05/26, read in part, Monitor/document/report PRN [as needed] any changes in skin status: appearance, color, wound healing, s/sx [medical abbreviation for signs and symptoms] of infection, wound size, stage .Pressure reducing/relieving mattress to bed .Skin assessment weekly as ordered.A Skin Assessment by Charge Nurse for Resident #26, dated 02/05/26 at 10:58 p.m., showed the resident had no open area and their coccyx was reddened.A bowel and bladder elimination report for Resident #26, dated 02/11/26 and 02/12/26, showed the resident had a total of four loose stools.A Skin Assessment by Charge Nurse for Resident #26, dated 02/12/26 at 10:58 p.m., showed the resident had no open area and their coccyx was reddened.A skin assessment for Resident #26, completed by the wound care nurse on 02/13/26, showed the resident had the following stage two open areas:a. right buttock measuring 1.5 cm by 1.5 cm,b. left buttock measuring 1.5 cm by 1.5 cm, andc. upper cerbe (upper part of the buttocks) measuring 1cm by 0.5 cm.Physician's orders for Resident #26 were reviewed for 02/2026. There were no orders for wound treatment. On 02/13/26 at 1:12 p.m., the wound care nurse stated Resident #26 did not have a wound and was not on their list for the provision of wound care.On 02/13/26 at 1:26 p.m., RN #1 stated they did not remember CNA #1 informing them of the Resident #26's wounds.On 02/12/26 at 10:43 a.m., CNA #1 stated Resident #26 had one open spot on their bottom and not three. They stated they had not taken care of the resident for the last couple of days.On 02/13/26 at 11:12 a.m., Resident #26 stated they were not aware they had three wounds on their buttocks.On 02/13/26 at 12:47 p.m., CNA #1 stated they were to report any skin issues immediately to the nurse. They stated they reported the wound observation to RN #1 after 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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	incontinent care observation on 02/12/26 and on 02/13/26. CNA #1 stated they asked RN #1 if there was anything else they could use for treatment and RN #1 informed them to use the vitamin A&D ointment.On 02/13/26 at 12:52 p.m., CNA #1 stated Resident #26 did not have a pressure relieving mattress on their bed.On 02/13/26 at 12:56 p.m., RN #1 stated the charge nurses were responsible for completing skin assessments when ordered.On 02/13/26 at 12:57 p.m., RN #1 stated Resident #26 only had redness to their bottom. They stated the last time they made an observation of the resident's bottom was last week. They were not sure of the date or time.On 02/13/26 at 1:05 p.m., RN #1 stated the skin breakdown interventions in place for Resident #26 was to educate the resident on skin breakdown, positioning, shift weight in wheelchair, use of moisture barrier, do not massage over bony areas, use of pressure reducing mattress, and weekly skin assessment. On 02/13/26 at 1:06 p.m., RN #1 stated all the residents in the facility had pressure relieving mattresses on their beds including Resident #26.On 02/13/26 at 1:17 p.m., the DON was asked if Resident #26 had a pressure relieving mattress to their bed per the resident's care plan. They stated that could mean pillows or wedges. They stated they were not aware the resident had wounds.On 02/13/26 at 1:18 p.m., the DON stated the 02/12/26 weekly skin assessment showed Resident #26 had no open areas.On 02/17/26 at 9:51 a.m., the wound care nurse stated Resident #26's previous mattress was a regular mattress and not a pressure relieving mattress. They stated they put the air flow pressure reducing mattress on the resident's bed on 02/13/26. They stated not all residents in the facility had a pressure relieving mattress. On 02/17/26 at 9:54 a.m., the wound care nurse stated the Resident #26's wound would be considered facility acquired and having a pressure reducing mattress could have helped in preventing it.On 02/17/26 at 10:50 a.m., the DON stated the facility trained nurses on proper skin assessment which involved assessing all areas of the skin during a weekly skin assessment and CNAs were to report to the charge nurse any skin issues noted during care.

