STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385049	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbia Basin Care Facility	1015 Webber Street The Dalles, OR 97058

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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 0880 Level of Harm - Immediate jeopardy to resident health or safety 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, interview and record review it was determined the facility failed to properly disinfect glucose monitors with approved disinfectant wipes between resident uses for 3 of 3 halls reviewed for CBG monitoring. This failure placed residents at risk for blood borne infection. The deficient practice was determined to be an Immediate Jeopardy (IJ) situation. Resident 1 had an active diagnosis of Hepatitis C, and received CBG checks from a community use glucometer, which was not properly sanitized before use with other residents. Findings include:The facility's 10/2011 Obtaining a Fingerstick Glucose Level Policy indicated, Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice.A 9/2024 Arkray Technical Brief Manufacturer Manual indicated, Disinfect common use glucometers with the use of approved disinfectant wipes. The glucometer was to be wiped with the disinfecting wipe and left wet for two minutes to ensure disinfection. Resident 1 was admitted to the facility on [DATE] with diagnoses including Hepatitis C (a viral and potentially deadly infection that affects the liver).12/2025 and 1/2026 MARs indicated Resident 1 received blood glucose monitoring before meals and at bedtime. On 1/27/26 from 11:03 AM through 11:33 AM, Staff 7 (LPN) used a single shared Arkray glucometer to check the CBGs for residents on the [NAME] hall and North hall. Between each resident, Staff 7 wiped the glucometer with an alcohol prep pad that was saturated with 70% isopropyl alcohol, which was not an acceptable disinfecting wipe based on manufacturer recommendations.On 1/27/26 at 11:26 AM, Staff 7 stated she was the primary nurse responsible for checking CBGs for the entire facility that day. Staff 7 stated she used alcohol wipes to disinfect the glucometers after each use. Staff 7 stated she was instructed to clean the glucometer with the alcohol wipe. Staff 7 stated no residents had their own glucometer for CBG checks. On 1/27/26 at 11:58 AM, Staff 15 (LPN) stated blood glucose monitors were shared between residents and he used approved disinfecting wipes to disinfect the glucometer after resident use. On 1/27/26 at 12:58 PM Resident 1 stated Staff 7 checked her/his blood sugar daily. On 1/27/26 at 1:49 PM, Staff 2 (DNS) stated she was unaware staff used alcohol pads to disinfect the blood glucose monitors. Staff 2 expected staff to use approved disinfecting wipes to sanitize the glucometer after each resident use. Staff 2 acknowledged using alcohol pads to disinfect glucometers was not sufficient. A facility census provided by Staff 2, dated 1/27/26, indicated there were 18 residents who received daily CBG checks, including Resident 1. On 1/27/26 at 3:57 PM, the facility administrative staff, including Staff 1 (Administrator), and Staff 2 were notified that the deficient practice related to the failure to properly disinfect the common use glucometer constituted an Immediate Jeopardy (IJ) situation and were provided a copy of the IJ Template. On 1/27/26 at 6:17 PM an acceptable plan to remove the IJ situation was submitted by the facility. The plan indicated the facility would implement the following actions:-All glucometers were removed from use and disinfected. Facility-approved EPA registered disinfectant wipes approved for blood glucose monitoring equipment were implemented immediately.-All licensed nurses working were immediately re-educated and competency-validated on proper glucometer cleaning, disinfection, and standard precautions on 1/27/26. All other licensed nurses would be educated and observed prior to their next scheduled shift. -Supplies of approved disinfectant wipes were stocked on all medication (continued on next page)

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

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	carts and treatment areas to ensure immediate access. -Competency-based training on CBG monitoring and infection prevention was implemented for all licensed nurses, medication aides and new hires during orientation. -Visual reminders and laminated instruction cards outlining proper glucometer cleaning steps were placed on medication carts. -The DNS or designee and the Infection Preventionist will conduct direct observational audits of CBG monitoring practices five times a week for two weeks, once a week for two months and quarterly thereafter. -Audit results will be reported to the QAPI Committee and reviewed at monthly Governing Body meetings.From 1/27/26 through 1/28/26 the IJ removal plan was verified as implemented by the survey team. No additional concerns related to the IJ situation were noted.

