STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385031	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Crestview of Portland	6530 SW 30th Avenue Portland, OR 97239

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review it was determined the facility failed to ensure medications were properly labeled and expired medications were removed from the cart immediately for 3 of 5 sampled medication carts reviewed for medication. This placed residents at risk for receiving expired medications. Findings include: The facility's 1/2025 Medication Storage/Storage of Medication policy instructed facility staff to immediately remove from stock outdated medications and note the date insulin vials and pens were first used.On 2/11/26 at 12:45 PM the 30/40 hall medication cart was observed to have the following:- One bottle of Fish oil 1000 mg with an expiration of 12/2025- One bottle of Aspirin 325mg with an expiration of 10/2025On 2/11/26 at 12:45 PM Staff 21 (CMA) confirmed the expired dates on the medications and stated they should have been removed and destroyed.On 2/11/26 at 1:14 PM the treatment cart number two was observed to have the following:- One vial of Humalog (insulin) without an open date written on it. The 7/2023 manufacturer's instructions revealed the medications should not be used past 28 days from the open date.- One tub of Eucerin lotion with no expiration date on the container.- One tub of Cetaphil lotion with no expiration date on the container.On 2/11/26 at 1:14 PM Staff 22 (LPN) confirmed the open date was missing on the insulin vial and the expiration dates were missing on the two lotions. She stated the insulin should have an open date but was unsure how long insulin could remain in use. On 2/11/26 at 1:30 PM the station three cart was observed to have the following:- One box of Nystatin powder (antifungal medication) with the expiration date of 12/2024On 2/11/26 at 1:30 PM Staff 14 (RN) confirmed the expiration date, removed the medication from the cart, and stated it would be destroyed. On 2/12/26 at 10:06 AM, Staff 2 (DNS) confirmed open dates should have been written on insulin vials and the medication carts should be checked for regularly before administering medication, powders, and other medications were not expired.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on interview and record review it was determined the facility failed to ensure residents were assessed for safe self-administration of medications for 1 of 5 sampled residents (#3) reviewed for unnecessary medications. This placed residents at risk for unsafe medication administration and adverse medication side effects. Findings include:The facility's Self-Administration of Medications policy, dated 2/2021, indicated the following: -Residents have the right to self-administer medications if the interdisciplinary team determines it is clinically appropriate and safe for the resident to do so. -The interdisciplinary team assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. Resident 3 was admitted to the facility in 6/2025 with diagnoses including fracture of the fourth lumbar vertebra (a break in the bone of the lower spine often causing severe pain or nerve damage). Resident 3's 12/23/25 Significant Change MDS indicated the resident had no cognitive impairment. An 8/11/25 physician order indicated Resident 3 was prescribed melatonin at bedtime with instructions that staff may leave the medication at bedside for Resident 3 to take when ready. Resident 3's 1/2026 and 2/2026 TAR revealed the resident received melatonin each evening. A review of Resident 3's clinical record revealed no evidence a self-administration of medication assessment was completed.On 2/12/26 at 8:28 AM, Resident 3 stated she/he received melatonin at bedtime to help with sleep. Resident 3 stated sometimes when the medication was brought to her/him, she/he was not ready to take the medication, and staff left the medication for her/him to take at a later time. On 2/12/26 at 8:32 AM, Staff 13 (CMA) stated medications could be left at a resident's bedside if the resident was assessed and was determined to be safe to leave the medication. On 2/12/26 at 9:09 AM, Staff 4 (LPN Care Manager) stated Resident 3 did not always want to take her/his melatonin when it was brought to her/him, so she obtained a physician's order to leave the medication at the resident's bedside to take at a later time. Staff 4 stated she did not complete a self-administration of medication because it didn't trigger in her mind. Staff 4 stated she expected a self-administration of medication assessment be completed when residents had medication left at their bedside and acknowledged she should have completed a self-administration of medication assessment on Resident 3 prior to medications being left at the bedside. On 2/12/26 at 2:09 PM, Staff 12 (CMA) confirmed she left melatonin at Resident 3's bedside when the resident stated she/he was not ready to take the medication.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview and record review it was determined the facility failed to obtain consent, assess, monitor and reevaluate a resident for a wheelchair seatbelt for 1 of 1 sampled resident (#60) reviewed for restraints. This placed residents at risk for being restrained. Findings include:Resident 60 was admitted to the facility in 9/2021 with diagnoses including cerebral palsy (a group of life-long neurological disorders appearing in infancy or early childhood that affect movement, muscle tone, posture and balance), stroke, dementia and muscle weakness. Resident 60's 1/17/26 Quarterly MDS indicated the resident used a wheelchair and no restraints were used. Review of Resident 60's clinical record revealed no documentation to indicate the resident was assessed, care planned or monitored for the use of the wheelchair seatbelt. There was no evidence a physician order was obtained, and the risks and benefits of the wheelchair seatbelt were not reviewed with the resident or resident representative since 9/3/24. Resident 60's care plan did not include the use of a wheelchair seatbelt. Observations conducted from 2/9/26 through 2/12/26 between the hours of 8:30 AM and 1:09 PM revealed when Resident 60 was in her/his wheelchair, the resident always had her/his wheelchair seatbelt fastened. On 2/9/26 at 9:49 AM, Resident 60 stated she/he always used her/his wheelchair seatbelt to prevent her/him from falling from the wheelchair. On 2/11/26 at 8:46 AM, Staff 5 (CNA) stated Resident 60 used her/his wheelchair seatbelt to feel more secure when sitting in her/his wheelchair. On 2/11/26 at 9:18 AM, Staff 6 (CNA) stated Resident 60 was supposed to have her/his wheelchair seatbelt fastened when she/he was up in her/his wheelchair and the resident used her/his wheelchair seatbelt to help her/him from sliding down in the wheelchair. 