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to ensure pain medication was administered as prescribed for 1 (#48) of 3 sampled residents reviewed for pain management.The administrator identified 63 residents resided in the facility. Findings: A policy titled Medication Administration, dated 04/2019, read in part, Medications are administered in accordance with prescriber orders. A policy titled Pain Assessment and Management, dated 03/2020, read in part, The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choice related to pain management. A care plan for Resident #48, dated 10/10/25, showed the resident had generalized pain. The care plan showed an intervention for pain management was to administer analgesic medications as ordered by the physician. A physician's order for Resident #48, dated 10/10/25, showed the resident was prescribed oxycodone 5 mg (an opioid analgesic) one every six hours as needed for pain. A quarterly assessment for Resident #48, dated 12/20/25, showed the resident had diagnoses which included gout and liver cirrhosis. The assessment showed Resident #48 had a BIMS of 12, which indicated moderate cognitive impairment. A medication administration record for Resident #48, dated 01/2026, showed the resident received oxycodone 5 mg one tablet one time on the 7:00 a.m. to 3:00 p.m. shift. They rated their pain at a four out of 10. Resident #48 received oxycodone 5 mg one time on the 3:00 p.m. to 11:00 p.m. shift on 01/17/26. They rated their pain a six out of 10. There was no documentation showing Resident #48 was administered oxycodone 5 mg on the 11:00 p.m. to 7:00 a.m. shift on 01/17/26 into 01/18/26. A nurse's charting note for Resident #48, dated 01/18/26, showed the resident requested their oxycodone from the nurse on duty and was advised there was no primary nurse to administer narcotics to Resident #48. Resident #48 was offered Tylenol (an analgesic), but Resident #48 stated they could not take Tylenol due to their liver condition. On 02/12/26 at 7:40 a.m., Resident #48 stated they hurt all over and all of the time. They stated they received oxycodone every six hours. Resident #48 stated their liver transplant physician advised them to not take Tylenol, but that was all they have been offered for break through pain. Resident #48 stated they were denied oxycodone in January due to no available staff. On 02/12/26 at 7:50 a.m., CMA #1 stated Resident #48 complained of pain frequently and had been prescribed oxycodone as needed until 02/06/26. They stated Resident #48's oxycodone had been changed to routinely every six hours on 02/05/26. On 02/12/26 at 8:38 a.m., LPN #4 stated Resident #48 requested their as needed oxycodone on 01/18/26, but they were the only nurse on duty for the overnight shift on 01/27/26 into 01/28/26. They stated they refused to accept the keys for the narcotic lockbox for Resident #48's hall and was told by administration they would try to have another nurse help fill the shift. LPN #4 stated they did not know where the keys for the narcotic lockbox for Resident #48's hall were during that shift. LPN #4 stated they offered Resident #48 Tylenol, but they refused. LPN #4 stated Resident #4 rated their pain 10 out of 10, so they called the provider and was told Resident #48 could only have Tylenol if oxycodone was not available. On 02/18/26 at 8:36 a.m., the DON stated it was the facility's policy to administer medications as ordered. They stated Resident #48's oxycodone should have been given and an alternative for Tylenol should have been available.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and interview, the facility failed to ensure the direct care staffing hours on the Quality of Care report was accurately reported to CMS during the months of 12/2025 through 01/2026. The administrator identified 63 residents resided in the facility.Findings: The Quality of Care report for the month of December 2025 showed the following was reported to CMS for direct care staffing hours for the 3 p.m. to 11 p.m. shift:a. 12/20/26, a census of 62 and 52.32 direct care staffing hours,b. 12/24/26, a census of 63 and 37.40 direct care staffing hours,c. 12/27/26, a census of 63 and 61.18 direct care staffing hours, andd. 12/28/26, a census of 61 and 61.00 direct care staffing hours. The facility payroll detail report for the month of December 2025 showed the facility had the following for the 3 p.m. to 11 p.m. shift:a. 12/20/26, 91.51 direct care staffing hours,b. 12/24/26, 63.27 direct care staffing hours,c. 12/27/26, 86.99 direct care staffing hours and,d. 12/28/26, 98.69 direct care staffing hours. The Quality of Care report for the month of January 2026 showed the following was reported to CMS for direct care staffing hours for the 3 p.m. to 11 p.m. shift:a. 01/03/26, a census of 65 and 33.75 direct care staffing hours,b. 01/20/26, a census of 66 and 38.21 direct care staffing hours,c. 01/21/26, a census of 66 and 41.11 direct care staffing hours,d. 01/24/26, a census of 65 and 72.50 direct care staffing hours,e. 01/27/26, a census of 64 and 37.83 direct care staffing hours,f. 01/28/26, a census of 64 and 38.44 direct care staffing hours, andg. 01/31/26, a census of 64 and 47.50 direct care staffing hours. The facility payroll detail report for the month of January 2026 showed the facility had the following for the 3 p.m. to 11 p.m. shift:a. 01/03/26, 104.74 direct care staffing hours,b. 01/20/26, 64.10 direct care staffing hours,c. 01/21/26, 65.13 direct care staffing hours,d. 01/24/26, 72.50 direct care staffing hours,e. 01/27/26, 75.80 direct care staffing hours,f. 01/28/26, 64.92 direct care staffing hours, andg. 01/31/26, 76.73 direct care staffing hours. On 02/18/26 at 12:05 p.m., the corporate nursing officer stated the facility had not accurately submitted staffing information to CMS.