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F 0691 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to provide necessary care and services for ileostomy (surgical opening in the abdominal wall that provides a way for the end of the small intestine to release stool) care for 1 of 1 sampled resident (#13) reviewed for bladder and bowel incontinence. This failure resulted in the Resident 13 experiencing excoriation (a skin injury involving the removal of skin), increased pain and discomfort, unmet ileostomy care needs, a delay in medical care and psychosocial harm. Findings include: The facility's 1/1/26 Ostomy (an artificial opening in an organ of the body, created during an operation) Care Policy instructed the following: -Ostomy care will be provided by licensed nurses under the orders of the attending physician.-The resident's goals and preferences for care and treatment of the ostomy will be used to formulate a plan of care for the ostomy. -The frequency of pouch changes and the products required for changing ostomy devices will be noted on the resident's person-centered care plan. -Direct care staff members will observe and respond to any signs of resident's discomfort about the ostomy or its care.-The surrounding skin of the ostomy will be monitored for excoriation (the act of scratching, rubbing or scraping the skin, often leading to raw, irritated lesions, sores, or wounds), abrasion (a superficial wound caused by the skin rubbing or scraping against a rough surface) and breakdown. Changes in the pouching system or frequency of pouch changes will be made, as appropriate. -The comprehensive care plan will reflect any special products or pouching techniques needed to prevent or manage any skin breakdown surrounding the ostomy. -For ongoing pouching problems or other problems associated with the ostomy, appropriate referrals will be made. Resident 13 was admitted to the facility in 1/2026 with diagnoses including the presence of an ileostomy.Resident 13's 1/6/26 Hospital Notes revealed the resident underwent a conversion of a gastric sleeve to a Single Anastomosis Duodeno-Ileal Bypass with Sleeve Gastrectomy (SADI-S, a revisional two-part surgery that modifies a previous sleeve gastrectomy to increase weight loss and improve metabolic issues) in 12/2025, which contributed to the resident receiving an ileostomy. Resident 13's 1/9/26 Hospital Discharge Orders and Instructions revealed the following:-Witness 1 (Bariatric Surgeon) was the resident's admitting and attending provider during her/his hospitalization. -The provider was to be contacted with any abnormal redness or other symptoms of concern. -Information on how to contact the provider included contact information for the resident's Bariatric Surgery Team. -An appointment was to be scheduled with the resident's primary care provider in one-to-two weeks for management of the resident's chronic conditions and home medication management. Resident 13's 1/9/26 Nursing admission Screening completed by Staff 8 (RN) did not indicate the resident experienced any skin issues. The Screening directed the reader to the Skin Observation Assessment. No Skin Observation Assessment was completed on 1/9/26.Resident 13's 1/10/26 Physician Orders directed the following:-The ostomy pouch was to be removed with adhesive remover.-The resident's skin was to be cleansed with warm water and dried thoroughly. -Stoma powder was to be applied onto red skin irritation.-The powder was to be dabbed with Cavilon skin prep (a liquid film-forming skin protectant that dries quickly to form a breathable, transparent, waterproof coating on the skin). -A barrier ring was to be placed around the stoma in a double layer with the inner edge of the ring caulked with paste. -A medium fistula pouch (a specialized, adhesive and usually drainable appliance designed to cover an abnormal opening between an internal organ and the skin) was to be applied with a hole cut to offset the pouch away from the midline incision. -The ostomy pouch was to be changed as needed for leakage. -The resident was to receive a head-to-toe skin observation weekly. All existing and new skin issues were to be documented and a summary provided.A review of Resident 13's TAR from 1/10/26 through 1/25/26 revealed the resident required her/his ostomy to be changed at least one time per shift on 14 different shifts, and the changes on five of the shifts were noted to be ineffective. (continued on next page)

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F 0691 Level of Harm - Actual harm Residents Affected - Few	A 1/11/26 Skin Observation Tool completed by Staff 10 (RN) revealed Resident 13 had an abdominal surgical site in the healing stage. The Tool revealed the resident's surgical site was under her/his navel, and she/he also had a feeding tube and ostomy. No additional details about the resident's skin were documented. A 1/12/26 Telemedicine Visit completed by Staff 17 (NP) revealed Resident 13 experienced a lot of pain, and as a result, new pain medication orders were provided. Staff 17 indicated the resident's skin that was visible was warm, dry and free of rashes. The Visit indicated any skin-related concerns could be found in the nursing assessment. Resident 13's 1/15/26 admission MDS revealed the resident was cognitively intact, had an ostomy and surgical wound, experienced occasional pain and participated in physical therapy. The Functional Abilities CAA revealed the resident required assistance managing her/his ostomy bag. Resident 13's 1/15/26 Wound Management Care Plan revealed the following:-The resident had a new ileostomy.-Staff were to monitor the ileostomy and abdominal surgical opening for redness, increased temperature, induration (hardening and thickening of skin tissue) and drainage. Concerns were to be reported to the resident's primary care physician. -The provider was to be notified if no signs of improvement on current wound regimen.