2/11/26 at 12:06 PM, Staff 14 (RN) stated Resident 60 used a wheelchair seatbelt because her/his oxygen fluctuated and Resident 60's wheelchair seatbelt was used to keep her/him in the wheelchair. She reported we usually do a restraint assessment, have a physician's order and care plan the use of a wheelchair seatbelt but was unsure if this was completed for Resident 60. 2/11/26 at 12:25 PM, Staff 3 (RNCM) confirmed Resident 60 used the wheelchair seatbelt and verified there was no physician order, safety device assessment and consent, monitoring or care planning completed for the resident's use of the wheelchair seatbelt. Staff 3 stated her expectations were to have a physician's order in place, a safety device and consent assessment completed quarterly to ensure it was safe for Resident 60 to use the wheelchair seatbelt and care plan interventions established regarding use of the wheelchair seatbelt.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review it was determined the facility failed to ensure dependent residents received showers and necessary care and assistance to maintain good grooming and hygiene for 2 of 3 sampled residents (#s 31 and 68) reviewed for ADLs. This placed residents at risk for lack of personal hygiene and dignity. Findings include: The facility's Activities of Daily Living policy, dated 7/2025, indicated residents who were unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming, personal and oral hygiene. 1. Resident 68 was admitted to the facility in 3/2024 with diagnoses including spinal stenosis (narrowing of the spine) and diabetes. Resident 68's 3/17/24 care plan indicated the resident had mixed bowel and bladder incontinence. Resident 68's 12/21/25 Quarterly MDS indicated the resident had mild to moderate cognitive impairments and required partial to moderate assistance with showering. The 2/6/26 updated shower schedule indicated Resident 68 was scheduled for showers on Sunday and Thursday, evening shift. Resident 68's 1/12/26 through 2/13/26 shower task logs revealed the resident did not receive showers on the following days: -Thursday, 1/15/26. -Sunday, 2/8/26 and -Thursday 2/12/26. A review of Resident 68's Progress Notes from 1/15/26 through 2/13/26 revealed no evidence the resident was provided with additional showering opportunities if showering was refused, or the resident's shower was not provided. Observations conducted from 2/9/26 through 2/13/26 between the hours of 8:21 AM and 2:49 PM revealed Resident 68 wore the same gray sweatpants each day. The resident wore the same dirty, white T-shirt until 2/12/26. Her/his hair appeared greasy and uncombed. On 2/9/26 at 9:59 AM and 2/13/26 at 8:13 AM, Resident 68 stated she/he did not receive showers as scheduled. Resident 68 stated on 2/8/26, she/he was supposed to receive a shower, staff said she/he would be showered but no staff came back so she/he missed her/his shower. Resident 68 also stated her/his shower was not provided on 2/12/26 and guessed staff forgot again. On 2/11/26 at 8:49 AM and 9:14 AM, Staff 5 (CNA) and Staff 6 (CNA) stated Resident 68 did not refuse showers. Staff 6 stated when showers were missed, she reported the missed shower to the charge nurse and would try to provide the resident a shower later that day or the next day. On 2/11/26 at 9:37 AM, Staff 14 (RN) stated residents were assigned specific days for showering and if a resident refused, she would talk with the resident to provide risk and benefits of not showering and try to see if they would accept a bed bath. Staff 14 stated there was an option for PRN showers if a resident refused or missed a shower and somehow the shower was made-up. On 2/11/26 at 12:38 PM, Staff 8 (CNA) stated Resident 68 required one-person assistance with showering, showered twice a week and always accepted showers. Staff 8 stated if a resident refused (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or missed a shower, she reapproached them two or three times, documented the number of times the resident was approached then filled out a form that was given to the charge nurse. Staff 8 stated if a resident missed a shower, they usually had to wait until their next scheduled shower day unless staff was able to complete a PRN shower another day. On 2/12/16 at 9:26 AM, Staff 3 (RNCM) stated residents were scheduled for showers at least twice a week or more, if they preferred. Staff 3 reviewed Resident 68's shower task logs and progress notes and acknowledged the resident missed scheduled showers and the missed showers were not made-up. Staff 3 stated Resident 68 accepted showers and her expectations were Resident 68's missed showers should have been made-up. 2. Resident 31 was admitted to the facility in 1/2025 with diagnoses including congestive heart failure and chronic respiratory failure with hypoxia (lungs cannot adequately transfer oxygen into the bloodstream.) A review of Resident 31's 6/6/25 Annual MDS revealed she/he had severe cognitive impairment and required substantial assistance with personal hygiene tasks. Resident 31's care plan dated 7/2/25 revealed she/he required one person assistance with combing