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review, and interview, the facility failed to ensure the physician was notified when a resident's blood sugar was above 350 for 1 (#2) of 2 sampled residents reviewed for insulin.The administrator identified 63 residents resided in the facility. Findings: A Physician Notification for Resident Change in Condition, policy undated, read in part, The licensed nurse assigned to the resident is responsible for notification of and communication to the medical staff regarding significant changes.Changes in the condition of the resident are determined by assessments utilizing parameters defined by physician orders/instructions. Document in the medical record the date, time and name of each physician notified, actions taken and/or resident's response to treatment. A physician's order for Resident #2, dated 12/31/25, showed Humalog (an insulin medication) 100 unit per milliliter, inject as per sliding scale, for blood sugar level of 350 to 400, give 10 units and notify medical doctor, subcutaneously before meals related to type two diabetes mellitus with unspecified complications. An admission resident assessment for Resident #2, dated 01/07/26, showed the resident had a diagnosis of diabetes. The assessment showed the resident's cognition was intact with a BIMS score of 14. A FSBS INJECTION for 02/2026 for Resident #2 showed 10 units of Humalog insulin was administered on: a. 02/06/26 at 11:00 a.m. with an FSBS of 365, b. 02/08/26 at 7:00 a.m. with an FSBS of 364 and 4:00 p.m. with an FSBS of 359, c. 02/09/26 at 11:00 a.m. with an FSBS of 351, and d. 02/11/26 at 11:00 a.m. with an FSBS of 375. Progress notes and a medication administration record for 02/2026 for Resident #2 were reviewed. There was no documentation the provider was notified of the above FSBS. On 02/10/26 at 9:43 a.m., Resident #2 stated their blood sugar was always high, and the facility did not know how to control it. They stated their usual blood sugar was around 100 to 200 before admission to the facility. Resident #2 stated their blood sugar at the facility went as high as 370. On 02/11/26 at 1:43 p.m., RN #1 stated the process for insulin administration was to obtain the resident's FSBS, document it, and administer the amount of insulin as ordered. On 02/11/26 at 1:44 p.m., RN #1 stated physician notifications of FSBS during insulin administration would be in resident's progress notes. On 02/11/26 at 1:49 p.m., RN #1 stated Resident #2's order showed to notify the physician if FSBS was 350 to 400. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/11/26 at 1:52 p.m., RN #1 stated they could not locate documentation the physician was notified of the above FSBS. They stated they have not notified the provider for the FSBS of 375 on 02/11/26 at 11:00 a.m. They stated the provider should have been notified as ordered. On 02/11/26 at 2:02 p.m., the DON stated staff should notify the physician if the order stated to notify the physician.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to comprehensively assess a resident's physical condition and needs for 1 (#10) of 18 sampled residents reviewed for comprehensive assessments.The administrator identified 63 residents resided in the facility. Findings:On 02/11/26 at 8:48 a.m., Resident #10's left hand was observed to be contracted and completely closed into a fist. There were no therapeutic devices in their left hand. Resident #10's left arm was observed to not raise above shoulder height. A policy titled Resident Assessments, dated 11/2019, showed appropriate resident assessments were to be completed.A Physician's Progress Note for Resident #10, dated 11/14/25, showed the resident had left sided weakness. An admission Assessment for Resident #10, dated 11/23/25, showed the resident was admitted to the facility on [DATE] with diagnoses which included renal failure and heart failure. The assessment showed Resident #10 had no impairment to their upper extremities. The assessment showed Resident #10 had a BIMS score of 14, which indicated they were cognitively intact. On 02/11/26 at 8:48 a.m., Resident #10 stated they had no use of their left hand and could not raise their left arm above their shoulders. On 02/12/26 at 9:54 a.m., CNA #2 was asked if Resident #10 had any physical limitations. They stated Resident #10 was unable to use their left hand and their left arm was weak. On 02/12/26 at 10:38 a.m., the MDS coordinator was asked how resident assessment information was collected for the comprehensive assessment. They stated, I read the chart and see the patient myself. The MDS coordinator was asked if Resident #10's comprehensive assessment showed any upper extremity impairments. They stated, No. The MDS coordinator stated Resident #10's assessment should have showed upper extremity impairment for their left-hand contracture and left arm weakness.

