STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385072	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corvallis Manor	160 NE Conifer Blvd Corvallis, OR 97330

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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 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 interview, observation, and record review it was determined the facility failed to ensure medications were safely stored with proper temperature monitoring for 1 of 2 refrigerators reviewed for medication storage. This placed all residents with refrigerated medications at risk for receiving ineffective or unstable medications, including insulin. Findings include: According to the American Diabetes Association, insulin stored too cold does not work as intended and has reduced effectiveness, which may cause hyperglycemia (high blood sugar) and left untreated, result in ketoacidosis (a life-threatening emergency where a high level of acids build up in the blood). Insulin stored below 36 degrees F should be discarded and replaced.On 5/5/26 at 1:37 PM, Staff 1 (Administrator) stated refrigerator temperatures were monitored with digital temperatures sent to an electronic application every hour. Staff 1 stated the system did not send out an alert if the temperature was an abnormal temperature, but he checked the application weekly.On 5/7/26 at 4:40 PM, Staff 1 provided the digital refrigerator temperature logs for the New Wing medication refrigerator. A review of the temperature logs indicated the New Wing medication refrigerator serviced rooms 208 through 316 and had temperatures below 36 degrees Fahrenheit for 19 of 30 days reviewed. Temperatures below 36 degrees were as follows:-4/13/26 one hour at 34.6 degrees F-4/19/26 three hours with the low of 25.7 degrees F-4/20/26 16 hours with a low of 19.6 degrees F-4/21/26 21 hours with a low of 20.5 degrees F-4/22/26 14 hours with a low of 21 degrees F-4/23/26 10 hours with a low of 22.9 degrees F-4/24/26 14 hours with a low of 23.3 degrees F-4/25/26 six hours with a low of 28.2 degrees F-4/26/26 eight hours with a low of 26.8 degrees F-4/27/26 four hours with a low of 28.4 degrees F-4/28/26 eight hours with a low of 27.5 degrees F-4/29/26 nine hours with a low of 27.8 degrees F-4/30/25 21 hours with a low of 24.9 degrees F-5/1/26 four hours with a low of 28.9 degrees F-5/2/26 nine hours with a low of 21.4 degrees F-5/3/26 24 hours with a low of 17.5 degrees F-5/4/26 24 hours with a low of 19.3 degrees F-5/5/26 four hours with a low of 25.6 degrees F-5/6/26 three hours with a low of 24.9 degrees F-5/7/26 seven hours with a low of 26.2 degrees F On 5/7/26 at 2:45 PM, Staff 2 (DNS) stated Staff 1 monitored the refrigerator temperatures. Staff 2 stated if the refrigerated medications were exposed to temperatures outside the safe range, the medication needed to be disposed of. On 5/8/26 at 8:15 AM the New Wing medication refrigerator was observed with Staff 15 (LPN). It held nine GLP injections (a medication used to treat diabetes and help with weight loss), 29 glargine insulin pens (long-acting insulin), one glargine insulin vial, 10 insulin aspart pens (short acting insulin), one insulin aspart vial, and one shingles vaccine. The glargine insulin vial was in a plastic bag against the back of the refrigerator and ice crystals were observed on the bag. On 5/8/26 at 2:17 PM, the information from the temperature logs was shared with Staff 16 (Pharmacist) who stated with that many hours under freezing, the insulin, GLP, and vaccine were no good and needed to be discarded.

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on interview and record review it was determined the facility failed to develop and implement an effective water management plan to identify potential areas of growth and spread of water-borne pathogens and illness. This placed all residents at risk for exposure to water-borne pathogens. Findings include: The Centers for Medicare and Medicaid Services Center for Clinical Standards and Quality/Safety and Oversight Group letter 17-30, revised on 7/6/18, Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease stated, Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water.A review of the facility's 3/2023 Infection Prevention and Control- Legionnaire's Disease Policy revealed the following:-Legionnaires' Disease is caused by the organism Legionella pneumophila. Although rare in long term care facilities, Legionnaires' Disease may occur and could be either facility or community acquired. Specific actions should be taken for prevention of Legionella and for investigation should a case occur.A review of the 12/30/25 Facility Assessment revealed no evidence a risk assessment was completed to prevent the growth and spread of water-borne pathogens in the facility's main water system.A review of the facility's 1/22/26 Risk Management plan for Legionella Control revealed no facility water system assessment identifying potential areas of growth and spread of water-borne pathogens and no risk analysis assessment with control measures to prevent opportunistic waterborne pathogens. The plan also contained another facility's name throughout the document.On 5/11/26 at 11:08 AM and at 11:30 AM Staff 9 (Maintenance Director) and Staff 1 (Administrator) stated they were provided the template Risk Management Plan for Legionella Control from another facility and could not remove the other facility's name within the plan, however Staff 1 stated he updated the information to reflect their facility. Staff 1 was asked if the facility developed and implemented a water management plan and Staff 1 stated facility staff identified there was nowhere water-borne pathogens could grow as the water was always in use and the facility never had an empty resident room. Staff 1 was asked for documentation of that assessment, and none was provided. Staff 1 stated Legionella control was not part of their Risk Management plan.