-Provide wound care per treatment order. A 1/17/26 Progress Note revealed Resident 13 was transferred to the emergency department per her/his request due to increased abdominal pain located near her/his ileostomy site. The ileostomy site and abdominal skin was noted to be free of redness with an ostomy bag in place and functioning at the time of her/his transfer. A 1/17/26 Emergency Department Note indicated Resident 13's ostomy was functioning and without signs and symptoms of an infection. A 1/18/26 Skin Observation Tool completed by Staff 14 (LPN) revealed Resident 13 had a rash on her/his right, front iliac crest (located just below the waistline). No additional details about the rash were provided. A 1/18/26 Progress Note written by Staff 11 (RN) indicated Resident 13 had a rash around her/his colostomy bag, and the bag was changed twice during the shift due to leakage. A 1/20/26 Progress Note revealed Resident 13's ostomy bag was leaking and repaired with tape. Resident 13's 1/2026 TAR revealed a weekly head-to-toe skin observation was completed by Staff 7 (LPN) on 1/21/26. A plus (+) sign was documented on the TAR, but no summary or note was found related to the resident's skin on 1/21/26. A review of Resident 13's Physical Therapy Notes revealed the resident was either not appropriate or unable to participate in therapy due to issues with her/his ostomy bag, including the bag not sealing and the bag needing to be removed due to skin irritation, on 1/21/26, 1/22/26 and 1/23/26. On 1/24/26 the resident's participation was limited as she/he refused to change position, ambulate or toilet on account of the issues with her/his ostomy bag.A 1/22/26 and 1/23/26 Progress Note revealed Resident 13's ostomy bag was off at this time due to excoriation and awaiting supplies. A 1/23/26 Telemedicine Visit completed by Staff 23 (Medical Director) indicated Resident 13 had burning on her/his skin around the ileostomy bag related to leaking stool, and she/he had a red rash to the right abdomen around the ileostomy bag near the tape and at the skin folds. Staff 23 ordered Silvadene cream (a prescription topical antibiotic cream used to prevent and treat wound infections in second-and-third-degree burns) to be applied around the ileostomy bag three times a day for five days. A 1/24/26 Progress Note revealed Resident 13's ostomy bag was changed twice during the shift related to leakage. A 1/25/26 Progress Note revealed Resident 13's ostomy bag was repaired at different instances due to leakage because there was no more bags left.A 1/25/26 Skin Observation Tool completed by Staff 14 documented a rash to Resident 13's front, right iliac crest that was being treated with Silvadene. No additional details about the rash were provided. On 1/26/26 at 10:28 AM, Resident 13 was observed in her/his room reclined in an armchair with an incontinence brief covering her/his abdomen. Resident 13 stated the facility ran out of ostomy bags because staff can't get the bags to stick. Resident 13 stated the ostomy bags did not stay on long because her/his stoma was surgically put in a difficult place. Resident 13 stated the facility ran out of ostomy supplies twice since her/his admission, and a result, she/he went days using an incontinent brief or pad to cover the site and to absorb the leakage. Resident 13 stated the briefs and pads did not fully absorb the leaking stool which resulted in the (continued on next page)

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F 0691 Level of Harm - Actual harm Residents Affected - Few	thicker stool just sitting on top of the skin. Resident 13 began to cry and stated her/his skin was so excoriated and it burned. On 1/26/26 at 11:50 AM, Resident 13 stated Staff 7 just put on a new ostomy bag, but it was already leaking. Resident 13 stated she/he was pouring shit everywhere. Resident 13 stated she/he reported the leakage to Staff 12 (LPN) and was told she/he would have to wait until after lunch to have the bag replaced. Brownish-green stool was observed to leak out of the right and left sides of the resident's ileostomy at this time. The skin surrounding the resident's ileostomy was observed to be bright red extending approximately five-to-six inches around the entirety of the ostomy along with a scattered red rash. In tears, Resident 13 stated it was an awful feeling, especially as it [stool] goes over that burnt skin. On 1/26/26 at 12:04 PM, Staff 7 yelled from the hallway into Resident 13's room that she had 800 things to do and then would be back to fix the ostomy. A 1/26/26 Progress Note written at 1:55 PM indicated Witness 1 was contacted regarding the concerns with Resident 13's ileostomy. The Note further indicated a picture of the resident's abdomen was provided to Witness 1, which resulted in Witness 1 directing the resident to return to the hospital. On 1/26/26 at 4:50 PM, Resident 13 stated she/he was being readmitted to the hospital on [DATE]. Resident 13 stated she/he experienced slight redness around her/his ostomy during her/his initial hospitalization, but the site had become bright red and burned since her admission to the facility. Resident 13 stated it hurts to move on account of the burning pain that is constant. Resident 13 stated she/he stopped participating in physical therapy because her/his bag constantly leaked. Resident 13 stated with tears in her/his eyes that she/he was embarrassed by the constant stool leaking, and she/he felt gross and like a burden. Resident 13 stated it sucked that the facility ran out of ostomy bags and they should have ordered more if they knew they weren't sticking instead of two little boxes. Resident 13 further stated she/he was so exhausted because every time she/he tried to sleep, the ostomy leaked, and she/he had to stay awake to hold it. On 1/27/26 at 8:30 AM, Resident 13 was observed in her/his room reclined in an armchair. The floor surrounding the right side of the resident's armchair was covered in stool-stained washcloths. Resident 13 covered her/his ileostomy with a washcloth that was soaked in stool. The resident removed the washcloth and brownish-green stool quickly and continuously leaked from the ostomy bag. The skin around the ileostomy appeared raw and bright red. Resident 13 stated her/his ileostomy bag was changed around 6:45 AM and started leaking almost instantly afterwards. Resident 13 stated she reported the leakage to two different CNAs who stated they informed the nurse, but no nurse had responded. At 8:34 AM, Staff 12 was at the resident's door and stated she was right in the middle of breakfast and would be there when done. At 8:35 AM Staff 12 returned to the resident's room to change the resident's leaking ostomy bag. Staff 12 removed the tape and ostomy bag and described the skin underneath to be bright red, irritated and excoriated. Staff 12 stated she was going to replace the resident's ostomy bag with a smaller bag than what was ordered because the larger bags lay on the skin and cause more skin problems. Staff 12 further stated the resident had an order for Silvadine but she did not use it because she did not know where they want me to put it because it will just make the adhesive not stick. On 1/27/26 at 9:04 AM, Staff 12 stated the resident's ileostomy bag required frequent changes since the resident's admission to the facility, and the hospital ordered bigger bags that did not work at all because the skin around the wound was weeping. Staff 12 stated they had been changing the resident's ileostomy bag at least three times daily instead of three times weekly which was the standard. Staff 12 stated the facility was out of the resident's ordered ostomy bags on 1/26/26, so she had the resident use an incontinence brief to keep it contained because she did not think of putting a smaller bag on at the time. On 1/27/26 at 10:17 AM, Witness 3 (Family Member) stated Resident 13's skin progressively worsened over her/his stay at the facility, the resident went for days with just a diaper covering [her/him] trying to air out the skin, and the resident was miserable at the facility. Witness 3 further stated stool constantly poured out of the resident's ileostomy bag at the facility, and she did not understand why Witness 1 was not contacted sooner. On 1/28/26 at 6:17 AM, Staff 18 (CNA) stated Resident 13 had been leaking liquid stool for at least a week. Staff 18 (continued on next page)