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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 a comprehensive care plan:a. included interventions for limited range of motion for 1 (#10) of 3 sampled resident reviewed for limited range of motion,b. was implemented for offering a meal replacement supplement for 1 (#48) of 3 sampled residents reviewed for nutrition, andc. included the use of a mechanical lift for transfer for 1 (#3) of 5 sampled residents reviewed for accidents.The administrator identified 63 residents resided in the facility and the DON identified six residents used a mechanical lift for transfers. Findings: A policy titled Care Plans, Comprehensive Person-Centered, dated 12/2016, read in part, A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.The comprehensive person-centered care plan will: describe the services that are furnished or attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; incorporate identified problem areas; aid in preventing or reducing decline in the resident's functional status and/or functional levels; enhance the optimal functioning of the resident by focusing on a rehabilitative program. 1. On 02/11/26 at 8:48 a.m., Resident #10's left hand was observed to be contracted and completely closed into a fist. There were no therapeutic devices in their left hand. Resident #10's left arm was observed to not raise above shoulder height. A care plan for Resident #10, dated 11/11/25, did not show any problem area related to limited range of motion or contractures. A physician's progress note for Resident #10, dated 11/14/25, showed the resident had left sided weakness. An admission assessment for Resident #10, dated 11/23/25, showed the resident was admitted to the facility on [DATE] with diagnoses which included renal failure and heart failure. The assessment showed Resident #10 had no impairment to their upper extremities. The assessment showed Resident #10 had a BIMS of 14, which indicated they were cognitively intact. On 02/11/26 at 8:48 a.m., Resident #10 stated they had no use of their left hand and could not raise their left arm above their shoulders. They stated there were no therapeutic devices or therapies used to maintain or improve function. On 02/12/26 at 9:54 a.m., CNA #2 stated Resident #10 was unable to use their left-hand and their left arm was weak. CNA #2 stated there were no therapeutic devices or therapies provided to Resident #10, but they needed both. On 02/12/26 at 10:04 a.m., LPN #2 stated Resident #10 did not have an order for therapeutic devices for their left-hand contracture, and no range of motion exercises were provided. On 02/12/26 at 10:11 a.m., CNA #6 stated Resident #10 was not on restorative services and had no (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	therapeutic devices for their left-hand contracture. On 02/12/26 at 10:16 a.m., the DON stated if a resident had limited range of motion or a contracture the resident was admitted to therapy or to their restorative program. The DON stated Resident #10 had not received assistance from the restorative program until today but should have been since admission. They stated a rolled-up wash cloth should have been placed in Resident #10's left hand to prevent further contracture, and staff should have been providing passive range of motion exercises. On 02/12/26 at 10:38 a.m., the MDS coordinator stated Resident #10's care plan did not include their upper extremity impairment, left-hand contracture, or interventions, but should have. 2. On 02/11/26 at 9:16 a.m., Resident #48 was observed lying in bed with their eyes closed. A breakfast tray was untouched sitting on their walker seat. A care plan for Resident #48, dated 10/10/25, showed the resident had a nutritional problem or potential nutritional problem related to protein calorie malnutrition. The intervention was for staff to offer Resident #48 a meal replacement supplement if 50% or less of their meal was consumed. An undated weight log for Resident #48 showed on 12/05/25, the resident weighed 170 pounds. An admission assessment for Resident #48, dated 12/20/25, showed the resident was admitted to the facility on [DATE] with diagnoses which included pancytopenia (a serious blood disorder characterized by dangerously low red blood cells, white blood cells, and platelets), renal insufficiency, and cirrhosis of the liver. The assessment showed Resident #48 had a BIMS of 12, which indicated moderate cognitive impairment. An undated weight log for Resident #48 showed on 01/05/26, the resident weighed 158.5 pounds. A dietician's note for Resident #48, dated 01/20/26, showed the resident had a significant weight loss of 8.8% in one month and 15.3% in six months. The note showed Resident #48's meal intake was poor to fair and ranged from 25 to 50% of meals. The dietician recommended health shakes three times daily with meals. An undated weight log for Resident #48 showed on 02/04/26, the resident weighed 155 pounds. On 02/11/26 at 1:46 p.m., Resident #48 stated they did not receive any meal supplements. They stated, I really like them. I'm not sure why I don't get them anymore. On 02/11/26 at 1:53 p.m., CNA #2 stated Resident #48 did not receive health shakes or additional supplements if meal consumption was 50% or less. They stated Resident #48 never ate much and did not have much of an appetite. On 02/13/26 at 8:52 a.m., the DON stated Resident #48 should have been receiving health shakes when 50% or less of their meals were consumed. 3. On 02/17/26 at 9:23 a.m., CNA #3 and the activities director were observed using the lift to transfer Resident #3 from the Geri chair to their bed and back to the Geri chair because the resident requested to be taken for a smoke break. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A significant change in status assessment for Resident #3, dated 01/20/26, showed the resident had diagnoses which included weakness and dementia. The assessment showed the resident was dependent on staff for transfer. The assessment showed the resident had severe cognitive impairment with a BIMS score of 06. A care plan for Resident #3, revised 02/05/26, did not show the use of a mechanical lift for transfers. On 02/10/26 at 12:10 p.m., Resident #3 stated they used a lift for transfers with one staff assistance. On 02/13/26 at 10:22 a.m., CNA #4 stated Resident #3 used a lift for transfers. On 02/17/26 at 9:22 a.m., CNA #3 stated Resident #3 had been using the lift for transfers since they were employed at the facility. On 02/17/26 at 9:30 a.m., the MDS coordinator stated they were responsible for completing care plans. They stated if a resident used a lift for transfers, the nurses would notify them, and they would make observation of the transfer. The MDS coordinator stated they would document lift use on the resident's care plan. On 02/17/26 at 9:33 a.m., the MDS coordinator stated Resident #3's care plan did not address the use of a lift for transfers.