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure residents were offered pneumococcal vaccines for 4 of 5 sampled residents (#s 7, 13, 18, and 34) reviewed for vaccines. This placed residents at risk for pneumonia. Findings include:A review of the facility's revised 8/2024 Infection Prevention and Control-Influenza and Pneumococcal Immunizations policy revealed the following:-Residents ^ [AGE] years of age and those aged 19-64 with chronic medical conditions or other risk factors, who have not previously received PCV, or whose previous vaccination history is unknown are offered pneumococcal vaccination per current CDC recommendations.-The resident record will reflect the provision of education and the administration or refusal of the immunization, or non-administration due to medical contraindication. 1. Resident 7 was admitted to the facility in 2021 with a diagnosis of heart failure.Resident 7's clinical record revealed she/he was eligible for, but was not offered, a pneumococcal vaccine.On 5/7/26 at 10:12 AM Staff 12 (Infection Preventionist LPN) stated a couple weeks ago she identified Resident 7 was eligible but was not offered pneumococcal vaccine yet.On 5/7/26 at 10:16 AM Staff 6 (LPN Resident Care Manager) stated she was the previous Infection Preventionist from November 2025 to March 2026 and never had the chance to offer the pneumococcal vaccination to eligible residents.On 5/7/26 at 1:46 PM Staff 2 (DNS) stated she was unsure what the regulation was to offer residents the pneumococcal vaccination. 2. Resident 13 was admitted to the facility in 2024 with a diagnosis of heart failure.Resident 13's clinical record revealed she/he was eligible for, but was not offered, a pneumococcal vaccine.On 5/7/26 at 10:12 AM Staff 12 (Infection Preventionist LPN) stated she a couple weeks ago she identified Resident 13 was eligible but was not offered pneumococcal vaccine yet.On 5/7/26 at 10:16 AM Staff 6 (LPN Resident Care Manager) stated she was the previous Infection Preventionist from November 2025 to March 2026 and never had the chance to offer the pneumococcal vaccination to eligible residents.On 5/7/26 at 1:46 PM Staff 2 (DNS) stated she was unsure what the regulation was to offer residents the pneumococcal vaccination. 3. Resident 18 was admitted to the facility in 2021 with a diagnosis of diabetes.Resident 18's clinical record revealed she/he was eligible for, but was not offered, a pneumococcal vaccine.On 5/7/26 at 10:12 AM Staff 12 (Infection Preventionist LPN) stated a couple weeks ago she identified Resident 18 was eligible but was not offered pneumococcal vaccine yet.On 5/7/26 at 10:16 AM Staff 6 (LPN Resident Care Manager) stated she was the previous Infection Preventionist from November 2025 to March 2026 and never had the chance to offer the pneumococcal vaccination to eligible residents.On 5/7/26 at 1:46 PM Staff 2 (DNS) stated she was unsure what the regulation was to offer residents the pneumococcal vaccination. 4. Resident 34 was admitted to the facility in 2024 with a diagnosis of dementia.Resident 34's clinical record revealed she/he was eligible for, but was not offered, a pneumococcal vaccine.On 5/7/26 at 10:12 AM Staff 12 (Infection Preventionist LPN) stated a couple weeks ago she identified Resident 34 was eligible but was not offered pneumococcal vaccine yet.On 5/7/26 at 10:16 AM Staff 6 (LPN Resident Care Manager) stated she was the previous Infection Preventionist from November 2025 to March 2026 and never had the chance to offer the pneumococcal vaccination to eligible residents.On 5/7/26 at 1:46 PM Staff 2 (DNS) stated she was unsure what the regulation was to offer residents the pneumococcal vaccination.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review it was determined the facility failed to obtain consent from residents with dosage changes to their psychotropic medications for 2 of 5 sampled residents (#s 4 and 7) reviewed for unnecessary medications. This placed residents at risk for being uninformed of their medication dosages. Findings include: A review of the 4/28/25 revised facility Use of Psychotropic Medication(s) policy revealed the following: -The facility will document the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and the preferred option to accept or decline in a format the facility deems to use (e.g., written consent form, narrative note, etc.). 1. Resident 4 was admitted to the facility in 6/2025 with diagnoses including depression and heart failure. The 6/23/25 admission MDS revealed Resident 4 had a BIMS of 15 indicating she/he was cognitively intact. A review of the 3/12/26 Consent for use of Psychotropic Medication revealed Resident 4 consented to the use of duloxetine (an antidepressant) 60 MG bid. A 3/20/26 Pharmacy Recommendation revealed Resident 4 was due for a gradual dose reduction (GDR) for duloxetine 60 MG bid. On 3/27/26 Resident 4's provider responded to the pharmacy recommendation stating to complete a GDR for duloxetine to 90 MG once a day. A 4/13/26 signed physician order revealed an order for duloxetine 90 MG once a day with a start date of 3/28/26. A review of the 3/2026 MAR revealed Resident 4 was administered duloxetine 90 MG once a day starting on 3/29/26. A review of Resident 4's medical record revealed no updated consent for duloxetine 90 MG once daily prior to Resident 4 receiving the medication. On 5/11/26 at 8:55 AM Resident 4 stated the facility did not talk to her/him about the decrease in her/his antidepressant medication. On 5/11/26 at 11:56 AM Staff 6 (LPN Resident Care Manager) stated the facility did not speak to the residents when a GDR occurred, only the provider did. On 5/11/26 at 1:30 PM Staff 2 (DNS) confirmed Resident 4 did not consent to the decrease in duloxetine medication that started on 3/28/26. Staff 2 stated the facility did not have a good process in place for residents to consent to GDR's and only the provider spoke to the resident. 