STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385222	A. Building B. Wing	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Helens Post Acute	75 Shore Drive Saint Helens, OR 97051

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review it was determined the facility failed to transmit resident assessments in the required timeframe for 20 of 20 residents (#s 20, 26, 36, 49, 53, 55, 56, 62, 64, 66, 73, 76, 78, 83, 106, 107, 108, 109, 110 and 111) reviewed for resident assessments. This placed residents at risk for inaccurate records. Findings include:The 4/14/26 Missing OBRA (Omnibus Budget Reconciliation Act of 1987 requiring assessment completion) Assessment Report revealed assessments were not transmitted to CMS in the required timeframe for Resident #s 20, 26, 36, 49, 53, 55, 56, 62, 64, 66, 73, 76, 78, 83, 106, 107, 108, 109, 110 and 111. On 4/24/26 at 10:00 AM Staff 10 (MDS Coordinator) stated she was aware the assessments for these residents were not transmitted to CMS in the required timeframe. Staff 10 stated the facility had a backlog of assessments to transmit when she accepted the position and she did not have adequate knowledge of the system or support to complete the workload in a timely manner.On 4/24/26 at 11:44 AM Staff 1 (Administrator) acknowledged the assessments for these residents were not transmitted to CMS in the required timeframe. Staff 1 stated he expected all assessments to be transmitted per the regulation because this process affects reimbursement and the facility's compliance.

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview and record review it was determined the facility failed to provide an effective pest control program for 1 of 1 facility reviewed for environment. This placed residents at risk for exposure to household pest and increased health risks. Findings include: On 4/22/26 at 9:19 AM Witness 9 (Agency Pest Control) was observed in the facility to place traps for roaches around the facility. AT 9:24 AM Witness 9 stated he came to the facility one time per month per the contract. Witness 9 stated he had not observed evidence of rodents in the facility but observed evidence of roaches for months.Review of the Pest Control Log on 4/22/26 at 1:10 PM revealed sightings of roaches had been reported from 10/2025 to 4/2026.On 4/22/26 at 1:52 PM Witness 9 stated the facility really needed services for two applications per month for pest control to eradicate the roaches.On 4/22/26 at 1:54 PM Staff 1 (Administrator) Staff 1 acknowledged concerns with roaches throughout the facility. Staff 1 stated he had asked Witness 9 to provide more service during his past and recent visits one time per month to control pests, especially roaches. On 4/23/26 at 12:11 PM and 4:45 PM Staff 43 (CNA) and Staff 44 (CNA) both reported sightings of roaches in the facility. Staff 43 and Staff 44 stated sightings were not always written or reported in the Pest Control Log.On 4/24/26 at 8:13 AM Staff 27 (CNA) stated she had observed roaches in the facility and was unaware of a Pest Control Log to report sightings of pests.On 4/27/26 at 9:38 AM Staff 1 confirmed the ongoing issue of roaches, and he expected the facility to be pest free.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review it was determined the facility failed to ensure CNA staff received 12 hours of annual in-service training for 5 of 5 randomly selected staff members (#s 11, 24, 27, 28 and 29) reviewed for evidence of in-service training. This placed residents at risk for lack of quality care. Findings include: On 4/23/26 at 10:43 AM, Staff 1 (Administrator) provided a list of annual training hours for CNA staff which revealed the following: -Staff 11 CNA: 6 annual training hours;-Staff 24 CNA: 6 annual training hours; -Staff 27 CNA: 6 annual training hours:-Staff 28 CNA: 6 annual training hours and-Staff 29 CNA: 6 annual training hours. On 4/23/26 at 10:43 AM and 4/24/26 at 1:46 PM, Staff 1 confirmed Staff 11, Staff 24, Staff 27, Staff 28 and Staff 29 did not complete the required 12 hours of annual in-service training. Staff 1 stated he expected CNAs to complete the required 12 hours of in-service training.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **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 a comfortable and homelike environment for 1 of 1 facility reviewed for environment. This placed residents at risk for an unsatisfying experience and living in an unkept environment. Findings include:Resident 41 was admitted to the facility in 2025 with a diagnoses including anxiety.A 1/28/26 Quarterly MDS assessed Resident 41 as cognitively intact.On 4/19/26 at 10:26 AM room [ROOM NUMBER]'s floor appeared unwashed and dark spots around the toilet and throughout the bathroom.On 4/19/26 at 10:49 AM Resident 41 stated her/his room was not cleaned regularly and had not been cleaned since Friday (4/17/26) because the facility was often short staffed.On 4/19/26 at 10:53 AM Staff 19 (Director of Housekeeping) was the only housekeeping staff observed to work in the facility. Staff 19 confirmed he was the only person working in housekeeping when the survey team entered on 4/19/26.On 4/19/26 at 10:59 AM the shared bathroom for room [ROOM NUMBER] was observed with dark stains in the toilet bowl.On 4/19/26 at 12:03 PM room [ROOM NUMBER] was observed with a dirty floor, debris spread throughout on the floor, dark stains in the toilet bowl and the bathroom smelled of urine.On 4/24/26 at 9:00 AM Staff 19 and Staff 20 (Regional Director of Housekeeping) walked throughout the facility with the surveyor. Staff 19 acknowledged he had scrubbed the resident's toilet bowls on 4/21/26 due to the dark stains. Staff 19 stated due to the older building some stains would not come off several surfaces. Staff 19 and Staff 20 confirmed the following observations:-room [ROOM NUMBER] shared bathroom with dark substance on the toilet seat, handle and tank.-room [ROOM NUMBER] floor baseboards were unclean.