hair and shaving for personal hygiene. On 2/9/26 at 12:14 PM Resident 31 was observed to have excessive visible facial hair and hair that appeared matted, tangled, and secured in a knotted ponytail. Resident 31 stated she/he was unable to shave and comb her/his hair independently because she/he was not able to lift her/his shoulders. On 2/10/26 at 12:41 PM Staff 18 (CNA) stated Resident 31 was total care and staff provided all care for the resident. Staff 18 acknowledged Resident 31's facial hair and the presence of a large knot in the resident's hair. Staff 18 stated the knot made hair care difficult and indicated the resident's hair was hard to wash and comb due to the condition. On 2/10/26 at 1:43 PM Staff 19 (LPN) acknowledged Resident 31 had excessive facial hair and a significant knot in her/his hair. Staff 19 stated Resident 31 was not care planned for grooming related to facial hair or interventions to address the knot in her/his hair. On 2/10/26 at 1:55 PM Staff 4 (LPN Care Manager) stated residents who required assistance with ADLs should receive assistance as needed. Staff 4 indicated she was aware Resident 31 had excessive facial hair and a knot in her/his hair. Staff 4 acknowledged Resident 31 had not consistently received grooming and hygiene care in accordance with her/his needs. On 2/10/26 at 2:07 PM Staff 2 (DNS) acknowledged the resident was observed with excessive facial hair and a large knot in her/his hair. Staff 2 stated staff were responsible for providing personal hygiene and grooming in accordance with the resident's care plan.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview and record review it was determined the facility failed to provide an ongoing person-centered activities program for 2 of 3 sampled residents (#s 35 and 43) reviewed for activities. This placed residents at risk of a decline in psychosocial well-being and diminished quality of life. Findings include: The facility's Activity Program, dated 11/2025, indicated the following: -The Activities Program is provided to support the well-being of resident and to encourage both independence and community interaction. -Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident. -Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs. -Our activity programs consist of individual, small group and large group activities that are designed to meet the needs and interest of each resident. 1.Resident 43 was admitted to the facility in 1/2026 with diagnoses including stroke and dysphagia (difficulty swallowing). Resident 43's 2/2/26 admission MDS indicated the resident was cognitively intact. The MDS also indicated having books, newspapers and magazines to read, being around animals, going outside to get fresh air when the weather was good, and participating in religious services or practices were very important activities to the resident. Resident 43's Activity Profile, initiated on 2/5/26, was reviewed. The Activity Profile contained the resident's name and date of birth ; the remainder of the assessment was incomplete. The record lacked documentation of the resident's activity preferences, interests, customary routines, or individualized needs, preventing the development of a person-centered activity plan. Resident 43's 2/10/26 Activity Care Plan revealed the following: -The resident preferred self-directed activities. -The resident's interests were news and sports. A review of Resident 43's Activity Task Records from 1/27/26 through 2/13/26 revealed the resident participated in one group activity on 2/7/26 and received one-to-one activities on 1/28/26, 2/2/26 and 2/7/26. Observations of Resident 43 from 2/9/26 through 2/13/26 from 8:00 AM to 4:00 PM revealed the resident was in her/his room in bed or sitting in her/his wheelchair. No books, magazines, newspapers were visible in the resident's room. On 2/11/26 at 3:17 PM Resident 43 was observed watching television in her/his room. Resident 43 stated activities were not offered to her/him and indicated she/he would participate in group activities if staff invited her/him. An activity calendar was observed taped to the wall in the (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's room. Resident 43 stated the print was too small to read from a distance. Resident 43 further stated she/he was not informed of the Bible Study held on 2/11/26 at 10:30 AM and stated she/he would have attended if she/he were aware of the activity. On 2/12/26 at 12:29 PM, Staff 8 (CNA) stated Resident 43 spent the majority of her/his time in her/his room in bed. Staff 8 stated she was unaware of any activities or resident preferences and indicated the resident did not participate in social outings. Staff 8 reviewed Resident 43's Kardex (bedside care plan) and confirmed there was no documented information to guide staff regarding the resident's activity interests or preferences. On 2/12/26 ats1:47 PM, Staff 16 (CNA) stated Resident 43 had not participated in group activities and she was unaware of the resident's preferences. Staff 16 reviewed Resident 43's Kardex and confirmed there was no documented information to guide staff regarding the resident's activity interests or preferences. On 2/13/26 at 9:01 AM Staff 4 (LPN Care Manager) stated it was her expectation Resident 43's interests and preferences would be identified upon admission and addressed in a comprehensive care plan. Staff 4 acknowledged Resident 43's interests and preferences were not identified on the resident's care plan. On 2/13/26 at 9:45 AM Staff 2 (DNS) stated the facility was responsible for determining each resident's activity interests and incorporating them into the care plan. Staff 2 confirmed Resident 43 did not have documented interests and preferences and acknowledged activities had not been individualized for the resident. 