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Park Place Healthcare and Rehab	1530 NE Grand Blvd Oklahoma City, OK 73117

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure:a. dirty linen was not placed on the floor for 1 (#41),b. soiled wipes and a soiled brief were not placed on the bed for 1 (#16),c. gloves were changed appropriately during incontinent care for 3 (#16, 40 and #41) of 4 sampled residents reviewed for activities of daily living, andd. staff worn a gown during incontinent care for 1 (#40) of 4 sampled residents reviewed for EBP.The DON identified 40 residents required assistance with incontinent care and 14 residents had EBP precautions. Findings: 1. On 02/12/26 at 5:46 a.m., CNA #5 was observed to don gloves to perform incontinent care on Resident #41. On 02/12/26 at 5:47 a.m., CNA #5 was observed to open a brief, set it on Resident #41's bedside table, remove the front of the resident's brief and assist them to turn to their left side. Fecal matter was observed on the resident's brief. CNA #5 cleaned the resident with wipes and discarded the dirty brief in the trash bag. With the same gloves, CNA #5 put a new brief and pad under the resident. They removed the old pad and dropped it on the floor. CNA #5 adjusted the resident's brief, bed, flat sheet, and placed the resident's call light and bedside table in reach. CNA #5 did not change their gloves during incontinent care. On 02/12/26 at 5:52 a.m., CNA #5 picked up the pad and trash bag from the floor with the brief and put them in two separate bins on the hallway. CNA #5 then removed their gloves. On 02/12/26 at 5:53 a.m., CNA #5 sanitized their hands with the alcohol-based hand rub. An Infection Prevention and Control Program policy, dated 05/12/23, read in part, Soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. A care plan for Resident #41, revised 01/07/26, showed the resident was incontinent of bowel and bladder. The care plan showed to clean perineal area with each incontinent episode. The care plan showed the resident had diagnoses which included dementia and senile degeneration of the brain. On 02/12/26 at 5:56 a.m., CNA #5 stated the process for incontinent care was to inform the resident of the procedure, turn them, wipe the resident, turn them again, and wipe them. They stated dirty linens were to be placed in a bag. CNA #5 stated they already knew they did something wrong the moment they placed the pad on the floor. On 02/12/26 at 5:57 a.m., CNA #5 stated they were supposed to change gloves twice during incontinent care. They stated they did not remember, not changing their gloves. On 02/12/26 at 5:59 a.m., CNA #5 stated they should not touch other surfaces with dirty gloves. They stated they did not have a trash bag in the room to put the dirty pad in it. They stated it is an infection control issue. 2. On 02/12/26 at 5:49 a.m., CNA #7 was observed to don gloves, prepare a clean brief and new bed pad for Resident #16's incontinent care. CNA #7 unfastened Resident #16's brief, which was soiled with urine. CNA #7 tucked the soiled brief between Resident #16's legs, wiped them front to back two (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	times, and placed dirty wipes on the foot of bed on top of the sheet. CNA #7 rolled Resident #16 onto their right side, tucked the soiled brief under the resident, and applied a clean brief under them. CNA #7 placed a clean bed pad in Resident #16's wheelchair. CNA #7 rolled Resident #16 onto their back and pulled the clean brief between their legs. CNA #7 then rolled Resident #16 onto their left side, removed the soiled brief and placed it at the foot of bed on top of the sheet. While still wearing the soiled gloves, CNA #7 handed Resident #16 their stuffed animal. CNA #7 placed the soiled brief and wipes in the trash can and removed the trash bag. CNA #7 was still wearing the same gloves and covered Resident #16 with their sheets and moved the resident's bedside table in closer reach. CNA #7 used the bed remote to raise the head of bed and handed it and the call light to Resident #16. CNA #7 reached into their jacket pocket with gloves still on, grabbed clean gloves and then put them back into their pocket. CNA #7 found the trash bag roll they had inside their jacket packet and replaced the trash bag in the trash can. CNA #7 doffed gloves and exited Resident #16's room, placing the trash bag into the trash barrel. A care plan for Resident #16, dated 11/14/25, showed the resident was admitted to the facility on [DATE] with diagnoses which included muscle wasting and atrophy. The care plan showed Resident #16 was occasionally incontinent and required staff assistance with perineal care. On 02/12/26 at 6:00 a.m., CNA #7 stated they should have changed gloves after touching Resident #16's dirty brief and before touching anything considered clean. CNA #7 stated they should not have placed the soiled wipes and brief on the bed. CNA #7 stated they should not have touched Resident #16's stuffed animal, clean sheets, bedside table, bed remote, or their call light with the same gloves on that they used to touch the soiled wipes and brief. CNA #7 stated they should