-The resident shower rooms on 3 of 3 halls appeared unclean and unkept by items left in the room.On 7/26/23 at 1:12 PM Staff 1 (Administrator) walked through the facility with surveyor. Staff 1 acknowledged he expected the residents' rooms and areas to be clean.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to monitor and assess resident skin conditions, administer psychotropic medications and insulin timely for 3 of 5 residents (#s 49, 82 and 94) reviewed for skin conditions, pain and insulin. This placed residents at risk for worsening skin conditions, increased anxiety and complications related to uncontrolled blood sugars. Findings include:1. Resident 49 was admitted to the facility in 9/2025 with diagnoses including diabetes. A 1/9/26 United Wound Healing Note revealed the following:-Resident 49 admitted to the facility with wounds of the bilateral lower extremities and right foot.-Interventions included offloading, repositioning and wound dressings, and the resident's tolerance of the treatment was reported to be good.-All wounds had healed, and treatment recommendations included to monitor for reopening of old wounds and for the presence of new wounds. Resident 49's 4/4/26 Quarterly MDS revealed the resident was severely cognitively impaired, experienced episodes of disorganized thinking (fragmented, illogical or disjointed thoughts often manifesting as incoherence or rapid shifting between unrelated topics) and did not have any ulcers, wounds or skin problems. Resident 49's 4/15/26 Potential for Impaired Skin Integrity and Diabetes Care Plans revealed the following:-Check skin when assisting with ADLs.-Ensure socks/hosiery were clean and absorbent every day.-Avoid constrictive shoes.-Carefully dry between toes but do not apply lotion between toes.-The resident refuses to take off her/his boots. Encourage the resident to remove them at night when in bed.-Inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness. Report any of the above to the provider.-Monitor/document/report to the provider as needed any signs and symptoms of infection.-Refer to foot care nurse/podiatrist. Resident 49's 4/2026 Physician Orders directed the following:-A nurse was to perform a diabetic foot check every week and notify the provider if a skin issue was noted.-A weekly head-to-toe skin inspection was to be completed by the nurse. The resident care manager was to be notified of any new skin issue and if the resident would benefit from a podiatry consult. Any refusals were to be documented in the electronic record. A review of Resident 49's 4/2026 TAR revealed the following:-Staff 17 (LPN) completed the residents' weekly diabetic foot check on 4/6/26 and 4/13/26 and no skin issues were noted.-Staff 15 (LPN) completed the resident's weekly skin inspection on 4/14/26 and no skin issues were noted. A 4/15/26 Nursing Quarterly Evaluation completed by Staff 3 (LPN-Resident Care Manager) indicated Resident 49 did not have any skin integrity concerns. A review of Resident 49's clinical record indicated the resident had routine refusals of all aspects of care. On 4/20/26 at 1:14 PM, Resident 49 was observed in her/his room, sat in her/his wheelchair and wore pants, thick socks and heavy boots. Resident 49 stated she/he was not going to participate in activities on this day as she/he was having trouble with my socks. The resident pulled up her/his right pant leg and revealed a dark red sock covered in flaked skin, and the exposed part of her/his (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	calf was bright red. The resident attempted to pull the right sock away from the skin but was only able to pull away the top part of the sock as the sock stuck to the resident's skin at her/his ankle. A large skin indent was observed where the top part of the sock had been, the skin that was visible underneath was bright red and appeared raw and exuded a malodorous odor. A dirty, blood-tinged bandage was observed underneath the resident's right sock and was stuck to the resident's skin. The resident, unprompted by the state surveyor, removed her/his boots at this time. The resident's socks appeared dirty and were covered in flaked skin. The resident was unable to answer any specific questions related to her/his skin as her/his speech was disorganized (incoherent, illogical or rambling speech) but stated her/his legs were getting more painful and she/he had been in pain for a couple of months because of her/his ankles. On 4/20/26 at 4:18 PM, Resident 49 was observed to ambulate down the hall towards the nurse's station. The resident wore dark red socks and did not wear any shoes or boots. Once at the nurse's station, Resident 49 lifted her/his right pant leg and asked Staff 30 (RN) for some help with this. Resident 49 returned to her/his room and Staff 30 remained at the nurse's station. On 4/21/26 at 11:26 AM, Staff 31 (LPN) stated some of the nurses at the facility do not complete resident skin checks, and they don't even offer. On 4/21/26 at 11:48 AM, Staff 12 (CNA) stated Resident 49 refused to shower, change clothes or remove her/his shoes. Staff 12 stated she had never visualized the resident's legs or feet. On 4/21/26 at 12:32 PM, Staff 15 stated she had never completed a head-to-toe skin inspection for Resident 49 and did not recall completing a skin assessment on 4/14/26. Staff 15 stated she thought she was able to visualize the resident's feet and legs on one occasion but it was not recent. Staff 15 stated she had not reported to the resident's provider her/his refusals of skin inspections. On 4/21/26 at 1:53 PM, Staff 44 (Physician Assistant-Certified) stated she was aware of Resident 49's daily refusals of care, but she would expect to be notified weekly of any refusals of skin inspections. Staff 44 stated she could not recall the last time she was notified Resident 49 refused a skin inspection. On 4/21/26 at 7:22 PM, Staff 17 stated she had never assessed Resident 49's feet. Staff 17 stated her documentation on the resident's TAR on 4/6/26 and 4/13/26 indicated she attempted to complete the resident's diabetic foot check, but the resident refused on both occasions. Staff 17 further stated she had notified the resident's resident care manager of her/his diabetic foot care refusals, but she had not notified the resident's provider. On 4/22/26 at 10:28 AM, Staff 3 stated she was unsure as to when to notify a resident's provider if a resident refused a skin inspection or a diabetic foot check. Staff 3 stated she observed Resident 49's feet on 4/21/26 after the resident had independently removed her/his boots but did not state the last time she had visualized the resident's feet prior to this opportunity. On 4/22/26 at 10:45 AM, Staff 2 (DNS) stated Resident 49's provider should have been notified each time the resident refused a skin inspection or diabetic foot care and confirmed the provider had not been notified. 