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F 0691 Level of Harm - Actual harm Residents Affected - Few	stated she did not notice redness around the ostomy site following the resident's admission to the facility nor did the resident complain about burning. Staff 18 stated she observed the resident's skin with the ileostomy bag removed about a week ago and it was red and raw. Staff 18 stated they used an incontinence brief to try and contain the leakage.On 1/28/26 at 6:32 PM, Staff 8 stated Resident 13 leaked liquid stool from her/his ileostomy on-and-off since her/his admission to the facility which caused increased redness and excoriation of the skin around the resident's ileostomy. Staff 8 stated the resident's ostomy site was between her/his skin folds, so whenever the resident would bend, the bag would leak and need to be changed. Staff 8 stated the facility ran out of ostomy bags for two days last week, so she was just trying to keep the area clean because the bags we had in the facility did not fit. Staff 8 stated she never applied Silvadine to the resident's skin because the order did not pop up for me but did not think the ointment would help because it would prevent the ostomy bags from adhering to the resident's skin. Staff 8 stated she did not notify the resident's provider of the stool leakage or difficulty with the ostomy bags because she was under the impression management was dealing with this.On 1/28/26 at 7:36 AM, Staff 11 stated Resident 13 required her/his ostomy bag to be changed two-to-three times per shift. Staff 11 stated she typically completed an assessment and notified the provider when a new skin issue was noted but stated she did not notify Resident 13's provider when she initially observed the resident's rash on 1/18/26. Staff 11 further stated she did not apply Silvadine when she changed the resident's ileostomy on 1/25/26, and stated she just cleaned the site and put the barrier cream instead. On 1/28/26 at 8:39 AM, Staff 14 stated the facility ran out of Resident 13's ostomy supplies rather quickly because of the location of the ostomy. Staff 14 stated the resident's ostomy leaked from the beginning, every day, sometimes as soon as you changed it. Staff 14 stated he used the bags provided by the hospital as well as the ones from the facility and neither worked, nothing would stick. Staff 14 stated the redness around the resident's ostomy was growing, the resident was tearful and she/he complained about her/his skin burning and being painful. Staff 14 stated he was the treatment nurse on 1/18/26, so he notified the charge nurse about the resident's rash on 1/18/26. Staff 14 stated he expected the charge nurse to notify the resident's provider of the new skin issue. On 1/28/26 at 10:17 AM, Staff 19 (CNA) stated she observed Resident 13's skin to be very red and irritated the last few days the resident was at the facility. Staff 19 stated the resident went through five or six bags in one shift because the bags would not stick to the skin. Staff 19 stated the resident had been out of ostomy bags for the last couple of days she/he was at the facility, and the solution was to cover her/his abdomen with a brief and change the brief out about every 30 minutes. Staff 19 said the resident never complained about the brief but you could tell it made [her/him] feel bad. On 1/28/26 at 1:25 PM, Staff 20 (CNA) stated Resident 13's ostomy leaked greenish-brown stool all of the time. Staff 20 stated the resident's skin became more red and irritated over time, and she/he was upset and embarrassed by the leaking stool. Staff 20 stated the resident was very distraught and angry at times and was in a lot of pain. Staff 20 further stated the resident wanted to be sent back to the hospital but was never sent. On 1/28/26 at 1:37 PM, Staff 17 stated she completed a virtual visit with Resident 13 on 1/12/26, and the focus of that visit was on pain management. Staff 17 stated she was informed the ostomy site was in a tricky place and that the bag would come off here and there. Staff 17 stated she was not aware the resident went for periods of time without an ostomy bag in place or that staff did not consistently utilize the Silvadine cream. Staff 17 stated she advised the facility to make Witness 1 aware of the difficulties around the bag coming off, and her primary role in the care of Resident 13 was pain management. Staff 17 further stated she deferred the care of Resident 13's ileostomy to Witness 1 because it was so complicated and it was standard to have the surgeon involved and cut out the [NAME]. On 1/29/26 at 9:14 AM, Witness 2 (Nurse Care Coordinator for Bariatric Surgery) stated the first time the hospital received contact from the facility regarding Resident 13 was on 1/26/26. Witness 2 stated the facility sent her team a picture of the resident's abdomen which was very concerning and that it definitely looked like there was something going on for a while. Witness 2 stated she did not (continued on next page)

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F 0691 Level of Harm - Actual harm Residents Affected - Few	understand why the facility did not report the resident's irritated skin and leaking ostomy sooner. On 1/29/26 at 10:04 AM, Witness 1 stated Resident 13 received such unfortunate care at the facility and was upset she was not notified sooner about the difficulties the facility experienced with her/his pouching situation. Witness 1 stated the resident experienced damaged, raw and painful skin and a burn from all of the contents of the ileostomy being exposed to her/his skin which extended out six inches on all sides as a result of the care provided at the facility. Witness 1 stated the first time her office was contacted regarding Resident 13 was on 1/26/26, and she could not believe that we are here and available and happy to talk and no one even tried. Witness 1 stated the resident's discharge paperwork contained all the contact information on how to get a hold of us. Witness 1 further stated from what she saw in the picture the facility sent on 1/26/26, it looked like the resident's skin concerns had been going on for maybe a week. On 1/29/26 at 11:01 AM, Staff 7 stated she observed Resident 13 to have some excoriation around her/his ostomy site a couple of days after she/he admitted to the facility which extend out approximately four-to-six centimeters. Staff 7 stated the resident would go through five-to-eight ostomy bags on her shift because of the challenging placement of the resident's ostomy. Staff 7 stated she recalled two different occasions the facility