2. Resident 7 was admitted to the facility in 7/2021 with diagnoses including bipolar disorder and post-traumatic stress disorder (PTSD). A 3/20/26 Optum Progress Note indicated Resident 7 was seen by Staff 13 (APRN-BC) on 3/19/26. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 3/20/26 pharmacy recommendation indicated a gradual dose reduction (GDR) for Resident 7's trazodone order which was signed on 3/25/26 by Staff 13. On 5/7/26 at 10:22 AM, Resident 7 stated she/he was not aware she/he took trazodone. On 5/7/25 at 1:14 PM, Staff 6 (LPN Resident Care Manager) stated she was not sure when or who reviewed the GDR for trazodone with Resident 7. On 5/7/26 at 1:50 PM, Staff 6 provided a progress note written by Staff 13 with an addendum written on 5/7/26 at 1:40 PM indicating Staff 13 discussed the GDR with Resident 7 during the 3/19/26 visit. On 5/7/26 at 2:14 PM, Staff 13 stated she was not sure when she received the pharmacy recommendation for Resident 7. Staff 13 stated she discussed the GDR with Resident 7 during the 3/19/26 visit. Staff 13 stated she signed the order on 3/25/26. A review of the medical record revealed no evidence of an updated consent form after the GDR. On 5/8/26 at 8:36 AM Staff 2 (DNS) stated the pharmacy recommendations were written on 3/20/26 and she received the recommendations via email on 3/24/26. Staff 2 also stated staff were expected to discuss GDRs with the residents or the resident representative prior to initiating a GDR and resident consent was only obtained when psychotropic medication doses were increased, not decreased.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, it was determined the facility failed to ensure all resident areas and equipment were in good repair for 2 of 6 sampled residents (#s 30 and 34) reviewed for environment. This placed residents at risk for not having a homelike environment. Findings include:1. Resident 30 was admitted to the facility in 7/2022 with diagnoses including hypo-osmolality (low blood tonicity) and hyponatremia (low electrolyte and sodium levels), and transient cerebral ischemic attack (mini-stroke). The 1/27/25 revised Care Plan indicated Resident 30 was bedridden and required a high level of caregiver support due to general muscle weakness and muscle atrophy.The 4/17/26 Quarterly MDS indicated Resident 30 had one-sided upper body range of motion impairment and required assistance for transfers and mobility. On 5/4/26 at 10:11 AM the resident's bed cane grips were observed to be ripped and peeling on the right and left side of the bed. Resident 30 stated she/he used the bed canes when turning in bed and could not recall a time when the grips were not ripped or peeling. On 5/6/26 at 11:01 AM Staff 7 (CNA) stated Resident 30 frequently utilized the bed canes to turn during care and to reposition in bed. Staff 7 acknowledged the bed cane grips were ripped and peeling and stated they were in that condition for a couple of months.On 5/6/26 at 1:53 PM Staff 9 (Maintenance Director) stated bed canes were checked monthly. Staff 9 acknowledged the ripped and peeling bed canes in Resident 30's room and confirmed they needed to be replaced. 2. Resident 34 admitted to the facility in 11/2024 with diagnoses including dementia and stroke. The 11/14/25 Annual MDS revealed Resident 34 received hospice care.On 5/4/26 three long gouges and scraped paint were observed in the resident's room behind the head of the bed. On 5/5/26 at 11:07 AM Staff 8 (CNA) indicated the wall damage in Resident 34's room was old and was there a very long time.On 5/6/26 at 1:53 PM Staff 9 (Maintenance Director) stated resident rooms were inspected monthly for repair needs and tasks such as painting and touch ups were done frequently. Staff 9 acknowledged the wall damage in Resident 34's room and stated it had been like that for a long time but was not repaired due to the resident's presence in the room.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review it was determined the facility failed to provide residents with written bed hold notifications, including reserved bed hold payments, at the time of transfer to the hospital and failed to provide appropriate information to a provider for 2 of 4 sampled residents (#s 4 and 96) reviewed for hospitalization and discharge. This placed residents at risk for rehospitalization and a lack of knowledge regarding their choices and potential financial responsibilities. Findings include: 1. Resident 4 was admitted to the facility in 6/2025 with diagnoses including heart failure and diabetes. A review of Resident 4's clinical record revealed she/he was transferred to the hospital on the following dates: 1/2/26, 1/22/26, 2/13/26, and 3/6/26. No evidence was found in Resident 4's clinical record to indicate written notice of the facility's bed hold policy was provided to the resident or her/his representative when she/he was transferred to the hospital. On 5/11/26 at 12:25 PM Staff 6 (LPN Resident Care Manager) stated upon transfer to the hospital, the charge nurse explained the bed hold policy, including the cost, to the resident and received a signature or verbal understanding. If the resident was not alert and oriented at the time of transfer to the hospital, the resident's representative was notified of the bed hold policy. Staff 6 stated the discussion would be documented in the resident's medical record. On 5/11/26 at 1:35 PM Staff 2 (DNS) confirmed a written bed hold notification was not provided to Resident 4 or her/his representative at the time of her/his transfer to the hospital on the specified dates. 