2. Resident 82 was admitted to the facility in 1/2026 with diagnoses including diabetes requiring hemodialysis (a medical procedure for advanced kidney failure that removes waste products, toxins (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and excessive fluids from the blood). Physician orders dated 2/20/26 and 3/19/26 indicated Resident 82 was prescribed the following diabetic medications: -Insulin aspart (fast-acting insulin) 2 units with meals, scheduled to be administered at 8:00 AM, 12:00 PM and 5:00 PM. -Insulin aspart before meals and at bedtime according to the prescribed sliding scale (insulin doses adjusted based on pre-meal blood sugars designed to correct high blood sugars), scheduled to be administered at 7:30 AM, 11:30 AM, 4:30 PM and 8:00 PM. A review of Resident 82's 4/1/26 through 4/20/26 DAR (Diabetic Administration Record) revealed the resident's insulin was not administered timely on the following days: -Insulin aspart on 4/2/26 was administered at 7:17 PM and should have been administered at 5:00 PM, 4/3/26 was administered at 6:13 PM and should have been administered at 5:00 PM and 4/7/26 was administered at 2:05 PM and should have been administered at 12:00 PM. -Sliding scale Insulin aspart on 4/3/26 was administered at 10:24 PM, 4/8/26 was administered at 9:36 PM, 4/13/26 was administered at 9:01 PM and 4/19/26 was administered 9:41 PM. These doses should have been administered at 8:00 PM. No evidence was found in Resident 82's clinical record as to why her/his insulin was administered late on the above dates. On 4/19/26 at 10:51 AM and 4/21/26 at 11:25 AM, Resident 82 stated, on many occasions, her/his insulin was not being administered timely. Resident 82 stated she/he was a brittle diabetic (a diabetic that experiences frequent and severe swings in blood sugars) and required hemodialysis so receiving her/his insulin timely to keep her/his blood sugars controlled was very important. Resident 82 stated it was frustrating to receive her/his insulin late and late administration mostly occurred with her/his bedtime insulin. On 4/22/26 at 11:38 AM, Staff 14 (RN) stated Resident 82's blood sugars go low really fast. Staff 14 stated Resident 82 reported to him that her/his nighttime insulin was administered late, at times. Staff 14 stated the night shift nurse (6:00 PM to 6:00 AM) was responsible for administering medications and insulin to residents so they could get busy and might not be able to administer insulin on time. 4/23/26 at 11:54 AM, Staff 3 (LPN-Resident Care Manager) stated when nurses administered insulin late, they were required to write a progress note explaining the reasoning for the late insulin administration. She reported the nighttime nurse could get busy and backed up with medication and insulin administration, resulting in insulin not being administered timely. Staff 3 reviewed Resident 82's 4/2026 DAR and confirmed the resident's insulin was not administered timely on the dates identified. Staff 3 stated it was her expectation that insulin be administered according to the times established on the DAR unless a progress note was written to explain the rationale for late administration. Staff 3 acknowledged the dates identified did not have progress notes written, and Resident 82's insulin was not timely administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 94 was admitted to the facility on [DATE] with diagnoses including spinal stenosis (a narrowing of spaces within the spine leading to pain), anxiety disorder, panic disorder, and opioid dependence. Resident 94's 2/28/26 admission MDS indicated the resident was cognitively intact. Resident 94's 2/24/26 admission orders included the following:- Lorazepam (a medication used to treat anxiety) 1 mg oral tablet, take 1.5 tablets by mouth two times a day (morning and lunch), and 1 tablet every evening as needed. Resident 94's 2/2026 MAR indicated the following medications were ordered on 2/24/26 at 10:26 AM:1. Lorazepam 1 mg oral tablet - give 1.5 tablets by mouth two times a day related to generalized anxiety disorder.-Scheduled administration times: 8:00 AM and 12:30 PM.-Not administered at either 8:00 AM or 12:30 PM on 2/25/26. 2. Lorazepam 1 mg oral tablet - give 1 tablet by mouth in the evening as needed related to generalized anxiety disorder.-Administered on 2/25/26 at 7:33 AM (not in the evening as ordered). On 4/21/26 at 1:01 PM Staff 33 (LPN) stated they did not recall Resident 94, the admission, or any issues related to the delivery of lorazepam. Staff 33 was unable to provide additional information regarding whether the lorazepam prescription was sent to the pharmacy, or why their was a delay in delivery. No documentation by Staff 33 was identified in the medical record to clarify the events surrounding the lorazepam prescription and its delivery. On 4/21/26 at 6:26 PM Witness 7 (Complainant) stated Resident 94 was admitted to the facility around noon on 2/24/26. Witness 7 stated the admitting nurse advised Resident 94's lorazepam would be delivered to the facility within a few hours of admission. Witness 7 stated at approximately 2:30 AM on 2/25/26 Resident 94 called them upset indicating she/he needed lorazepam, and it was not available. Witness 