2. Resident 35 was admitted to the facility in 7/2024 with diagnoses including post-traumatic stress disorder (PTSD, a mental health condition triggered by experiencing or witnessing terrifying, life-threatening or traumatic events that causes persistent symptoms, such as flashbacks, nightmares and severe anxiety). Resident 35's 7/7/25 Significant Change in Status MDS revealed the resident was severely cognitively impaired and the resident's preferred activities included keeping up with the news and having books, newspapers and magazines available to read. Resident 35's 7/22/25 Activity Care Plan revealed the following:-The resident preferred to self-initiate and direct activities. -The resident's self-directed activity pursuits included television, music, bingo and current events. -Staff were to provide the resident with self-directed material as needed/requested. -The resident enjoyed watching the news and football on television. -The resident was not interested in reading. A review of Resident 35's Activity Task Logs from 1/19/26 through 2/13/26 revealed the resident did not participate in a reading activity. Random observations of Resident 35 from 2/9/26 through 2/11/26 between 8:16 AM to 4:04 PM revealed the resident to be in the dining room or in her/his room both awake and asleep. The resident's television played cartoons, and no books, newspapers or magazines were available for the resident to read. On 2/10/26 at 9:50 AM, Witness 1 (Family Member) stated Resident 35 had become less responsive (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	over the past year but still enjoyed watching television. Witness 1 stated he preferred the resident avoid news programming even though it was a preference as it triggered the resident's PTSD. Witness 1 stated Resident 35 liked to watch nature shows and would not choose to watch cartoons. On 2/11/26 at 8:16 AM, Resident 35 was observed in her/his room in her/his wheelchair. Resident 35 stated watching cartoons was a waste of time, and she/he preferred to watch mysteries and studies. Resident 35 was unable to answer additional questions regarding her/his activity preferences and interests. On 2/11/26 at 3:25 PM, Staff 10 (CNA) stated Resident 35 spent most of her/his day sleeping or watching television in her/his room outside of mealtimes. Staff 10 stated the resident enjoyed watching sports on television, was unsure if she/he liked cartoons, and she/he required staff assistance to use the television remote. Staff 10 stated he did not know if the resident liked to read but he could find activity preference information in the resident's care plan. On 2/11/26 at 3:32 PM, Staff 23 (CNA) stated Resident 35 spent her/his time either sleeping or watching television in her/his room. Staff 23 stated she did not really know what the resident liked to watch on television and was unsure of other activity preferences. On 2/11/26 at 3:50 PM, Staff 27 (CNA) stated Resident 35 liked to watch westerns and old television shows. Staff 27 stated the resident never requested to watch cartoons on television. On 2/12/26 at 9:03 AM and 12:38 PM, Staff 24 (CNA) stated Resident 35 enjoyed watching music and sports on television and did not seem to care too much for watching cartoons. Staff 24 stated the resident enjoyed reading books and newspapers. Staff 24 further stated the resident was unable to initiate activities and additional activity preferences were found in the resident's care plan. On 2/12/26 at 9:31 AM and 12:41 PM, Staff 5 (CNA) stated Resident 35's television was on a lot, but he was not sure what the resident liked to watch. Staff 5 stated the resident was unable to self-initiate activities and required staff assistance to change the channel on the television and to turn it on-and-off. Staff 5 stated the resident enjoyed reading the newspaper, Staff 26 (Activity Director) was responsible for distributing newspapers to residents, and he had never seen Resident 35 offered the newspaper. On 2/12/26 at 11:15 AM, Staff 25 (RN) stated he was unsure of Resident 35's television preferences, but they could be found in the resident's care plan. On 2/12/26 at 12:18 PM, Staff 7 (Social Services Director) stated Resident 35 spent her/his day watching television. Staff 7 stated South Park (an adult animated sitcom) was the only cartoon Resident 35 enjoyed. Staff 7 stated Staff 26 was responsible for distributing newspapers, she did not know if Resident 35 enjoyed reading the newspaper, and she could not recall the last time she saw the resident with a newspaper. Staff 26 was not available for an interview. On 2/12/26 at 1:03 PM, Staff 1 (Administrator) acknowledged Resident 35's activity care plan was in need of revision as the resident was no longer able to self-initiate activities. Staff 1 stated television programming should be selected according to resident preference, and she/he acknowledged that cartoons were not Resident 35's preference. Staff 1 further stated newspapers were delivered to the facility four days a week and should be distributed to residents with an expressed interest.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review it was determined the facility failed to ensure staff followed care plans related to fall safety for 3 of 3 sampled residents (#s 3, 6 and 35) reviewed for falls. This placed residents at risk for continued falls and potential injury. Findings include: The facility's Falls and Fall Risk Managing policy, dated 10/2025, indicated the following: -Based on previous evaluations and current data, staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. -The staff, with the input of the provider, would implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. 