2. Resident 96 was admitted to the facility in 1/2026 with diagnoses including broken bones of the right arm, right thigh and respiratory failure. A 1/13/26 BIMS Evaluation revealed a score of 15 (cognitively intact) for Resident 96. A 1/13/26 Progress Note Discharge Evaluation revealed Resident 96 made improvements in her/his functional status while in the facility and was appropriate for discharge. Home health was arranged for the resident and she/he was discharged in stable condition. A 1/13/26 Discharge Planning and Summary Plan revealed the discharge was driven by Resident 96 and the home health agency was contacted. A 1/18/26 ED (Emergency Department) Provider Note revealed Resident 96 reported pain and swelling in her/his right leg since 1/16/26 that did not allow the resident to stand. A follow up appointment was scheduled on 1/21/2026 with the resident's provider. A 1/23/26 Message Text to the home health agency from Witness 4 (NP) indicated Resident 96 was seen by appointment and a referral for home health was sent. On 5/5/26 at 7:47 PM, Witness 1 (Complainant) stated he was contacted by Resident 96 because home health services did not contact the resident after her/his discharge and the resident went to the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	emergency department due to swelling. Witness 1 stated Resident 96 was concerned she/he had incorrect phone numbers and gave up when she tried to contact Staff 3 (Social Worker) and home health services. On 5/6/26 at 9:12 AM, Resident 96 stated she/he saw Witness 5 (NP) to obtain a referral for home health services a month after she/he discharged from the facility. On 5/7/26 at 9:55 AM, Staff 3 (Social Worker) stated emails were sent to obtain home health services for residents who discharged and acknowledged no email for home health services was found for Resident 96. On 5/11/26 at 8:49 AM, Witness 2 (RN Clinical Manger) confirmed the home health agency did not receive a referral from the facility for Resident 96 and the resident did not receive a home health service referral until 1/23/26 when it was completed by Witness 5. On 5/11/26 at 12:32 PM, Staff 2 (DNS) acknowledged the facility was responsible and did not ensure Resident 96 received home health services after she/he discharged .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interview and record review it was determined the facility failed to implement a baseline care plan for required care and interventions for 1 of 4 sampled residents (#105) reviewed for ADLs. This placed residents at risk for unmet needs and unnecessary pain. Findings include:Resident 105 was admitted to the facility in 4/2026 with diagnoses including compression fracture of the spine and muscle weakness.The 4/13/26 Admit Visit Progress Note revealed Resident 105's chief complaint was her/his compression fracture of the spine and generalized weakness. The 4/14/26 admission MDS and associated CAA indicated Resident 105 reported frequent severe pain, sustained a compression fracture of the spine from a fall, and had a BIMS assessment score of 13 (cognitively intact). The resident was at risk for unrelieved pain.The 4/17/26 baseline Care Plan indicated Resident 105 required staff assistance for toileting and hygiene. The resident was also at risk for pain related to chronic pain and had limited physical mobility. Staff were to respond to any complaints of pain and report any decreases in functional abilities. No reference to the prevention of pain or care associated with Resident 105's compression spine fracture was identified in the care plan. A 4/23/26 typed and signed note by Staff 4 (Unit Manger-LPN) revealed Resident 105 had an incident on 4/22/26 with Staff 25 (CNA). Resident 105 indicated Staff 25 moved her/him quickly while the resident was in bed and caused pain in her/his back. The note further revealed Resident 105 indicated it was painful to move, Staff 25 did not follow the resident's verbal direction for care, and the resident requested education for Staff 25.On 5/5/26 at 8:46 AM, Resident 105 stated she/he had back pain when moved and requested a slight adjustment of her/his position in bed from Staff 25 on 4/22/26. Resident 105 stated Staff 25 used a draw sheet (cloth placed under the resident to assist with movement) and jerked her/his back which caused the resident to yell out. On 5/6/26 at 12:37 PM, Staff 4 stated she was informed of the incident with Staff 25 and acknowledged Resident 105 experienced pain because of the care provided by Staff 25. Staff 4 stated Resident 105 declined to file a complaint and Staff 4 believed no further action was necessary.On 5/10/26 at 7:57 PM, Staff 25 stated she was aware Resident 105 had a bad back based on information shared by other CNAs and followed the care plan as written. On 5/11/26 at 10:58 AM, Staff 4 acknowledged Resident 105's care plan did not address the resident's back fracture and associated pain prevention. On 5/11/26 at 12:32 PM, Staff 2 (DNS) acknowledged the care needed to address Resident 105's fractured back and associated pain was not in the care