not have touched the clean gloves or trash bag roll in their pocket with soiled gloves on. 3. On 02/12/26 at 6:02 a.m., an EBP sign was observed outside of Resident #40's room. Personal protective equipment was located in a hanging organizer on the outside of their door. CNA #7 entered Resident #40's room, utilized hand sanitizer and donned gloves. CNA #7 prepared a clean brief and changed their gloves. CNA #7 unfastened Resident #40's brief and tucked the brief between Resident #40's legs. Resident #40's brief was free of urine. CNA #7 rolled Resident #40 onto their left side and feces was observed in the resident's brief. CNA #7 wiped the resident front to back three times and tucked the soiled brief under Resident #40. A wound dressing was observed clean, dry, and intact to Resident #40's coccyx. CNA #7 applied a clean disposable pad and clean brief under the resident. CNA #7 rolled Resident #40 onto their left side, removed the soiled brief and disposed of it in the trash can. CNA #7 pulled the clean brief under Resident #40, placed the brief between the resident's legs and doffed their gloves. CNA #7 removed a pair of gloves from their jacket pocket and donned them. They placed a pillow between Resident #40's legs, covered them with a blanket, lowered the bed and placed the fall mat on the floor. CNA #7 removed the trash bag, replaced it with a clean one, and doffed gloves. CNA #7 then washed their hands with soap and water. A policy titled Enhanced Barrier Precautions, dated 04/01/24, read in part, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.High contact care activities include: changing briefs or assisting with toileting. A care plan for Resident #40, dated 12/11/25, showed the resident was admitted to the facility on [DATE] with diagnoses which included pressure ulcer of sacral region and other specified local (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infections of the skin and subcutaneous tissue. The care plan showed Resident #40 was on enhanced barrier precautions and personal protective equipment was to be used throughout out their stay or until their wounds healed. On 02/12/26 at 6:15 a.m., CNA #7 stated EBP meant to wash their hands or use hand sanitizer, wear gloves and a gown. They stated they did not think about wearing a gown during incontinent care. CNA #7 stated they should have changed their gloves after removing Resident #40's soiled brief. On 02/12/26 at 7:16 a.m., the DON stated the facility's process for incontinent care was to change gloves between clean and dirty surfaces and soiled briefs. They stated for residents on EBP staff were to wear gloves and a gown for incontinent care. They stated CNA #7 should have followed the facility's process.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure range of motion exercises and equipment for a contracture to maintain or improve mobility for 1 (#10) of 2 sampled residents reviewed for range of motion and mobility.The DON identified two residents had limited range of motion. Findings:On 02/11/26 at 8:48 a.m., Resident #10's left hand was observed to be contracted and completely closed into a fist. There were no therapeutic devices in their left hand. Resident #10's left arm was observed to not raise above shoulder height. A policy titled Restorative Nursing Services, dated 07/2017, read in part, Residents will receive restorative nursing care as needed to help promote optimal safety and independence.A physician's progress note for Resident #10, dated 11/14/25, showed the resident had left sided weakness. An admission assessment for Resident #10, dated 11/23/25, showed the resident was admitted to the facility on [DATE] with diagnoses which included renal failure and heart failure. The assessment showed Resident #10 had no impairment to their upper extremities or diagnosis for left-hand contracture. The assessment showed Resident #10 had a BIMS score of 14, which indicated they were cognitively intact. On 02/11/26 at 8:48 a.m., Resident #10 stated they had no use of their left hand and could not raise their left arm above their shoulders. They stated there were no therapeutic devices or therapies used to maintain or improve function. On 02/12/26 at 9:54 a.m., CNA #2 stated Resident #10 was unable to use their left hand, and their left arm was weak. CNA #2 stated there were no therapeutic devices or therapies provided to Resident #10, but they needed both. On 02/12/26 at 10:04 a.m., LPN #2 stated Resident #10 did not have an order for therapeutic devices for their left-hand contracture, and no range of motion exercises were provided. On 02/12/26 at 10:11 a.m., CNA #6 stated Resident #10 was not on restorative services and had no therapeutic devices for their left-hand contracture. On 02/12/26 at 10:16 a.m., the DON stated if a resident had limited range of motion or a contracture the resident was admitted to therapy or to their restorative program. The DON stated Resident #10 had not received assistance from the restorative program until today but should have been since admission. They stated a rolled-up wash cloth should have been placed in Resident #10's left hand to prevent further contracture, and staff should have been providing passive range of motion exercises.