7 stated they contacted the facility, advised the nurse the resident needed lorazepam and were told the prescription for lorazepam had not been sent to the pharmacy. On 4/27/26 at 12:49 PM Staff 36 (CNA) stated Resident 94 was agitated the night of admission to the facility and the resident requested anti-anxiety medication several times which they reported to the nurse. Staff 36 stated Resident 94 was in distress because her/his lorazepam was not available and upon admission she/he was told it would be. Staff 36 stated the resident also called Witness 7 twice and reported she/he needed her medication and had not received it. On 4/22/26 at 5:24 PM Staff 37 (RN) stated the night of Resident 94's admission they received a call from Witness 7 requesting lorazepam for the resident and upon assessment the resident appeared agitated. Staff 37 stated Resident 94 had admitted to the facility earlier that day with orders for lorazepam 1mg tablet, but the prescription had not been sent to the pharmacy and the resident's medication was not available for administration. Staff 37 contacted the on-call provider and requested a prescription. Staff 37 then requested a pull-code (a code for secure access) from the pharmacy to access the facility's backup supply of lorazepam and was denied because the resident's order was for lorazepam 1mg tablets, whereas the available dose was for 0.5mg tablets. Staff 37 stated they were unable to administer Resident 94 her/his lorazepam. On 4/24/26 at 10:35 AM Staff 3 (LPN-Resident Care Manager) and Staff 4 (RNCM) stated the resident was admitted to the facility from home without a hard copy of the prescription for lorazepam. Staff 4 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated in such cases the admitting nurse should have requested a STAT (immediate) prescription from the on-call provider for Resident 94's lorazepam for delivery as soon as possible and ideally within four hours. Staff 3 and Staff 4 stated there should have been diligent follow-up by the floor nurse and documentation reflecting the cause of any delay and the status of the prescription delivery, especially given Resident 94's diagnoses. Staff 3 acknowledged there was no record of follow-up on the lorazepam prescription in Resident 94's medical record. Staff 3 acknowledged Resident 94 did not receive her/his requested dose of lorazepam the night of admission and did not receive her/his scheduled doses as ordered the following day.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. Based on interview and record review it was determined the facility failed to ensure facility staff had the appropriate competencies to work with residents with substance use disorders for 1 of 1 facility reviewed for substance use disorder training. This placed residents at risk for diminished physical, mental and psychosocial well-being. Findings include:Resident 9 was admitted to the facility in 3/2026 with diagnoses including psychoactive substance dependence (a chronic condition where an individual requires a substance, such as alcohol, nicotine or drugs to function normally), other stimulant use (the consumption of illicit, prescription or over-the-counter substances that increase alertness and energy) and sedative, hypnotic or anxiolytic abuse (the misuse of central nervous system depressants for euphoric effects or beyond their prescribed purpose, leading to addiction, coma or death). Resident 9's 3/10/26 Hospital History & Physical revealed the resident had a diagnosis of polysubstance abuse disorder, which included abuse of opioids, benzodiazepines and methamphetamine. The History & Physical revealed the resident reported using each of these drugs daily prior to her/his hospitalization. No evidence was found in Resident 9's 4/2026 Care Plan to indicate she/he had a diagnosis of substance use disorder (SUD) or interventions to help staff identify the signs and symptoms of substance use or how to manage and treat the resident's addiction through individualized and person-centered approaches. A review of the facility's annual nursing department trainings revealed no evidence SUD training was provided to facility staff. On 4/24/26 at 9:09 AM, Staff 12 (CNA) stated she had never received any training on working with residents with SUD, including identifying the signs and symptoms of substance use in a resident with SUD. Staff 12 stated she thought Resident 9 had a drinking problem but was unaware of any additional substance abuse concerns for the resident. Staff 12 stated she thought information about a resident with a known SUD could be found in the resident's care plan. On 4/24/26 at 9:20 AM, Staff 34 (Agency CNA) stated she never received any training on working with residents with SUD, including identifying the signs and symptoms of substance use in a resident with SUD. Staff 34 stated she knew Resident 9 drank alcohol but was unaware of any additional substance abuse concerns for the resident. Staff 34 stated there were times when the resident was so drowsy that she/he could barely wake up. Staff 34 did not indicate an understanding of what she was supposed to do on those occasions when she could not rouse the resident as she stated she was unsure of the resident's baseline. On 4/24/26 at 9:44 AM, Staff 27 (CNA) stated she thought the facility admitted a lot of residents with diagnoses SUDs, but she had not received any training on working with residents with SUDs. Staff 27 stated she was unaware Resident 9 had a diagnosis of SUD. On 4/24/26 at 9:58 AM, Staff 33 (LPN) stated she had not received any training at the facility related to working with residents with SUDs. Staff 33 stated she thought Resident 9 had a diagnosis of SUD and interventions related to the resident's substance use and what staff should be on the lookout for was found in the resident's care plan. On 4/24/26 at 10:54 AM, Staff 6 (Social Services Director) stated she could not remember participating in any trainings at the facility related to SUDs. Staff 6 stated residents who had a diagnosis