plan and a correction to the care plan was needed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to develop and implement a comprehensive care plan for 2 of 4 sampled residents (#s 82 and 84) reviewed for ADLs. This placed residents at risk for unmet care needs related to toileting hygiene and meal tray set up for dependent residents. Findings include:1. Resident 84 was admitted to the facility in 12/2024 with diagnoses including stroke and chronic pain. The 6/13/25 revised Care Plan revealed Resident 84 was dependent on staff for meeting physical needs due to physical limitations. The 11/17/25 revised Care Plan revealed Resident 84 had an ADL self-care performance deficit due to residual right-side weakness from a history of stroke. The 12/26/25 Annual MDS indicated Resident 84 had upper and lower impaired range of motion on one side and required set-up assistance for eating. The 12/30/25 revised Care Plan indicated Resident 84 required set up assistance of one staff for eating. A 4/22/26 Quarterly Care Conference note indicated Witness 4 (Family Member) expressed Resident 84's left hand was used for eating, so the utensils were to be on the resident's left side. Resident 84's Kardex indicated staff were to provide assistance with dining, such as tray set up. A review of the resident's care plans did not reveal any information related to placing food items and utensils to the resident's left side, or to ensure all food packing was opened. On 5/4/26 at 10:09 AM Resident 84 had a sign in her/his room which indicated meal trays were to be set up on the resident's left side. On 5/4/26 at 11:17 AM Witness 4 (Family Member) stated Resident 84 was only able to use her/his left hand for eating and required her/his tray set up with utensils on the left side, with all items unwrapped and opened. Witness 4 stated she put up the sign in the resident's room to remind staff where to position tray items. On 5/5/26 at 12:48 PM Resident 84's lunch tray included fruit salad in a bowl placed on the right side of the tray, out of reach of the resident. On 5/6/26 at 8:35 AM Resident 84's breakfast tray included a bowl of plain oatmeal with the lid on. In addition, the resident had butter and jelly in un-opened sealed packets on the right side of the tray, out of the resident's reach. On 5/6/26 at 5:08 PM Staff 10 (CNA) indicated Resident 84 needed all food items opened and placed on her/his left side. On 5/7/26 at 1:59 PM Staff 6 (LPN Resident Care Manager) stated Resident 84's care plan did not (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	direct staff to set up meal trays on the resident's left side and to open all food packaging. 2. Resident 82 was admitted to the facility on [DATE] with diagnoses including bilateral lower limb reduction defects (congenital deficit where both legs fail to form completely) and weakness. The 4/9/26 admission MDS revealed Resident 82 had a BIMS score of 15 indicating she/he was cognitively intact. The 4/9/26 admission MDS Urinary Incontinence CAA revealed Resident 82 was incontinent of bowel and bladder and was dependent on staff for with perineal hygiene and brief changes. A review of the 4/3/26 care plan revealed Resident 82 required staff assistance for toileting hygiene and staff were to keep Resident 82's skin clean and dry. On 5/4/26 at 2:53 PM and on 5/7/26 at 11:18 AM Resident 82 stated she/he was unable to assist with toileting hygiene and depended on staff. Resident 82 stated a couple weeks ago her/his skin became sensitive to the wipes used during toileting hygiene care. Resident 82 stated Staff 22 (LPN) completed various treatments for her/him and implemented the use of a warm wet washcloth during toileting hygiene care to reduce any irritation. Resident 82 stated she/he had to remind staff what supplies to use and felt she/he should not have to remind staff. On 5/7/26 at 9:35 AM Staff 17 (CNA) stated recently staff started to use a warm wet washcloth to assist with toileting hygiene clean up as the wipes were irritating Resident 82's skin. On 5/7/26 at 11:23 AM Staff 29 (CNA) stated when she assisted Resident 82 with toileting hygiene, she used wipes to clean up. Staff 29 stated she was unaware Resident 82 preferred washcloths. On 5/7/26 at 11:31 AM Staff 19 (CNA) stated recently Resident 82 informed her the wipes were causing irritation and Resident 82 wanted to use washcloths during toileting hygiene care. On 5/7/26 at 2:28 PM Staff 30 (CNA) stated when Resident 82 first admitted to the facility, she/he had her/his own wipes for toileting hygiene due to sensitive skin but eventually ran out of those wipes so staff started to use the facility's wipes. Staff 30 stated the facility wipes irritated Resident 82's skin. She/he stated Staff 22 implemented the use of washcloths with baby soap. Staff 30 stated since the switch of supplies she noticed Resident 82's skin to be less irritated. On 5/11/26 at 9:23 AM Staff 22 stated she completed various treatments for Resident 82 and a couple weeks ago Resident 82 stated the facility wipes caused burning and skin irritation. Staff 22 stated she suggested the use of washcloths and baby soap during cares to reduce the irritation and Resident 82 agreed. Staff 22 stated she told Resident 82 to tell staff what her/his preferences were during cares. Staff 22 acknowledged Resident 82's preferences should be in the care plan for all staff to know. On 5/11/26 at 12:56 PM Staff 4 (LPN Resident Care Manager) stated she was not aware Staff 22 implemented the use of washcloths and baby soap for Resident 82 during toileting hygiene care and that information should be placed in the care plan. On 5/11/26 at 1:23 PM Staff 2 (DNS) acknowledged Resident 82's preferences should be in the care plan.