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, record review, and interview, the facility failed to ensure weight loss was unavoidable by providing meal replacement supplements for 1 (#48) of 3 sampled residents reviewed for nutrition.The administrator identified 63 residents resided in the facility. Findings:On 02/11/26 at 9:16 a.m., Resident #48 was observed lying in bed with their eyes closed. A breakfast tray was untouched sitting on their walker seat.A care plan for Resident #48, dated 10/10/25, showed the resident had a nutritional problem or potential nutritional problem related to protein calorie malnutrition. The intervention was for staff to offer Resident #48 a meal replacement supplement if 50% or less of their meal was consumed.An undated weight log for Resident #48 showed on 12/05/25, the resident weighed 170 pounds.An admission assessment for Resident #48, dated 12/20/25, showed the resident had diagnoses which included pancytopenia (a serious blood disorder characterized by dangerously low red blood cells, white blood cells, and platelets), renal insufficiency, and cirrhosis of the liver. The assessment showed Resident #48 had a BIMS of 12, which indicated moderate cognitive impairment.An undated weight log for Resident #48 showed on 01/05/26, the resident weighed 158.5 pounds. A dietician's note for Resident #48, dated 01/20/26, showed the resident had a significant weight loss of 8.8% in one month and 15.3% in six months. The note showed Resident #48's meal intake was poor to fair and ranged from 25 to 50% of meals. The dietician recommended health shakes three times daily with meals. There was no documentation showing Resident #48 received health shakes. Resident #48 did not receive health shakes three times daily for the following dates:a. 01/21/26,b. 01/22/26,c. 01/23/26,d. 01/24/26,e. 01/25/26,f. 01/26/26,g. 01/27/26,h. 01/28/26,i. 01/29/26,j. 01/30/26,k. 01/31/26,l. 02/01/26,m. 02/02/26,n. 02/03/26,o. 02/04/26,p. 02/05/26,q. 02/06/26,r. 02/07/26,s. 02/08/26,t. 02/09/26,u. 02/10/26, andv. 02/11/26. An undated weight log for Resident #48 showed on 02/04/26, the resident weighed 155 pounds. On 02/11/26 at 1:46 p.m., Resident #48 stated they did not receive any meal supplements. They stated, I really like them. I'm not sure why I don't get them anymore. On 02/11/26 at 1:53 p.m., CNA #2 stated Resident #48 did not receive health shakes or additional supplements if meal consumption was 50% or less. They stated Resident #48 never ate much and did not have much of an appetite.On 02/13/26 at 8:52 a.m., the DON stated Resident #48 should have been receiving health shakes when 50% or less of their meals were consumed.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to accurately complete a weekly skin assessment for 1 (#26) of 3 sampled residents reviewed for pressure ulcers and skin conditions.The wound care nurse identified 12 residents had wounds in the facility. Findings:On 02/12/26 at 10:40 a.m., Resident #26 was observed with three open areas to their coccyx and buttocks during an incontinent care observation.A physician order for Resident #26, dated 01/23/26, showed weekly skin assessment every Thursday evening night shift.An admission assessment for Resident #26, dated 01/29/26, showed the resident had diagnoses which included unspecified fracture of sacrum and abnormalities of gait and mobility. The assessment showed the resident's cognition was intact with a BIMS score of 15. The assessment showed the resident was admitted on [DATE]. A Skin Assessment by Charge Nurse for Resident #26, dated 02/12/26 at 10:58 p.m., showed the resident had no open area and their coccyx was reddened.A skin assessment for Resident #26, completed by the wound care nurse on 02/13/26, showed the resident had the following stage two open areas:a. right buttock measuring 1.5 cm by 1.5 cm,b. left buttock measuring 1.5 cm by 1.5 cm, andc. upper cerbe (upper part of the buttocks) measuring 1 cm by 0.5 cm.On 02/10/26 at 10:00 a.m., Resident #26 stated they had a small open area on their bottom.On 02/13/26 at 1:18 p.m., the DON stated the 02/12/26 weekly skin assessment showed Resident #26 had no open areas.On 02/13/26 at 3:15 p.m., LPN #1 stated the process for weekly skin assessment was to assess the resident's skin from head to toe.On 02/13/26 at 3:20 p.m., LPN #1 stated to their knowledge they did visualize Resident #26's coccyx and buttocks on the 02/12/26 weekly skin assessment. LPN #1 stated they did not do a complete skin assessment.On 02/17/26 at 10:50 a.m., the DON stated the facility trained nurses on proper skin assessments which involved assessing all areas of the skin during a weekly skin assessment.