1. Resident 3 was admitted to the facility in 6/2025 with diagnoses including fracture of the fourth lumbar vertebra (a break in the bone of the lower spine often causing severe pain or nerve damage). Resident 3's Morse Fall Scale (an evidence-based assessment of a resident's fall risk) completed on 7/25/25, 8/12/25, 9/5/25, 9/15/25, 10/29/25, 12/1/25, 12/9/25, 12/15/25, 12/22/25 and 2/5/26 indicated the resident was at high risk for falling. Resident 3's 12/23/25 Significant Change MDS indicated the resident had no cognitive impairment, was dependent for toileting, required partial to moderate assistance to come to a standing position from sitting to standing, required partial to moderate assistance for transferring to and from a bed to a chair or wheelchair and Resident 3 had two or more falls since admission or prior assessment. Resident 3's Fall CAA indicated the resident had several falls since admit due to loss of balance and getting up unassisted. Resident 3 was cooperative with care and utilized her/his call light. Current interventions included ensuring the call light and grabber were within reach. Resident 3's fall investigations for the past six months revealed the resident experienced the following falls: -8/11/25;-9/4/25; -10/12/25;-10/29/25;-11/14/25;-11/30/25;-12/9/25;-12/15/25 and-12/19/25. Resident 3's fall care plan indicated the resident was at risk for falls due to weakness, impulsivity, mixed incontinence, known to self-transfer, need for assistance and history of falls. The following care plan interventions were in place: -Keep bed in low position except during care. Initiated 6/10/25. -call, don't fall sign in resident's line of sight. Initiated 8/12/25. -Ensure grabber is within the resident's reach. Initiated 12/22/25. -Falling star program to alert staff of high risk for falls. A management risk form was completed which allowed the resident to keep her/his door shut due to noise. Initiated 9/5/25 and revised on 1/16/26. Observations from 2/9/26 through 2/13/26 revealed the following: -2/9/26 at 9:22 AM, Resident 3's bed was in the high position, her/his grabber was on a dresser which was in the corner, across the room, out of reach of the resident. No call, don't fall sign was posted in the resident's room. There was no yellow falling star sign posted outside the room, by the resident's door nameplate. -2/10/26 at 12:56 PM, 2:41 PM and 3:33 PM, Resident 3's bed was in the high position, her/his grabber was on a dresser which was in the corner, across the room, out of reach of the resident. No (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	call, don't fall sign was posted in the resident's room. There was no yellow falling star sign posted outside the room, by the resident's door nameplate. -2/11/26 at 8:26 AM, 1:02 PM and 2:22 PM, Resident 3's bed was in the high position, her/his grabber was on a dresser which was in the corner, across the room, out of reach of the resident. There was no yellow falling star sign posted outside the room, by the resident's door nameplate. There was no call, don't fall sign posted in the resident's room until the 1:02 PM observation. During the 8:26 AM observation, Staff 5 (CNA) came into Resident 3's room to bring her/him a menu, Resident 3's bed was in the high position, and Staff 5 did not offer to lower the resident's bed to a low position. -2/11/26 at 11:05 AM and 12:01 PM, Resident 3 was in the dining room with no grabber available to her/him. -2/12/26 at 8:32 AM and 11:55 AM, Resident 3's bed was in the high position, her/his grabber was on a dresser which was in the corner, across the room, out of reach of the resident. There was no yellow falling star sign posted outside the room, by the resident's door nameplate. -2/13/26 at 8:29 AM, Resident 3's bed was in the high position. There was no yellow falling star sign posted outside the room, by the resident's door nameplate. On 2/9/26 at 1:22 PM, 2/11/26 at 8:18 AM and 1:03 PM, 2/12/26 at 8:32 AM and 11:55 AM, Resident 3 reported she/he experienced several falls since her/his admission. Resident 3 stated she/he used to have a yellow falling star sign outside of her/his door, but she/he did not want to have the room door left open because of the screamer and the guy next door who yelled frequently and the next thing I know the yellow sign was gone. Resident 3 stated she/he did not know where her/his grabber was, but she/he was supposed to use the grabber if something fell on the floor because one of her/his falls happened when she/he bent over to pick up an item that fell on the floor. Resident 3 stated staff often left her/his bed in the high position after completing care and a call, don't fall sign used to be posted in her/his other room but was not in her/his current room, which she/he was in for the past several months. On 2/11/26 at 1:03 PM, Resident 3 stated someone posted a call, don't fall sign on the wall when she/he was out of the room. On 2/11/26 at 8:33 AM, Staff 5 stated Resident 3 had a few falls. He stated the resident's fall interventions consisted of staff reminding the resident to use her/his call light and checking on the resident since her/his door was always closed. On 2/11/26 at 9:20 AM, Staff 6 (CNA) stated all residents determined to be at high risk for falling, had yellow signs with a star on it posted outside their doors and that is how we know which residents are considered high fall risks. Staff 6 reported Resident 3's bed should always be in the low position and her/his call light within reach. Staff 6 was not aware of additional fall precautions for Resident 3. On 2/11/26 at 12:44 PM, Staff 8 (CNA) stated she learned Resident 3 was at high risk for falling when the resident recently mentioned it during care. Staff 8 reported residents at high risk for falling had a yellow falling star sign posted outside their doors to alert staff of the resident's high fall risk and some residents had call, don't fall signs visible in their rooms to help them remember they needed assistance when transferring. Staff 8 was unsure of Resident 3's specific fall precautions. On 2/11/26 at 3:18 PM, Staff 10 (CNA) stated Resident 3 was considered at high risk for falling and had a yellow falling star sign outside her/his door. Staff 10 went to Resident 3's room and confirmed (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there was no falling star sign present. Staff 10 was unaware of Resident 3's specific fall precautions with the exception of reminding