of SUD should have been care planned regarding SUDs. Staff 6 stated she was unaware Resident 9 had a history of drug abuse. On 4/24/26 at 11:50 AM, Staff 4 (RNCM) stated she had not received or provided any trainings related to residents with a diagnosis of SUD. Staff 4 stated she was unaware of other substance abuse concerns for Resident 9 outside of her/his misuse of diazepam (a prescription benzodiazepine medication). Staff 4 stated residents diagnosed with a SUD should have a care plan in place and confirmed Resident 9 did not have a care plan for SUD. O 4/24/26 at 12:12 PM, Staff 2 (DNS) stated she had not provided any staff training specific to residents with a diagnosis of SUD, including identifying the signs and symptoms of substance use in a resident with SUD. Staff 2 stated all residents with a diagnosed SUD should have a related care plan and confirmed Resident 9 did not have a SUD care plan in place.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **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 therapy services as ordered for 4 of 4 sampled residents (#s 8, 50, 82 and 95) reviewed for rehabilitation services. This placed residents at risk for a decline in functional abilities and diminished quality of life. Findings include: Resident 95 was admitted to the facility on [DATE] with a diagnoses including a stroke and a history of falls. The 1/8/26 physician orders prescribed Resident 95 to receive Physical therapy, Occupational therapy and Speech therapy evaluations and treatments as indicated from assessments and evaluations. On 1/9/26 Resident 95 was assessed by Physical therapy to receive therapy five times per week for the certification period of 1/9/26 through 3/9/26. Record review of the Physical therapy records revealed Resident 95 was provided with therapy only four times per week in the following weeks:-2/2/26, 2/3/26, 2/4/26, 2/5/26;-2/9/26, 2/10/26, 2/11/26, 2/12/26;-2/24/26, 2/25/26, 2/26/26 and 2/27/26. On 1/14/26 Resident 95 was assessed for Speech therapy services and not recommended for therapy services at this time. On 1/19/26 Resident 95 was assessed by Speech therapy to require therapy two times per week for the next 60 days. No documentation was provided that indicated Resident 95 was treated by Speech therapy after 1/19/26. Resident 95 was evaluated for Occupational therapy on 2/23/26, 42 days after admission. Record review of the Occupational therapy records revealed Resident 95 was evaluated to need Occupational therapy for five days per week for 60 days. Resident 95 only received Occupational therapy on the following dates: -2/23/26 to 2/27/26 (assessment plus four days);-3/2/26, 3/3/26, 3/4/26 and 3/6/26 (four days);-3/9/26. Resident 95 discharged from the facility on 3/18/26. On 4/24/26 Staff 1 (Administrator) Staff 1 verified Resident 95's therapy services on his computer. Staff 1 confirmed Resident 95 was not provided with therapy services as prescribed. Staff 1 stated he expected Resident 95's Occupational and Speech therapy assessments to be completed in a timely manner and therapy evaluations should have been completed within 48 hours of her/his admission. Staff 1 expected all therapy services provided to residents as often as determined by therapist assessments and signed by the physician. 2. Resident 82 was admitted to the facility in 1/2026, was transferred to the hospital on 2/9/26 and readmitted to the facility on [DATE] with diagnoses including diabetes and mild protein-calorie malnutrition, a form of malnutrition arising from a deficiency of protein, calories and fats necessary to meet bodily needs. Resident 82's 2/13/26 Hospital Discharge and Transfer Orders indicated the resident was prescribed (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a mechanical soft diet (foods that were chopped, ground, mashed or pureed). Resident 82 was to be evaluated and treated by a SLP. Resident 82's SLP records indicated the resident was not assessed by a SLP until 3/2/26, 17 days after her/his readmission. The resident received mechanical soft diet textures until the SLP assessment was completed. On 4/19/26 at 10:50 AM, Resident 82 stated it took a month to get off puree foods. Resident 82 reported she/he was told the facility needed to hire more SLP staff in order to assess her/him and determine if her/his diet could be changed. On 4/22/26 at 12:16 PM, Staff 9 (Regional Director of Rehabilitation) reviewed Resident 82's SLP documentation and confirmed the resident was not assessed until 3/2/26. Staff 9 was unsure why Resident 82 was not assessed by SLP prior to 3/2/26. On 4/22/26 at 1:00 PM and 4/24/26 at 1:46 PM, Staff 1 (Administrator) acknowledged on 2/13/26 Resident 82 was readmitted to the facility with SLP evaluation and treatment orders and confirmed the resident was not assessed until 3/2/26. Staff 1 stated he expected Resident 82's SLP assessment to be completed in a timely manner and the SLP evaluation should have been completed within 48 hours of her/his readmission. 3. Resident 8 was admitted to the facility in 2/2026 with diagnoses including muscle weakness. Resident 8's 2/12/26 Physician Orders directed the resident to be evaluated and treated by OT (Occupational Therapy). Resident 8's 2/17/26 admission MDS revealed the resident was able to make her/himself understood and understand others without difficulty, and she/he had not received any therapy services in the previous seven days. A 4/20/26 OT Evaluation & Plan of Treatment Form revealed Resident 8 received an initial evaluation by OT on 4/20/26. On 4/19/26 at 1:36 PM, Resident 8 was observed in her/his room and sat in her/his wheelchair. Resident 8 stated she/he did not receive any OT and was interested in participating in any therapy that could help her/him to get out of here. On 4/27/26 between 9:29 AM to 10:10 AM, Staff 27 (CNA), Staff 30 (RN), Staff 34 (Agency CNA) and Staff 35 (CNA) stated they had never observed Resident 8 work with therapy since the resident's admission to the facility. On 4/27/26 at 10:36 AM, Staff 8 (Rehabilitation Director) stated therapy evaluations were typically completed the day of or day after an order for therapy was received. Staff 8 stated Resident 8 had an order for an OT evaluation and treatment from 2/12/26 but the evaluation was not completed until 4/20/26 as he had experienced difficulty maintaining Certified Occupational Therapy Assistants. Staff 8 acknowledged Resident 8's therapy evaluation was not timely. 