ran out of the resident's ostomy bags, so they used an incontinence brief to absorb the leakage. Staff 7 stated the leaking ostomy made it difficult for the resident to sleep and made the resident feel disgusting. Staff 7 stated she did not notify the resident's provider about the frequent leakage of the resident's ostomy bag or of the difficulty keeping the bag on as she was a treatment nurse and charge nurses were responsible for notifying providers. Staff 7 stated she completed the resident's head-to-toe skin assessment on 1/21/26, and the plus sign she documented indicated the resident had a new or worsening skin issue. Staff 7 stated she did not report this observation to anyone as everybody had seen it and Staff 2 (DNS) and Staff 4 (RNCM) were aware. Staff 7 stated the resident's skin excoriation was huge on 1/23/26 but she was not involved in the resident's telehealth visit with Staff 7. Staff 7 further stated when she observed the resident's skin on 1/23/26 there were pustular blisters around the stoma (a surgically made hole in the abdomen that allows body waste to be removed from the body directly through the end of the bowel into a collection bag) and could tell the excoriation was going to a deeper level of the skin.On 1/29/26 at 12:11 PM, Staff 14 (RN) stated he observed Resident 13's abdomen skin about a week or 10 days ago and it was quite red. Staff 14 stated he did not contact the resident's provider regarding her/his excoriated skin because Staff 4 was aware, he was a charge nurse and treatment nurses were responsible to communicate this information to the provider. On 1/29/26 at 1:16 PM, Staff 21 (Director of Rehab) stated Resident 13 refused physical therapy on 1/21/26, 1/22/26 and 1/23/26 due to issues with her/his ostomy bag. Staff 21 stated the resident's participation on 1/24/26 was limited to exercises in bed. On 1/29/26 at 1:30 PM, Staff 22 (Central Supply) stated Resident 13 required a different type of ostomy bag compared to the ones the facility kept on hand. Staff 22 stated the resident ran out of ostomy bags on two different occasions because she was not notified about the need to order until they were low or until it's too late. On 1/29/26 at 3:24 PM, Staff 2 and Staff 4 were present for an interview. Staff 4 stated Resident 13 admitted to the facility with a high output of brown-green stool, and staff tried lots of things to get the resident's ostomy bag to adhere to her/his skin but nothing would work. Staff 4 stated she was not aware of the resident's recent therapy refusals or of the resident not sleeping at night because of the ostomy leakage. Staff 4 stated charge nurses should have notified the resident's doctor of these concerns. Staff 2 stated she observed the skin around Resident 13's ostomy on 1/22/26 and it was red, raw and irritated. Staff 2 stated the resident used four-to-five ostomy bags a day because of the difficulty they experienced to get the bag to seal on account of the location of the ostomy. Staff 2 stated she was not aware the resident went for periods of time without an ostomy bag in place and the provider should have been notified. Staff 2 stated she was not aware the resident utilized an incontinent brief to absorb ostomy leakage and that should never be a solution. Staff 2 stated she was not aware the resident was unable to sleep at night because of the leakage or that (continued on next page)

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F 0691 Level of Harm - Actual harm Residents Affected - Few	nurses did not consistently utilize the Silvadene cream. Staff 2 further stated Witness 1 was not contacted because the facility relied on Staff 17 and Staff 23 for guidance. On 1/30/26 at 7:32 AM, Staff 23 stated she completed a video call with Resident 13 on 1/23/26 for a routine visit. Staff 23 stated the redness around the ostomy bag caught her attention, and she thought the resident could be allergic to the tape, and as a result, ordered Silvadine cream for the resident. Staff 23 stated the resident's ostomy was covered with a bag during the telehealth visit, so her view of the abdomen was limited. Staff 23 stated she was not informed of the excoriation or redness underneath the bag, and staff never sent her a picture of the resident's abdomen. Staff 23 stated she was unaware the resident was going periods of time without a bag in place and was never informed the Silvadine was not being used. Staff 23 further stated Staff 17 managed the resident's day-to-day needs but Witness 1 should have been managing the resident's ostomy because it was a surgical situation.

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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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on interview and record review the facility failed to ensure residents were fully informed and understood the binding arbitration agreement for 3 of 3 sampled residents (#s 1, 2 and 45) reviewed for binding arbitration agreement. This placed residents at risk of being uninformed regarding their legal rights. Findings include:The facility's 1/1/26 Binding Arbitration Agreements Policy indicated the facility shall do the following when explaining the arbitration agreement:-Explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at this facility.-Explain to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands. -Ensure the resident or his or her representative acknowledges that he or she understands the agreement. The facility's undated Arbitration Agreement included the following:-You acknowledge that you have the option of not signing this Agreement and not being bound by the arbitration provisions contained herein. The execution of this Arbitration Agreement is voluntary and is not a condition of residency to the facility and not a requirement to continue to receive care at the facility. -You understand that you have the right to seek legal counsel concerning this arbitration agreement, the execution of this arbitration agreement is not a pre-condition to residency of the resident to the facility and this arbitration agreement may be withdrawn by written notice to the facility from the resident within 30 days of signature.