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure a dependent resident received assistance with toileting hygiene for 1 of 1 sampled resident (#82) reviewed for bowel incontinence. This placed residents at risk for skin related issues and infections. Findings include: Resident 82 was admitted to the facility on [DATE] with diagnoses including bilateral lower limb reduction defects (congenital deficit where both legs fail to form completely) and weakness.The 4/9/26 admission MDS revealed Resident 82 had a BIMS of 15 indicating she/he was cognitively intact.The 4/9/26 admission MDS Urinary Incontinence CAA revealed Resident 82 was incontinent of bowel and bladder and was dependent on staff for perineal hygiene and brief changes.A review of the 4/3/26 care plan revealed Resident 82 required the assistance of one staff member for toileting hygiene and staff were to keep Resident 82's skin clean and dry. On 5/4/26 at 2:53 PM and on 5/7/26 at 11:18 AM Resident 82 stated she/he was unable to assist with toileting hygiene and depended on staff. Resident 82 stated some staff were not thorough when providing toileting hygiene care and she/he did not feel fully clean after an incontinent bowel episode resulting in redness to the skin. Resident 82 stated Staff 19 (CNA) and Staff 22 (LPN) observed her/him with inadequate toileting hygiene care.On 5/7/26 at 9:35 AM Staff 17 (CNA) stated she assisted Resident 82 with toileting hygiene and observed Resident 82 to have feces in her/his genital area from a prior brief change. Staff 17 stated it happened a couple times and she did not report her observations to the nurse.On 5/7/26 at 9:43 AM Staff 18 (CNA) stated she observed feces left in Resident 82's genital area during toileting hygiene. Staff 18 stated Resident 82 was compliant with cares and prior shift staff were not thoroughly cleaning the resident. Staff 18 stated she told the oncoming CNA during shift change and the charge nurse but did not recall who that was.On 5/7/26 at 11:31 AM Staff 19 stated Resident 82 was good about letting you know when she/he required toileting hygiene. Staff 19 stated about one to two weeks ago she started to notice Resident 82 to not be thoroughly cleaned when she provided toileting hygiene care. Staff 19 stated there was an occurrence when Resident 82 was incontinent of bladder and when she performed toileting hygiene, she observed feces in the genital area, left from another shift.On 5/7/26 at 12:46 PM Staff 20 (CNA) stated she had not observed Resident 82 with feces left on her/him. However, Resident 82 mentioned other staff were not providing thorough toileting hygiene care. Staff 20 stated she told Staff 21 (Agency LPN) some residents were not receiving thorough toileting hygiene care but did not state which residents.On 5/10/26 at 6:45 PM Staff 21 stated he had not observed feces left on Resident 82's genital area but heard about it from other staff members. Staff 21 stated he felt it wasn't intentional, just lack of providing thorough care. Staff 21 stated he did not report the lack of thorough toileting hygiene care reported to him to the Resident Care Manager or the DNS.On 5/11/26 at 9:23 AM Staff 22 stated she completed various treatments for Resident 82 and during a treatment a couple weeks ago she observed the resident to have smeared feces in her/his genital area. Staff 22 stated feces left in the genital area increased the risk of infections.On 5/11/26 at 12:56 PM Staff 4 (LPN Resident Care Manager) stated she was not aware staff were finding Resident 82's toileting hygiene care inadequate and Resident 82 had not mentioned this to her.On 5/11/26 at 1:23 PM Staff 2 (DNS) stated she was not aware Resident 82 was not receiving thorough toileting hygiene care. Staff 2 stated she expected staff to provide thorough ADL care for residents who required it.

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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 and to document or provide necessary wound care for 2 of 6 sampled residents (#s 4 and 95) reviewed for UTIs, wound care and medications. This placed residents at risk for untreated weight gain, infections and worsening wounds. Findings include: 1. Resident 4 was admitted to the facility in 6/2025 with diagnoses including heart failure and diabetes. A 4/13/26 signed physician order revealed a start date of 3/12/26 to check Resident 4's weight daily for congestive heart failure (fluid buildup into the lungs, legs and body due to the heart muscle being too weak or stiff to pump blood efficiently) and to notify the provider of a three pound weight gain overnight or a five pound weight gain within a week. A review of the March 2026 TAR revealed the resident had a weight gain of 4.2 pounds from 3/30/26 to 3/31/26. A review of Resident 4's medical record revealed no indication the resident's provider was notified of the overnight weight gain. A review of the April 2026 TAR revealed Resident 4 had a weight gain of three pounds or more on the following days: -4/1/26 to 4/2/26, a weight gain of seven pounds. -4/13/26 to 4/14/26, a weight gain of 5.2 pounds. -4/24/26 to 4/25/26, a weight gain of 4.2 pounds. A review of Resident 4's medical record revealed no indication the resident's provider was notified of any of the overnight weight gains. On 5/11/26 at 12:09 PM Staff 6 (LPN Resident Care Manager) reviewed the dates of overnight weight gain and confirmed Resident 4's provider was not notified. On 5/11/26 at 1:26 PM Staff 2 (DNS) stated she expected staff to follow the physician's order. 