her/him to utilize the call light. On 2/12/26 at 8:32 AM, Staff 13 (CMA) stated residents who were at risk for falling had a yellow sign outside of their door. Staff 13 went to Resident 3's room and confirmed the resident's grabber was on a dresser which was in the corner, across the room, out of reach of the resident and there was no yellow sign outside of Resident 3's door. Resident 3 reported to Staff 13 that staff often left her/his bed in the high position after providing care and the call, don't fall sign had not been posted since she/he moved rooms several months ago, until 2/11/26. Staff 13 confirmed Resident 3's bed was supposed to be in the low position. On 2/12/26 at 8:53 AM, Staff 3 (RNCM) stated Resident 3 had several falls in the past few months, was considered a high fall risk and the resident's primary fall interventions included keeping the bed in the lowest position except during care, having her/his grabber within reach and having a call, don't fall sign posted. Staff 3 reported Resident 3's yellow falling star sign was removed because the resident wanted her door closed at all times, so the resident no longer met the criteria for the falling star program. Staff 3 confirmed there was no call, don't fall sign posted in the resident's room but she placed one in Resident 3's room, yesterday. Staff 3 stated her expectations were staff needed to provide fall interventions as care planned. 2. Resident 6 was admitted to the facility in 3/2024 with diagnoses including repeated falls. Resident 6's 10/21/25 At Risk for Falls Care Plan revealed the resident's bed was to be kept in a low position at all times outside of when care was provided. Resident 6's 1/29/26 Fall Risk Evaluation revealed the resident was at high risk to fall. Resident 6's 2/3/26 Quarterly MDS revealed the resident was cognitively intact and did not have a fall since her/his prior assessment. On 2/11/26 at 11:42 AM, Resident 6 was observed in her/his bed asleep. The resident's bed was positioned between knee-to-waist height. Staff 15 (Infection Preventionist), Staff 14 (RN) and Staff 4 (RNCM) were present in the resident's room assisting the resident's roommate. No staff were observed to encourage Resident 6 to lower her/his bed. On 2/11/26 at 12:44 PM, Staff 28 (CNA) stated Resident 6 was at risk to fall as she/he liked to lean over the side of the bed a lot. Staff 28 stated the resident's bed should always be in the lowest position. On 2/12/26 at 8:42 AM, Resident 6 was observed in her/his room in bed. The resident's bed was at waist height. Staff 5 (CNA) lowered the resident's head of bed per the request of the resident and exited the room without assisting or encouraging the resident to lower the rest of her/his bed. On 2/12/26 at 8:55 AM, Staff 24 (CNA) stated Resident 6 was at risk to fall. Staff 24 stated interventions to prevent resident falls were found in the resident's care plan, and Resident 6's bed was to be in a low position when occupied because of her/his history of falls. On 2/12/26 at 9:24 AM, Staff 5 stated he was not aware of any interventions to prevent falls for Resident 6 outside of encouraging her/him to wear non-skid socks or shoes when transferring. Staff 5 stated he preferred to keep Resident 6's bed at waist height. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/26 at 11:12 AM, Staff 25 (RN) stated Resident 6's bed was to be kept in the lowest position when occupied as she/he had a history of a fall. Staff 25 observed Resident 6 in bed and confirmed the resident's bed was at waist height. Staff 25 further stated the resident's bed was a little high and he would want it lower. On 2/12/26 at 1:47 PM, Staff 4 stated Resident 6's bed should be kept in a low position when occupied. Staff 4 further stated staff should encourage the resident to lower her/his bed when observed to be in a high position as the resident was able to independently use her/his bed remote. 3. Resident 35 was admitted to the facility in 7/2024 with diagnoses including history of falls. Resident 35's 10/20/25 At Risk for Falls Care Plan revealed the resident's bed was to be kept in a low position at all times outside of when care was provided. Resident 35's 1/5/26 Fall Risk Evaluation revealed the resident was at high risk to fall. Resident 35's 1/7/26 Quarterly MDS revealed the resident was severely cognitively impaired and experienced a fall since her/his prior assessment. On 2/9/26 at 10:20 AM, 2:13 PM and 3:36 PM, Resident 35 was observed in her/his room in bed. The bed was positioned at waist height. On 2/11/26 at 3:25 PM, Staff 10 (CNA) stated Resident 35 was at risk to fall and her/his bed height should be on the lower side. On 2/11/26 at 3:32 PM, Staff 23 (CNA) stated Resident 35 was not considered at risk to fall, she did not know if the resident experienced any falls, and she did not know what height the resident's bed should be kept at when she/he was in bed. On 2/12/26 at 9:03 AM, Staff 24 (CNA) stated Resident 35 fell a couple of times in the past, and as a result, the resident's bed was to be kept in a low position. On 2/12/26 at 9:31 AM, Staff 5 (CNA) stated Resident 35's bed should be kept in the lowest position as she/he will try to crawl out of bed when anxious. On 2/12/26 at 11:15 AM, Staff 25 (RN) stated Resident 35 was considered at risk to fall and her/his bed should be kept in a low position when occupied. On 2/12/26 at 1:47 PM, Staff 4 (RNCM) stated Resident 35 had a history of falls, and her/his bed was to be kept in the lowest position. Staff 4 stated the resident's bed should not be at waist height when occupied.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on observation, interview and record review it was determined the facility failed to ensure residents who were trauma survivors received trauma-informed care for 1 of 1 sampled resident (#35) reviewed for mood. This placed residents at risk for re-traumatization and decreased quality of life. Findings include:The facility's 8/2025 Trauma-Informed and Culturally Competent Care Policy instructed the following:-All residents were screened for possible exposure to traumatic events. -The initial screening was utilized to identify the need for further assessment and care.