-The parties understand and agree that by entering into this Arbitration Agreement they are agreeing to submit any dispute to an arbitrator instead of decided by a judge and a jury. If you sign this agreement, you will not have the right to have your case decided by a judge and a jury. -By signing, you acknowledge that you have been afforded an opportunity to read the arbitration agreement, had it explained to you in a language/form/manner that you understand, had an opportunity to ask questions about this agreement and that you understand and accept the terms as described herein. On 2/2/26 at 9:55 AM, Staff 25 (Social Services Director) stated she was responsible for reviewing and explaining the facility's Arbitration Agreement with residents and/or their representatives. Staff 25 stated when she reviewed the form with residents and/or their representatives, she explained a signature on the form indicated their acknowledgement the form had been reviewed, not that they were entering into an arbitration agreement. Staff 25 further stated she had not paid close attention to the form and did not discuss with residents and/or their representatives they had 30 days to withdraw this agreement. Resident 1 was admitted to the facility in 11/2025 with diagnoses including diabetes. Resident 1's 11/18/25 admission MDS revealed the resident was cognitively intact. Resident 1's health record included the facility's Arbitration Agreement, dated 11/18/25 and signed by the resident. On 2/2/26 at 10:36 AM, Resident 1 stated she/he signed the facility's Arbitration Agreement because it was explained to her/him that her/his signature indicated arbitration was available. Resident 1 stated she/he was not sure if she/he would have signed the form if she/he understood she/he was agreeing to arbitration. Resident 2 was admitted to the facility in 12/2025 with diagnoses including chronic obstructive pulmonary disease. Resident 2's 12/11/25 admission MDS revealed the resident was cognitively intact. Resident 2's health record included the facility's Arbitration Agreement, dated 12/10/25 and signed by the resident. On 2/2/26 at 10:42 AM, Resident 2 stated she/he recalled signing the facility's Arbitration Agreement but was not informed she/he had 30 days to rescind the agreement. Resident 45 was admitted to the facility in 12/2025 with diagnoses including femur fracture. Resident 45's 12/16/25 admission MDS revealed the resident was cognitively intact. Resident 45's health record included the facility's Arbitration Agreement, dated 12/19/25 and electronically signed by the resident. On 2/2/26 at 10:50 AM, Resident 45 stated she/he recalled signing the facility's Arbitration Agreement but was not informed she/he had 30 days to rescind the agreement. On 2/2/26 at 10:56 AM, Staff 1 (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Administrator) was notified Staff 25 did not fully understand and did not comprehensively explain the Arbitration Agreement to residents. Staff 1 was notified Residents 1, 2 and 45 did not fully understand the Arbitration Agreement, and the residents did not recall it being explained to them in detail. Staff 1 stated he expected the residents, and especially the families, to receive a verbal explanation on their right to rescind the agreement within 30 days of signing but also stated a resident's signature on the Arbitration Agreement meant I have seen it and read it.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility failed to timely report an allegation of physical abuse for 1 of 2 sampled residents (#24) reviewed for abuse. This placed residents at risk for potential abuse. Findings include:The facility's 1/1/26 Abuse and Neglect Protections and Responsibilities Policy directed the Executive Director (Administrator) or designee to immediately report all allegations of suspected abuse through a FRI. During the 1/26/26 at 9:26 AM entrance conference meeting, Staff 1 (Administrator) notified the surveyor the facility had an incident over the weekend and were going to submit a FRI to the SA (state agency).On 1/26/26 at 12:14 PM Staff 2 (DNS) notified the surveyor Resident 24 was involved in an allegation of abuse on 1/24/26 and the facility would complete a FRI when the investigation was complete.On 1/29/26 at 7:16 PM the SA received a FRI and investigation about the 1/24/26 allegation of abuse for Resident 24. On 1/30/26 at 11:16 AM Staff 14 (LPN) stated she/he called Staff 2 the morning of 1/24/26 to report the Police were at the facility for an allegation of abuse for Resident 24. On 1/30/26 at 12:00 PM Staff 1 stated he was aware of the allegation of abuse with Resident 24 on 1/26/26. He stated he expected the facility to investigate the allegation and report to the SA in 24 hours. After further discussion Staff 1 stated he was aware of the two-hour required reporting time to the SA and confirmed the FRI was not reported to the SA within the required two-hours.

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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 assistance with shaving for 1 of 4 sampled residents (#24) reviewed for ADLs. This placed residents at risk for lack of personal hygiene and loss of dignity. Findings include:The facility's 1/1/26 Activities of Daily Living Policy indicated a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene. The facility will maintain individual objectives of the care plan and periodic review and evaluation. Resident 24 was admitted to the facility in 6/2024 with diagnoses including dementia.Resident 24's 10/16/25 Care Plan revealed the following:-Staff were to set the resident up for daily hand and face washing and combing of hair and assist as needed. -The resident required assistance from one staff person with bathing. Resident 24's 1/2/26 Quarterly MDS revealed the resident was cognitively intact and required partial-to-moderate assistance from staff with personal hygiene. On 1/26/26 at 9:46 AM, Staff 30 (CNA) was observed in Resident 24's room preparing to assist the resident with a shower. On 1/26/26 at 12:50 PM, Resident 24 was observed in her/his room in her/his wheelchair. Gray and white facial hair, approximately an eighth-to-a-quarter of an inch long, was observed on the right and left sides of the resident's chin. On 1/28/26 at 11:53 AM, Resident 24 was observed in the facility's independent dining room, and gray and white facial hair, approximately an eighth-to-a-quarter of an inch long, was observed on the right and left sides of the resident's chin. Resident 24 stated the facial hair really bothers me and I want it gone. Resident 24 stated no one offered to assist her/him to trim the facial hair in about a week, and it was irritating to have facial hair. Resident 24 further stated she/he had not been asked regarding facial hair preferences, and she/he would never refuse to have it trimmed when offered. On 1/28/26 at 1:10 PM, Staff 20 (CNA) stated resident preferences for facial hair trimming were listed in their care plan. Staff 20 stated he did not regularly work with Resident 24 but stated her/his family requested the resident's facial hair to be removed. On 1/28/26 at 1:20 PM, Staff 18 (CNA) stated staff were expected to assist residents with removing facial hair on shower days and as needed. Staff 18 stated Resident 24 had a personal shaver, and she/he preferred staff to remove her/his facial hair. Staff 18 stated the resident never requested to be shaved but was always cooperative when offered. On 1/28/26 at 12:41 PM, Staff 27 (CNA) stated she assisted Resident 24 with facial hair trimming on shower days and the resident did not refuse. On 1/28/26 at 3:45 PM, Staff 30 (CNA) stated he provided assistance to residents with facial hair trimming on their scheduled shower days. Staff 30 stated he assisted Resident 24 with a shower on 1/26/26 but did not offer to assist the resident to trim her/his facial hair at this time. Staff 30 further stated Resident 24 was cooperative with facial hair trimming.On 1/28/26 at 4:17 PM, Staff 4 (RNCM) stated resident facial hair grooming should be offered to residents on a daily basis and specific resident preferences for facial hair trimming were located in the resident's care plan. Staff 4 observed Resident 24's facial hair and confirmed the resident was in need of facial hair trimming.