2. Resident 95 was admitted to the facility in 1/2026 with diagnoses including heart failure and diabetes. a. A public complaint was received on 2/19/26 which alleged the facility failed to treat and document a skin tear for Resident 95. A 2/26/26 progress note indicated Resident 95 had an existing skin tear on her/his left arm and treatment was started. On 5/6/26 at 12:13 PM, Staff 14 (LPN Resident Care Manager) stated an agency nurse found the skin tear on Resident 95 on 2/1/3/26 but did not document it or start a treatment. Staff 14 stated another (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	agency nurse found the existing skin tear on 2/26/26 and started treatment. On 5/6/26 at 1:32 PM, Witness 6 (Family Member) stated on 2/13/26 she noted a skin tear on Resident 95's left arm. Witness 6 stated a nurse came in and put a band aid on the skin tear. Witness 6 stated on 2/26/26 she notified the nurse on duty the same band aid, with the date 2/13/26 written on it, was still on Resident 95's skin tear. Witness 6 stated the nurse changed Resident 95's dressing. On 5/7/26 at 1:09 PM, Staff 2 (DNS) acknowledged the 2/13/26 skin tear on Resident 95's left arm was not documented or treated until 2/26/26. Staff 2 stated staff were expected to document and treat any new wounds. b. On 2/28/26 Resident 95 went to the emergency department and returned with orders for antibiotics twice a day for 10 days. The first dose was received in the emergency department. The 3/2026 MAR indicated Resident 95 received the antibiotic twice a day from 3/1/26 through 3/4/26 and one dose on 3/5/26. The 3/2026 MAR indicated Resident 95 received additional antibiotics from 3/15/26 through 3/17/26. On 5/6/26 at 1:30 PM, Staff 2 (DNS) acknowledged Resident 95 did not receive the antibiotic treatment as prescribed. Staff 2 stated the physician's order was transcribed to the medical record incorrectly as 10 doses, not 10 days, as ordered.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview and record review the facility failed to provide immediate monitoring and documentation of the status of a resident's access site upon return from dialysis treatment for 1 of 1 sampled resident (#6) reviewed for dialysis. This placed residents at risk for delayed treatment and dialysis complications. Findings include: A review of the facility revised 3/2023 Quality of Care-Dialysis Policy revealed the following:-The facility will assess the resident's condition and monitor for complications before and after dialysis treatments received at a certified dialysis facility.-Facility staff will monitor and document the status of the resident's access site upon return from the dialysis treatment center to observe for bleeding or other complications.Resident 6 was admitted to the facility in 5/2025 with diagnoses including end-stage renal disease and dependence on dialysis (a medical treatment that removes waste products from the blood when the kidneys are not working properly).The 1/12/26 dialysis care plan revealed Resident 6 went to dialysis treatment three times a week on Monday, Wednesday, and Friday. Staff were to monitor vital signs frequently and notify the provider of any significant abnormalities. Staff were to also monitor, document, and report any signs or symptoms of infection to the dialysis access site located on her/his left chest.The 2/20/26 Quarterly MDS revealed Resident 6 had a BIMS of15 indicating she/he was cognitively intact.A review of the 5/3/26 signed physician's order revealed staff were to complete the dialysis post assessment form when the resident returned from dialysis; ensure the pre-dialysis form and communication form were also returned with the resident; and review and follow up as indicated.On 5/4/26 at 10:10 AM Resident 6 was observed to return to her/his room accompanied by Staff 27 (Restorative Aide).On 5/4/26 at 10:12 AM Resident 6 stated she/he just returned from a dialysis treatment which was three times a week on Monday, Wednesday, and Friday; left the facility around 4:20 AM and returned around 10 AM. Resident 6 stated her/his dialysis access site was a port located on her/his left chest. Resident 6 stated the nurse assessed her/him before leaving for dialysis at 4:20 AM but had not assessed her/him upon return to the facility.On 5/4/26 at 10:38 AM Staff 5 (CMA) was observed to put on PPE and enter Resident 6's room with a digital blood pressure machine and asked Resident 6 if anyone had taken her/his blood pressure since her/his return from dialysis. Resident 6 said no.On 5/4/26 from 10:10 AM through 10:55 AM (45 minutes) Resident 6's room was observed from the hallway and no nurse entered to assess her/him. On 5/6/26 at 10:08 AM Resident 6 was observed to enter the facility's main door. Resident 6 self-propelled in her/his wheelchair down the hallway when Staff 11 (CNA) offered assistance which Resident 6 accepted. Staff 11 stopped at the scale, obtained Resident 6's weight, then accompanied Resident 6 to her/his room. Staff 11 exited the resident's room, put on PPE, then re-entered Resident 6's room to check her/his vitals.On 5/6/26 at 10:16 AM Staff 11 was observed to tell Staff 5 Resident 6's vitals and weight were obtained and would be documented in the medical record.On 5/6/26 at 10:18 AM Resident 6 stated she/he just returned from dialysis and was tired from a long morning. Resident 6 stated the nurse observed her/his dialysis access site prior to leaving for dialysis. However, a nurse did not observe her/his dialysis access site upon return from dialysis on 5/4/26 until that evening or the next day. Resident 6 stated she/he had not seen a nurse