-Individualized care plans were developed to address past trauma in collaboration with the resident and family, as appropriate. -The care plan was to identify and decrease exposure to triggers that may re-traumatize the resident and incorporate language needs, culture, cultural preferences, norms and values. Resident 35 was admitted to the facility in 7/2024 with diagnoses including post-traumatic stress disorder (PTSD, a mental health condition triggered by experiencing or witnessing terrifying, life-threatening or traumatic events that causes persistent symptoms, such as flashbacks, nightmares and severe anxiety). Resident 35's 7/4/24 Trauma Informed Care Evaluation completed by Staff 7 (Social Services Director) revealed the resident did not want to complete the assessment and/or stated she/he had not experienced trauma. Resident 35's 7/10/24 Trauma Care Plan revealed the following interventions to address the resident's PTSD:-Develop trust by being forthright with the plan of care, inform of intentions during interactions, do not startle, announce presence and tell the resident your name and why you were there. -Empowerment to achieve goal and focus on strengths. -If triggered, inform the nurse, keep a comfortable distance and do not encroach on personal space. Remind the resident she/he was safe, draw attention to environment and offer water. -Stop direct care if the resident was uncomfortable. Discuss action to be taken and allow the resident to attempt as desired. Offer assistance as needed. -Self-reported Trauma History Questionnaire was provided. Resident 35's 7/22/25 Activity Care Plan revealed the resident enjoyed listening to patriotic music, watching the news and she/he served in the military.Resident 35's 1/7/26 Quarterly MDS revealed the resident experienced severe cognitive impairment and had an active diagnosis of PTSD.Resident 35's 1/12/26 Social Service Quarterly Review revealed the resident experienced episodes of anxiety often for which she/he received psychotropic medications. On 2/9/26 at 10:20 AM, Resident 35 was observed in her/his room asleep in bed. Following the surveyor's knock on the door, the resident yelled out multiple times with her/his eyes closed but did not awaken.On 2/10/26 at 9:55 AM, Witness 1 (Family Member) stated Resident 35 experienced PTSD as a result of her/his military service. Witness 1 stated the resident had not slept well for decades as a result of the nightmares she/he experienced which centered around the resident's belief she/he was still in the war. Witness 1 stated it was helpful for staff to enter the resident's room quietly as she/he startled with louder noises. Witness 1 stated Resident 35's trauma triggers also included listening to the news, any discussion about war or the military and seeing her/his military uniform. Witness 1 stated he had not spoken to anyone at the facility about Resident 35's specific trauma triggers because staff were aware of the resident's military background and had access to the resident's health records. On 2/11/26 at 3:25 PM, Staff 10 (CNA) stated Resident 35 experienced anxiety when she/he turned from side-to-side in bed. Staff 10 stated he was unaware of the resident's trauma history or of any potential trauma triggers but stated this information could be found in the resident's care plan.On 2/11/26 at 3:32 PM, Staff 23 (CNA) stated she was unaware of Resident 35's service in the military and did not know if conversations about the military were appropriate to have with the resident. Staff 23 stated resident-specific trauma triggers were found in the resident's care plan. On 2/12/26 at 9:03 AM, Staff 24 (CNA) stated Resident 35 had high anxiety, confusion and delusions, and any task, even a simple task such as washing the resident's face caused her/him anxiety. Staff 24 stated she was able to minimize the resident's anxiety when she explained every step of the task to the resident, took her time with the resident and reminded her/him she was not out to get [her/him]. Staff 24 stated she (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	avoided conversations about the military and war with the resident because they definitely caused anxiety and scared the resident. Staff 24 stated she was unsure if watching the news triggered the resident's PTSD but she would look in the resident's care plan to find this information in addition to other resident-specific trauma triggers.On 2/12/26 at 9:31 AM, Staff 5 (CNA) stated he was not sure what caused Resident 35's anxiety, but he did know the resident was in the military and fought in a war. Staff 5 stated the resident woke up scared at least weekly talking about being in the military and being tortured. Staff 5 stated he did not approach the resident when she/he was resting or appeared asleep because when he did, the resident would wake up, believe she/he was in the military and yell and jump, even with a gentle tap to wake up. Staff 5 stated the resident previously requested medication to help with her/his feelings of anxiety but no longer did so on account of her/his decline in cognition. Staff 5 further stated he was unsure if military movies or watching the news would trigger the resident, but he would look in the resident's care plan to find additional trauma triggers. On 2/12/26 at 11:15 AM, Staff 25 (RN) stated Resident 35 experienced a lot of PTSD. Staff 25 stated the resident experienced nightmares about her/his war experience. Staff 25 stated he tried to create a supportive environment for the resident when she/he experienced a nightmare, which did not seem to help but did not exacerbate the resident's anxiety around her/his PTSD. Staff 25 stated he was unsure if resident-specific trauma triggers were listed in the care plan. On 2/12/26 at 12:18 