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on observation, record review, and interview, the facility failed to ensure residents were provided with necessary behavioral health care and services for 1 (#10) of 3 sampled residents reviewed for behavioral health care needs.The administrator identified 63 residents resided in the facility. Findings: On 02/11/26 at 8:47 a.m., Resident #10 was observed to be tearful in their room. A physician's order for Resident #10, dated 11/11/25, showed the resident was to receive a psychiatric consultation for mental health needs if criteria was met as needed. An admission assessment for Resident #10, dated 11/23/25, showed the resident had a diagnosis of depression. The assessment showed it was very important for them to participate in activities. The assessment showed no behaviors and their depression screening showed no concerns. The assessment showed Resident #10 had a BIMS of 14, which indicated they were cognitively intact. A physician's order for Resident 310, dated 12/20/25, showed the resident was prescribed fluoxetine 20 mg (an anti-depressant medication) once daily for depression. A review of physician progress notes showed no psychiatric consultations. An activity note for Resident #10, dated 12/29/25, showed the resident did not participate in any activities in December 2025. On 02/11/26 at 8:48 a.m., Resident #10 stated they were depressed and it made them not want to get out of bed. They stated they would miss dialysis because of their depression. On 02/12/26 at 9:57 a.m., CNA #2 stated Resident #10 was easily upset and isolated in their room. On 02/12/26 at 10:02 a.m., LPN #2 stated Resident #10 was not social and stayed in their room. They stated Resident #10 refused dialysis several times. On 02/13/26 at 8:48 a.m., the DON stated any residents on antidepressants with behaviors were sent for a psychiatric consultation. They stated criteria for determining a resident required a psychiatric consultation would be refusing dialysis, isolating in their room, and refusing care. The DON stated Resident #10 should have been seen for psychiatric consultation.

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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, record review, and interview, the facility failed to ensure a medication error rate was less than five percent for 2 (#53 and #56) of 4 sampled residents observed during medication pass. The facility's medication error rate was 7.41%.The administrator identified 63 residents resided in the facility. Findings:1. On 02/12/26 at 8:03 a.m., CMA #1 was observed to administer one tablet of vitamin D3 25 mcg to Resident #56.An Administering Medications policy, dated 04/2019, read in part, Medications are administered in a safe and timely manner, and as prescribe.A physician's order for Resident #56, dated 07/19/23, showed vitamin D3 50 mcg, give one tablet by mouth in the morning for supplement.On 02/12/26 at 11:29 a.m., CMA #1 stated Resident #56 was supposed to receive vitamin D3 50 mcg. They stated they should have given the resident two tablets of the house stock vitamin D3 25 mcg to equal 50 mcg.On 02/12/26 at 11:31 a.m., CMA #1 stated they did not follow the physician's order.2. On 02/12/26 at 8:37 a.m., CMA #2 was observed to administer one tablet of senna (a laxative medication) to Resident #53.A physician's order for Resident #53, dated 10/16/25, showed senna-lax, give two tablets by mouth one time a day related to constipation.On 02/12/26 at 10:06 a.m., CMA #2 stated they gave Resident #53 one tablet of the senna. They stated it was supposed to be two tablets per the physician's order.On 02/12/26 at 11:47 a.m., the DON stated staff were supposed to follow the rights of medication administration and to use the punch, initial, give method. They stated staff were to follow physician's orders.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, record review, and interview, the facility failed to ensure a weekly skin assessment was accurately documented for 1 (#26) of 3 sampled residents reviewed for pressure ulcers and skin conditions.The wound care nurse identified 12 residents had wounds in the facility. Findings:On 02/12/26 at 10:40 a.m., Resident #26 was observed with three open areas to their coccyx and buttocks during an incontinent care observation.A Charting and Documentation policy, revised 07/2017, read in part, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.A physician's order for Resident #26, dated 01/23/26, showed weekly skin assessment every Thursday evening night shift.An admission assessment for Resident #26, dated 01/29/26, showed the resident had diagnoses which included unspecified fracture of sacrum and abnormalities of gait and mobility. The assessment showed the resident's cognition was intact with a BIMS score of 15.A Skin Assessment by Charge Nurse for Resident #26, dated 02/12/26 at 10:58 p.m., showed the resident had no open area and their coccyx was reddened.A skin assessment for Resident #26, completed by the wound care nurse on 02/13/26, showed the resident had stage two open areas to their cerbe and both buttocks. On 02/13/26 at 3:15 p.m., LPN #1 stated the process for weekly skin assessment was to assess the resident's skin from head to toe.On 02/13/26 at 3:20 p.m., LPN #1 stated to their knowledge they did visualize Resident #26's coccyx and buttocks on the 02/12/26 weekly skin assessment. LPN #1 stated they did not do a complete skin assessment.On 02/17/26 at 10:51 a.m., the DON stated nurses were to document only observed findings on the skin assessment.