4. Resident 50 was re-admitted to the facility in 10/2025 with diagnoses including anoxic brain injury (damage to the brain due to a lack of oxygen) and right femur fracture (thighbone fracture). (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 50's 11/12/25 Orthopedic After Visit Summary included an order for PT (Physical Therapy). A review of the resident's clinical record revealed no evidence the PT order was acknowledged, clarified, or given to the therapy department. On 4/23/26 at 3:24 PM Staff 4 (RNCM) stated the order must have been missed. She confirmed the therapy department was not informed of the order, the therapy order was not clarified, and the resident did not receive therapy services.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, and record review it was determined the facility failed to complete an accurate assessment prior to initiating restraint use and did not conduct ongoing assessments for 1 of 1 sampled residents (#50) reviewed for restraints. This placed residents at risk for unnecessary restraint use and reduced self-mobility. Findings include: The facility's 4/2017 Use of Restraints policy listed examples of restraints, which included a Geri-chair (medical chair that is a combination of a wheelchair and recliner chair). The policy instructed the facility:- restraints were only to be used when a resident's specific medical condition that could not be addressed by another less restrictive intervention and a restraint is required to a. treat the medical condition; b. protect the resident's safety; and help the resident attain the highest level of her/his physical or psychological well-being.- to complete a pre-restraining assessment, review the assessment, review the risks verses benefits of the restraint use and obtain consent from the resident and/or representative, and obtain a written physician order before the restraint was used.-re-assessment should be completed at least quarterly for possible reduction or discontinuation.Resident 50 was re-admitted to the facility in 10/2025 with diagnoses including anoxic brain injury (damage to the brain due to a lack of oxygen) and right femur fracture (thighbone fracture), which required use of a knee immobilizer to prevented bending of her/his knee.The 3/24/26 Quarterly MDS revealed the Resident 50's cognition was severely impaired.A review of Resident 50's clinical record revealed no evidence of a pre-restraint use assessment, risks/benefit review, consent, physician order for the use of a Geri-chair, or a care plan regarding the Geri-Chair use. On 4/19/26 at 11:45 AM, 4/19/26 at 1:33 PM, 4/19/26 at 3:38 PM, and 4/21/26 at 11: 54 AM Resident 50 was observed in a Geri-chair with her/his feet elevated and the back of the chair reclined. The resident was observed repeatedly raising and dropping her/his head, moving her/his arms and legs.On 4/21/26 at 12:09 PM Resident 50 was observed in the Geri-chair with the footrest lowered and the back of the chair upright. The resident was repeatedly crossing, uncrossing, bouncing, and kicking her/his feet and legs. On 4/21/26 at 4:35 PM Resident 50 was observed attempting to get out of the Geri-chair, leaning forward. Two staff were attempting to keep Resident 50 in the chair. Staff 23 (CMA) told the two staff to lean Resident 50 back by tilting the chair backwards. Resident 50 was observed pushing the footrest back down after the staff had lifted it up. The staff reclined the chair and elevated the footrest a second time, but the resident lowered the footrest again. The staff were observed holding the resident's legs off the ground and began pushing the resident to her/his room.During interviews on 4/23/26 at 11:05 AM Staff 24 (CNA) and 4/24/26 at 9:24 AM with Staff 28 (CNA) stated Resident 50 had a Tilt-in-space wheelchair (a zero-gravity wheelchair) until sustaining the femur fracture. Staff 24 and Staff 28 stated they requested changing from the Geri chair back to the tilt-in-space wheelchair since Resident 50 could bend her/his knee now. Staff 24 and Staff 28 stated Resident 50 used to propel the wheelchair but cannot propel the Geri-chair. On 4/23/26 at 3:24 PM Staff 4 (RNCM) stated she had not identified the Geri-chair as a restraint because she believed the chair to be a tilt-in-space or reclining wheelchair (wheelchair with a back reclines back) since the Geri-chair reclined back. After looking up the difference between the three types of chairs, Staff 4 acknowledged she had incorrectly identified the chair type; the resident was using a Geri-chair. She confirmed an assessment was not completed, and she had not obtained consent from Resident 50's guardian or an order from the physician before using the Geri Chair.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, and record review it was determined the facility failed to provide meaningful activities for dependent residents for 1 of 1 sampled resident (#43) reviewed for activities. This placed residents at risk for lack of social interaction and isolation. Findings include:The facility's Activity Program policy, dated 6/2018, indicated the following: -The Activities Program was provided to support the well-being of residents and to encourage both independence and community interaction.