today since returning from dialysis.On 5/6/26 at 10:08 AM through 11:12 AM (1 hour 4 minutes) Resident 6's room was observed from the hallway and no nurse entered Resident 6's room to assess her/him post dialysis treatment.On 5/6/26 at 12:18 PM Staff 28 (LPN) stated she was the charge nurse for Resident 6, and the resident went to dialysis on Monday, Wednesday, and Friday. Staff 28 stated it was her responsibility to complete the post dialysis assessment for Resident 6. When asked if she observed Resident 6 after her/his from dialysis today, she stated she did at 10:45 AM and the dialysis access site looked okay. Staff 28 was informed Resident 6's room was observed from the hallway at 10:45 AM and she was not seen to enter Resident 6's room. Staff 28 stated, well it was around 10:20 AM to 10:45 AM, I was bopping here and there.On 5/6/26 at 12:41 PM Staff 2 (DNS) stated she would have to look at the policy to know when nurses were expected to assess a (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident post dialysis, but standard of care was a couple of hours after returning from dialysis. Staff 2 was informed of the observations on 5/4/26 and 5/6/26 and of Staff 28's statements on 5/6/26 at 12:18 PM. Staff 2 did not have anything further to add.On 5/6/26 at 12:55 PM Staff 2 stated she took Staff 28 into Resident 6's room to ask if Staff 28 assessed her/him post dialysis and Resident 6 stated Staff 28 did.On 5/6/26 at 1:24 PM Resident 6 was observed asleep in bed and was not disturbed.On 5/7/26 at 10:51 AM in a follow up interview with Resident 6, she/he stated the nurse did not assess her/him post dialysis the morning of 5/6/26 when she/he returned to the facility. Resident 6 reiterated the nurse never assessed her/him upon return to the facility on dialysis days. The nurse assessed her/him and her/his dialysis access site the evening of dialysis treatment or the next day. On 5/11/26 at 1:43 PM Staff 2 acknowledged the findings and had nothing further to add.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, it was determined the facility failed to ensure adequate monitoring and indications for use of blood pressure medication for 1 of 5 sampled residents (#84) reviewed for unnecessary medications. This placed residents at risk for receiving blood pressure medications without adequate monitoring and indications for use. Findings include:Resident 84 was admitted to the facility in 12/2024 with diagnoses including stroke and hypertension (high blood pressure). Physician Orders revealed a 9/9/25 order for lisinopril 10 MG oral tablet given one time per day for hypertension. The order indicated to hold the medication if the systolic blood pressure (the top number in a blood pressure reading) was less than 120. The 3/2026 and 4/2026 MARs revealed Resident 84 received lisinopril five times in March and seven times in April with a systolic blood pressure reading under 120. All administrations were given by Staff 5 (Certified Medication Aide).A review of the resident's clinical record revealed no rationale for giving the lisinopril outside of the ordered parameters. On 5/7/26 at 9:01 AM Staff 5 acknowledged she gave Resident 84 the lisinopril outside the ordered blood pressure parameters on the identified dates, and she was unable to provide a rationale for administration of the medication. On 5/7/26 at 9:58 AM Staff 6 (LPN Resident Case Manager) confirmed the dates in 3/2026 and 4/2026 when Resident 84 was given lisinopril outside of the ordered blood pressure parameters.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review it was determined the facility failed to provide cut up foods for 1 of 4 sampled residents (# 84) reviewed for food. This placed residents at risk for unmet individualized food needs. Findings include:Resident 84 was admitted to the facility in 12/2024 with diagnoses including stroke and chronic pain. The 6/13/25 revised Care Plan revealed Resident 84 was dependent on staff for meeting physical needs due to physical limitations.The 11/17/25 revised Care Plan revealed Resident 84 had an ADL self-care performance deficit due to residual right-side weakness from a history of stroke.The 12/26/25 Annual MDS indicated Resident 84 had upper and lower impaired range of motion on one side and required set-up assistance for eating.The 12/30/25 revised Care Plan indicated Resident 84 required assistance with set up for eating. A 4/22/26 Quarterly Care Conference note indicated Witness 4 (Family Member) expressed the need for Resident 84's food to be cut up due to her/his inability to cut her/his own food. Resident 84's Kardex indicated staff were to provide assistance with dining, such as cutting up food. On 5/4/26 at 11:17 AM Witness 4 (Family Member) stated Resident 84 was only able to use her/his left hand for eating and required all food items to be cut up. Witness 4 stated she put up the sign in the resident's room to remind staff to cut up food. On 5/5/26 at 12:48 PM Resident 84's lunch tray included a cut up burger patty inside a whole (uncut) bun. On 5/6/26 at 8:35 AM Resident 84's breakfast tray included full slices of bacon and a whole piece of frittata (a baked egg dish). On 5/6/26 at 12:53 PM Resident 84's lunch tray included large chunks of chicken and potato, and whole asparagus spears. On 5/6/26 at 5:08 PM Staff 10 (CNA) indicated Resident 84's food was supposed to be cut up by the kitchen staff, but she could cut it if needed. On 5/7/26 at 4:38 PM Staff 6 (LPN Resident Care Manager) stated staff were to cut Resident 84's food at bedside and acknowledged the care plan did not provide clear instruction to cut the resident's food.