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review it was determined the facility failed to follow physician orders for 1 of 5 sampled residents (# 3) reviewed for unnecessary medications. This placed residents at risk for adverse side effects. Findings include:Resident 3 was admitted to the facility in 2/2023 with a diagnosis including chronic atrial fibrillation (irregular heart rhythm), diabetes and hyperlipidemia.Physician orders dated 11/2/25 indicated Resident 3 was prescribed the following medications:-Insulin aspart (fast-acting insulin)100 units/ml pen to be given before meals.-Insulin glargine Solostar (long-lasting insulin) 60 units every 12 hours.-Potassium citrate (helps prevent kidney stones) 2 tablets by mouth two times a day.-Senna Plus (bowel medication) two times a day.-Venlafaxine HCl (antidepressant) one time a day.-Gemfibrozil (treats high cholesterol) one time a day.-Metoprolol Succinate (treats high blood pressure) one time a day.-MiraLAX (bowel medication) one time a day.-Atorvastatin (treats high cholesterol) one time a day.-Digoxin (treats heart failure and abnormal heart rhythms) one time a day.-Vitamin D one time a day.-oxycodone (pain medication) three times a day.-Losartan potassium (treats high blood pressure) one time a day. A review of Resident 3's 12/2025 through 1/2026 MARs and DARs (diabetic administration record) revealed the following medications were not administered on the following days:*Insulin Aspart on 12/12/25 and 1/27/26 lunch missed both days.*Insulin Glargine Solostar on 1/27/26 AM dose was missed.*Potassium Citrate on 12/14/25, 12/15/25, 12/26/25 (twice), 12/29/25, 1/13/26, 1/16/26, 1/18/26, 1/20/26, 1/21/26, 1/23/26, and 1/27/26.*Senna Plus on 12/14/25, 12/15/25, 12/26/25 (twice), and 12/29/25.*Venlafaxine on 12/26/25, 1/13/26, 1/16/26, 1/18/26, 1/20/26, 1/21/26, 1/23/26, and 1/27/26.*Gemfibrozil on 1/26/25, 1/13/26, 1/16/26, 1/18/26, 1/20/26, 1/21/26, 1/23/26, and 1/27/26.*Metoprolol Succinate on 12/26/25, 1/13/26, 1/16/26, 1/18/26, 1/20/26, 1/21/26, 1/23/26, and 1/27/26.*MiraLAX on 12/26/25 1/13/26, 1/16/26, 1/18/26, 1/20/26, 1/21/26, 1/23/26, and 1/27/26.*Atorvastatin on 12/14/25, 12/15/25, 12/26/25, and 12/29/26.*Digoxin on 12/14/25, 12/15/25, 12/26/25, and 12/29/25.*Vitamin D on 1/13/26, 1/16/26, 1/18/26, 1/20/26, 1/21/26, 1/23/26, and 1/27/26.*Senna plus on 1/13/26, 1/16/26, 1/18/26, 1/20/26, 1/21/26, 1/23/26, and 1/27/26.*Oxycodone on 1/13/26, 1/16/26, 1/18/26, 1/20/26, 1/21/26, 1/23/26, and 1/27/26.*Losartan potassium on 1/13/26, 1/16/26, 1/18/26, 1/20/26, 1/21/26, 1/23/26, and 1/27/26.On 1/30/26 at 11:03 AM Staff 15 (LPN) reviewed Resident 3's 12/2025 and 1/2026 MAR and DAR and stated he did not administer the resident's medications as ordered. Staff 15 stated he had not administered the medications because Resident 3 was sleeping. Staff 15 stated he did not notify the physician until the week of 1/26/26 regarding the missed medications for Resident 3.On 1/30/26 at 12:13 PM Staff 3 (RNCM) and 12:34 PM Staff 2 (DNS) were interviewed. Both stated the physician should have been notified after each missed medication, and each missed medication should have been documented as to why the medication was not administered in the health record. Staff 2 stated staff were expected to implement and follow physician's orders. Staff 2 acknowledged Resident 3's medications were not administered per physician orders, and the physician was not notified timely.

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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 physician orders and interventions were followed to reduce the risk of accidents for 1 of 1 sampled resident (#24) reviewed for food. This placed residents at risk for choking and aspiration. Findings include:The facility's 1/1/26 Accidents and Supervision Policy indicated the resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents, including monitoring for effectiveness and modifying interventions when necessary. Resident 24 was admitted to the facility in 6/2024 with diagnoses including oral dysphagia (difficulty chewing, manipulating and controlling food or liquid within the mouth using the tongue, lips and jaw) and oropharyngeal dysphagia (difficulty moving food from the mouth to the throat, often causing coughing, choking or food sticking in the throat). Resident 24's 7/3/24 SLP Evaluation and Plan of Treatment indicated the resident was not to use straws. Resident 24's 9/3/25 SLP Evaluation and Plan of Treatment completed by Staff 26 (SLP) revealed the resident experienced moderately severe oropharyngeal dysphagia (significant difficulty moving food/liquid from the mouth to the throat and is marked by an ineffectual cough reflex, frequent choking and a high risk of aspiration pneumonia). The Evaluation did not make mention about the resident's use of straws. Resident 24's 10/20/25 Care Plan revealed the following:-The resident was able to feed her/himself with supervision as she/he was at risk to choke. -Staff were to encourage the resident to be upright for all meals related to dysphagia. -The resident was to take small single bites/sips and alternate liquids and solids. -Reduce distractions. -No straws. Resident 24's 1/2/26 Quarterly MDS revealed the resident was cognitively intact and on a mechanically altered diet. Resident 24's current Physician Orders revealed the resident was not to use straws. On 1/26/26 at 1:00 PM, Resident 24 stated she/he was on a pureed diet because she/he had difficulty swallowing. The resident did not indicate any restrictions regarding the use of straws. On 1/27/26 at 8:28 AM, Resident 24 was observed to drink with a straw from a paper cup in the facility's assisted dining room. The resident was observed to cough after she/he took a drink. On 1/28/26 at 11:45 AM, Resident 24 was observed to eat lunch in the facility's independent dining room with her/his family present. A paper cup that contained milk and a straw was observed on her/his meal tray. The resident was not observed taking a drink of milk with the straw. On 1/28/26 at 12:41 PM, Staff 27 (CNA) stated Resident 24 used straws all of the time as they helped the resident to swallow. Staff 27 stated the resident needed to be cued to slow down at mealtimes and some days [she/he] had more choking than others.On 1/28/26 at 12:48 PM, Resident 24 was observed in her/his wheelchair in her/his room. The resident's overbed table