-Activities were based on the comprehensive resident-centered assessment and preferences of each resident. -The Activities Program was ongoing and included facility-organized group activities, independent activities and assisted individual activities. -Activity programs were designed to encourage maximum individual participation and geared to individual resident's needs. Resident 43 was admitted to the facility in 2/2026 with diagnoses including alcoholic cirrhosis of the liver (the final irreversible stage of alcoholic liver disease), encephalopathy (brain dysfunction characterized by altered mental status, confusion and memory loss) and bipolar disorder (a chronic mental health condition characterized by extreme mood swings). Resident 43's 2/25/26 admission MDS indicated the resident had severe cognitive deficits. Resident 43's activity preferences indicated it was very or somewhat important to have newspapers, books and magazines to read, listen to music, do favorite activities, go outside when the weather was good, be around animals, keep up with the news, do things with groups of people and participate in religious services or practices. A 2/26/26 Activities Initial Review revealed Resident 43 enjoyed watching basketball and cooking shows and listening to Rap and metal music. Resident 43 wanted to participate in group, independent and one-on-one activities, including going on facility outings. Resident 43's activities needed to be modified to accommodate the resident's cognitive deficits. Resident 43's 3/4/26 activity care plan indicated the resident had cognitive impairments and required activity engagement to support psychosocial well-being and safe leisure involvement. Activity staff were to: -Offer activities based on Resident 43's interests including video games, basketball viewing, cooking/food shows and music.-Provide access to magazines and encourage reading as a preferred independent activity. -Encourage participation in television programs related to grocery, cooking, sports and educational programming. -Encourage supervised walking within the facility. -Offer conversation and discussion groups related to sports, cooking and television to encourage social interaction. -Provide opportunities for independent leisure such as magazines or TV when Resident 43 did not want to attend group activities. Resident 43's Activity Participation Logs including group, one-on-one and independent activities from 3/20/26 through 4/20/26 revealed: -The resident participated in TV and movies: 4/7/26 and 4/14/26. Resident 43's health record revealed no evidence the resident was provided with magazines, books, newspapers, video games, walks in the facility, educational television programming or music. No evidence was found that Resident 43 was offered or participated in one-to-one visits, group activities of interest to her/him or independent activities from 3/20/26 through 4/20/26 except for a television/movie on 4/7/26 and 4/14/26. Random observations from 4/19/26 through 4/24/26 between the hours of 8:40 AM and 5:04 PM revealed Resident 43 lying on her/his bed wearing a brief, partially covered with a sheet, and the room was typically dark with no stimulation for the resident such as a television show or music playing. The resident often had her/his eyes closed but, at times, was talkative. There were no magazines, newspapers, books, video game equipment, or staff engaging in topics of interest with the resident. Resident 43 was not observed out of her/his bed at any time during the week.On 4/22/26 at 9:09 AM, Staff 11 (CNA) stated most of the time Resident 43 was in bed. She stated she was unable to recall any times when Resident 43 had one-on-one activities provided to her/him. On 4/22/26 at 9:46 AM, Staff 23 (CMA) stated Resident 43 was rarely awake and when awake, she/he had a short attention span. Staff 23 stated Resident 43 loved to walk and eat food. She stated the resident especially enjoyed pumpkin pie and Pepsi.On 4/22/26 at 10:27 AM, Staff 24 (CNA) stated Resident 43 was in bed, a lot and liked (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	video games. She reported occasionally the resident's television was on but not often. Staff 24 stated she did not see any activities occurring with the resident. On 4/23/26 at 11:03 AM, Staff 18 (Activity Director) stated Resident 43 liked to talk and walk in the hallway; otherwise, she did not know much about her/him. Staff 18 stated with residents that had cognitive impairments, she would provide one-on-one activities in the resident's room, bring music to their room, turn on the television to their favorite shows and have conversations or read poems with residents. Staff 18 stated she did not schedule time for one-to-one activities with Resident 43, and there should be things the resident liked in her/his room such as a radio or tablet for music. Staff 18 acknowledged Resident 43 was not being provided with activities of her/his interest or participation level.On 4/23/26 at 4:06 PM, Staff 38 (CNA) stated Resident 43 just lays there. She stated there was no music or television on in the resident's room and five percent of the time she/he might go walking. Staff 38 stated one time she took Resident 43 to the family room where a 90's movie was playing, and the resident enjoyed the movie and was laughing. Staff 38 stated there were no activities or stimulation in Resident 43's room except for a couple of times when the television was on a nature show or soft music was playing. On 4/23/26 at 4:10 PM, Resident 61 (Resident 43's roommate) stated there was no staff interaction or activities occurring with Resident 43 except when staff assisted the resident with eating or changing her/his brief.