PM, Staff 7 stated she completed the initial trauma evaluations for all residents in order to get an understanding of resident-specific traumas, triggers and potential coping strategies that she included in the residents' care plans. Staff 7 stated she completed a generalized care plan for residents with a diagnosis of PTSD who declined to complete the initial trauma evaluation. Staff 7 stated she completed Resident 35's initial trauma evaluation. Staff 7 stated she was aware the resident served in the military, but she was unable to get a clear understanding of the resident's trauma from the resident. Staff 7 stated she did not reach out to the resident's family to get a more thorough understanding of the resident's trauma and potential trauma triggers. Staff 7 stated she was unaware the resident experienced nightmares as a result of her/his past trauma and was unsure if conversations about her/his military service or watching the news were potential trauma triggers. On 2/12/26 at 1:03 PM, Staff 1 (Administrator) stated she expected residents with a diagnosis of PTSD or a history of trauma to have care plans that included resident-specific trauma triggers and interventions. Staff 1 stated Resident 35's trauma care plan was general and did not include specific trauma triggers, interventions or activities to avoid.

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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, and record review, it was determined the facility failed to ensure a medication error rate of less than five percent. There were 2 errors out of 25 medication administration opportunities, resulting in an 8% error rate. This placed residents at risk of receiving a sub-therapeutic medication dose and reduced medication efficacy. Findings include:The 2020 insulin NPH (Humulin N) KwikPen Manufacturer Instructions For Use and the 2014 insulin aspart FlexPen Manufacturer Patient Fact Sheet - How To Use FlexPen indicated the insulin pens should be primed with two units of insulin prior to each administration to ensure the correct dose was delivered.Resident 9 was admitted to the facility in 1/2026 with diagnoses including aftercare following a liver transplant. Resident 9's 1/26/26 admission MDS indicated the resident was cognitively intact.Resident 9's 2/2026 Physician Orders included the following:- insulin NPH (an intermediate-acting medication for diabetes) 100 units/ml inject 21 units in the morning.- insulin aspart (a fast-acting medication for diabetes) 100 units/ml 15 units before meals. - insulin aspart 100 units/ml 4 units with meals per sliding scale.On 2/10/26 at 7:32 AM Staff 17 (LPN) administered insulin NPH and insulin aspart to Resident 9 and did not prime the insulin pens prior to administration.On 2/10/26 at 7:32 AM Staff 17 acknowledged they did not prime the insulin pens prior to administration and expressed they were not aware priming was required. 02/11/2026 8:15 AM Staff 2 (DNS) was notified Resident 9's insulin pens were not primed prior to administration. Staff 2 stated they expected all nursing staff to prime insulin pens prior to administering insulin.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review it was determined the facility failed to provide appetizing and palatable food for 1 of 2 sampled residents (#43) reviewed for food. This placed residents at risk for unmet nutritional needs and poor intake. Findings include: The facility's Food and Nutrition Services Policy, dated 10/2017, indicated the following: Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.Resident 43 was admitted to the facility in 1/2026 with diagnoses including stroke and dysphagia (difficulty swallowing). On 2/9/26 at 2:17 PM, Resident 43 stated she/he was on a puree diet, and it was yuck, everything was bland, and the potatoes tasted like powder.A review of the 2/11/26 lunch menu revealed the facility was to provide: [NAME] herbed baked chicken, roasted red potatoes, cauliflower au gratin, dinner roll with margarine, pumpkin cake with whipped topping and beverage.On 2/11/26 at 11:34 AM kitchen meal service was observed. Staff prepared rosemary herbed chicken, roasted red potatoes, cauliflower au gratin, dinner roll with margarine and pumpkin cake with whipped topping were observed to be served. The chicken appeared overcooked. A test tray was requested.On 2/11/26 at 1:38 PM, the test tray for puree diets was sampled with the following findings:-rosemary herbed chicken was bland in taste and lacked visual appeal.-cauliflower au gratin was bland in taste and lacked identifiable characteristics.-dinner role was doughy and lacked visual appeal.-pumpkin cake with whipped topping was bland in taste and lacked visual appeal. On 2/12/26 at 11:45 AM, a test tray for puree diets was sampled with the following findings:-braised roast pork was bland and was not identifiable by taste.-garlic green beans were bland. -dinner role was doughy and lacked visual appeal.-sherbet cup was bland with no flavor. On 2/12/26 at 11:54 AM, Staff 1 (Administrator) was asked to test the meal. Staff 1 stated the braised roast pork did not taste consistent with the menu item and stated the green beans were not identifiable by taste. Staff 1 further stated the meal presentation was not good and indicated it was her expectation for residents to be informed of the food items served. On 2/13/26 at 7:43 AM Resident 43 stated the breakfast meal was bland, stated she/he was unable to identify the scrambled eggs, and stated the biscuits and gravy tasted like cornmeal mush, resulting in the resident not consuming the biscuits and gravy. On 2/13/26 at 7:57 AM Staff 20 (Dietary Manager) stated she was aware concerns existed with the appearance of puree diets and acknowledged puree meals did not always present well. Staff 20 stated it was the facility's responsibility to ensure meals were palatable and visually appealing. Staff 20 acknowledged the kitchen needed to improve puree meal quality, including flavor and presentation.