was within reach. A water bottle contained a large bore straw (a drinking tube with a wide internal diameter that reduces the suction effort required to drink) sat on top of the overbed table. On 1/28/26 at 1:20 PM, Staff 18 (CNA) stated Resident 24 was allowed to use straws, but she/he tended to eat and drink too fast and required reminders to slow down. Staff 18 stated Resident 24 had not had a choking episode, just coughing.On 1/28/26 at 4:08 PM, Staff 28 (RD) stated Resident 24 should not use straws with a physician's order in place that directed no straws. On 1/29/26 at 8:12 AM, Staff 14 (LPN) stated the resident required cues to take smaller bites and smaller sips at mealtimes. Staff 14 reviewed the resident's care plan and stated she/he was not to use straws. On 1/29/26 at 8:19 AM, Staff 29 (Dietary Manager) stated the dietary program he utilized in the kitchen indicated Resident 24 was not to use straws. On 1/29/26 at 8:23 AM Staff 21 (Director of Rehabilitation) stated Resident 24's SLP evaluation on 9/3/2025 was completed by Staff 26 after a choking episode, which was a result of the resident's family providing the resident with a regular textured cookie. Staff 21 stated the choking incident was not really liquids and the intervention related to the resident not using straws had been in place since her/his admission to the facility. Staff 21 further stated Staff 26 was on vacation and unavailable for an interview. On 1/29/26 at 9:55 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AM, Staff 4 (RNCM) and Staff 2 (DNS) were present for an interview. Staff 4 stated Resident 24's care plan for no straws reflected the resident's physician orders, and she would not alter the resident's care plan unless directed to do so by the SLP. Staff 4 further stated she had not been instructed by Staff 26 to remove the no straws intervention from the resident's care plan. Staff 2 stated either the resident can have straws and the care plan was wrong or [she/he] can't. Staff 2 stated the physician's orders and the resident's care plan needed to align with actual practice.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview and record review it was determined the facility failed to follow physician orders related to enteral (tube) feeding for 1 of 1 sampled resident (#13) reviewed for tube feeding. This placed residents at risk for complications related to the use of a feeding tube. Findings include: The facility's 1/1/26 Care and Treatment of Feeding Tubes Policy directed feeding tubes to be utilized according to physician orders, which typically included the kind of feeding and its caloric value, volume, duration, mechanism of administration and frequency of flush. Resident 13 was admitted to the facility in 1/2026 with diagnoses including other artificial openings of gastrointestinal tract status (the status of having an artificial opening [stoma] in the digestive tract that requires monitoring). Resident 13's 1/15/26 admission MDS revealed the resident was cognitively intact and used a feeding tube. Resident 13's 1/22/26 Physician Orders indicated the following:-The resident was to receive 65 ml of Jevity (a brand of fiber-fortified, therapeutic medical nutrition formula designed primarily for tube feeding) via her/his J-Tube (Jejunostomy tube, a soft feeding tube inserted through the abdominal skin directly into the mid-section of the small intestine to deliver nutrition and fluids) for 18 hours per day from 6:00 PM through 12:00 PM. -The nutrition formula container, syringe and administration set was to be labeled with the resident's name, date, time and nurse's initials and changed daily on night shift. -The syringe used for the tube feeding was to be changed daily on day shift. -The feeding tube was to be flushed with 200 cc (cubic centimeter) of water every eight hours and with 60 cc before and after medication administration. On 1/26/26 at 11:58 AM, Resident 13 was observed reclined in an armchair in her/his room. An undated and unlabeled plastic cylinder filled with 250 ml of water sat on the counter next to the resident's sink in her/his room. An undated and unlabeled plastic syringe rested inside the cylinder. Resident 13 stated staff regularly reported to her/him that facility was out of the syringes she/he needed for her/his tube feed flushes and medication administration. Resident 13 stated I can't tell you how long that one has been used in reference to the syringe in the cylinder on the counter next to her/his sink.On 1/26/26 at 4:50 PM, an undated and unlabeled plastic cylinder filled with 250 ml of water sat on the counter next to the resident's sink in her/his room. An undated and unlabeled plastic syringe rested inside the cylinder. On 1/27/2026 at 8:30 AM, Resident 13 was observed reclined in an armchair in her/his room. An unlabeled and undated nutrition bag was hung on a feeding pole and the resident's tube feed was running. An undated and unlabeled plastic cylinder filled with 100 ml of water sat on the counter next to the resident's sink in her/his room. An undated and unlabeled plastic syringe rested inside the cylinder. On 1/27/26 at 9:50 AM, Staff 7 (LPN) was observed to stop and unhook the resident's tube feed as the resident was leaving the facility. Staff 7 was observed to insert 60 ml of water from the unlabeled and undated cylinder with the unlabeled and undated syringe into the resident's feeding port. Staff 7 stated the syringe she used to complete the flush of the resident's port was the same syringe the resident was sent with from the hospital. Staff 7 stated it was standard practice to use a new syringe every 24 hours, but the facility did not have the specific syringes Resident 13 required for her/his tube feed. Staff 7 stated the plastic cylinders should be labeled and dated and changed out every day and was unsure when the cylinder in the resident's room was last changed. Staff 7 stated the resident's current nutrition bag was not dated or labeled, and she did not usually pay attention to the bag, she just unhooked and threw it away on her shift. On 1/28/26 at 7:36 AM, Staff 11 (RN) stated syringes used for Resident 13's tube feeds were to be discarded after each use and nutrition bags were to be dated and labeled. On 1/28/26 at 8:39 AM, Staff 14 (LPN) stated he always labeled and dated Resident 13's nutritional bags when he started the resident's tube feed. Staff 14 stated he changed the syringe every few days because he was unsure of when it was last changed since it was not dated. On 1/28/26 at 1:37 PM, Staff 17 (NP) stated she expected staff to follow whatever orders were in place with regards to resident tube feeds. On (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/29/26 at 3:24 PM, Staff 4 (RNCM) stated she expected nutritional bags to be labeled and dated when they were hung. Staff 4 further stated she expected syringes used to flush feeding ports and to administer medications to be labeled, dated and discarded every 24 hours.