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review it was determined the facility failed to implement interventions to prevent skin breakdown for 1 of 4 sampled residents (#8) reviewed for pressure ulcers. This placed residents at risk for the development of pressure ulcers and skin breakdown. Findings include:Resident 8 was admitted to the facility in 2/2026 with diagnoses including muscle weakness. Resident 8's 2/17/26 admission MDS revealed the resident was able to make her/himself understood and understand others without difficulty, was at risk to develop pressure ulcers and was to have a pressure reducing device for her/his chair. The Pressure Ulcer CAA indicated a care plan would be developed to improve continence status and to decrease the risk of pressure ulcers. No evidence was found in Resident 8's 4/2026 Care Plan to indicate she/he was to utilize a pressure reducing device in her/his chair. On 4/19/26 at 1:36 PM, Resident 8 was observed in her/his room and sat in her/his wheelchair. No pressure reducing device was observed in the resident's wheelchair. Resident 8 stated she/he had never been offered a cushion for her/his wheelchair, she/he wanted one, and her/his butt hurt when she/he sat in the wheelchair. Random observations of Resident 8 from 4/20/26 to 4/27/26 between 7:38 AM and 3:43 PM revealed the resident to be in her/his room either in her/his wheelchair or in bed. The resident's wheelchair remained within the resident's reach when she/he was in bed. No pressure reducing cushion or device was observed in the resident's wheelchair. On 4/27/26 at 9:29 AM, Staff 27 (CNA) stated she had never observed Resident 8 to use a cushion in her/his wheelchair. Staff 27 stated she thought therapy had to evaluate a resident for a wheelchair cushion prior to it being used and further stated she did not think Resident 8 had been seen by therapy. On 4/27/26 at 9:39 AM, Staff 30 (RN) stated she had never looked to see if Resident 8 had a cushion in her/his wheelchair. Staff 30 stated information on whether a resident utilized a pressure reducing device, such as a cushion for their wheelchair, could be found in the resident's care plan. Staff 30 reviewed Resident 8's care plan and confirmed it did not indicate the resident was to have a pressure reducing device in her/his wheelchair. On 4/27/26 at 9:59 AM, Staff 34 (Agency CNA) stated Resident 8 spent about two-and-a-half hours during dayshift up in her/his wheelchair. Staff 34 stated she was not sure if Resident 8 had a cushion for her/his wheelchair but thought most residents utilized cushions in their wheelchairs to protect their bottoms. On 4/27/26 at 10:10 AM, Staff 35 (CNA) stated Resident 8 was in her/his wheelchair for meals and whenever her/his family visited. Staff 35 stated he could not recall if the resident had a cushion in her/his wheelchair but thought every resident was supposed to have one. On 4/27/26 at 11:02 AM, Staff 3 (LPN-Resident Care Manager) stated information on the use of pressure reducing devices, such as a cushion for a wheelchair, should be found in a resident's care plan. Staff 3 stated Resident 8 was to have a pressure reducing cushion in her/his wheelchair and confirmed it was not identified in her/his care plan. Staff 3 observed Resident 8's wheelchair and confirmed it did not have a pressure reducing cushion in place.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview and record review it was determined the facility failed to provide appropriate wheelchair positioning and head/neck support for 1 of 1 sampled resident (#50) reviewed for mobility and positioning. This placed residents at risk for decreased range of motion and pain. Findings include: Resident 50 was re-admitted to the facility in 10/2025 with diagnoses including anoxic brain injury (damage to the brain due to a lack of oxygen) and right femur fracture (thighbone fracture).Resident 50's 12/25/25 Annual and 3/24/26 MDS revealed the resident had a BIMS score of zero, which indicated she/he was severely cognitively impaired, and did not talk. The resident required substantial/maximal assistance and dependence for bed mobility ADLs. The Pressure Ulcer/Injury and Pain CAA identified Resident 50 to have impaired mobility and had chronic pain.Review of the 3/5/26 Nursing Assessment revealed Resident 50 was completely immobile without assistance and maintained good positioning in the chair and bed.Between 4/19/26 through 4/22/26 between the hours of 8:00 AM through 4:00 PM Resident 50 was observed in a Geri-chair with the backrest upright and the footrest raised. While awake Resident 50 repeatedly dropped and snapped their head back. When Resident 50 was asleep, her/his head was bent and rested on their chest. Resident 50 would awaken after a few minutes and abruptly raise and lower her/his head. Staff passed by without intervening or repositioning the resident. Resident 50's 4/20/26 care plan indicated the resident used a Tilt-in-Space (zero gravity-provides advance postural support including headrest, lateral supports, and adjustable features) wheelchair but did not indicate use of the Geri-chair (medical recliner, or positional care recliner), head/neck positioning preferences, or interventions to prevent forward flexion.Review of Resident 50's clinical records revealed there was no evidence of when the resident was switched from the Tilt-in-Space wheelchair (which had head support) to the Geri-chair (which did not). On 4/20/26 at 6:53 PM Witness 6 (Family Member) stated Resident 50 had altered communication abilities and hung her/his head since the resident sustained the anoxic brain injury. Witness 6 stated they were unaware of any interventions to support the resident's head post brain injury. On 4/22/26 at 9:45 AM Staff 11 (CNA) stated the resident had been bending their head forward for a long time, but was not instructed to reposition or recline the resident and stated it looked painful. On 4/24/26 at 9:24 AM Staff 47 (Activity Staff/CNA) stated she was unsure why Resident 50 bent her/his head to her/his chest. She stated the resident did not have any care planned interventions regarding support for the resident's head but used the resident's stuffed animals to support the resident's head. On 4/24/26 at 11:13 AM Staff 28 (CNA) stated when Resident 50 used the Tilt-in-Space wheelchair, the headrest had side panels that supported the resident's head, so she/he kept her/his head in a supported position, which the Geri-chair did not and the resident struggled holding her/his head up. Staff 28 stated she requested to start using the Tilt-in-Space wheelchair with Resident 50 again but was told to continue using the Geri-chair. On 4/23/26 at 3:24 PM Staff 4 (RNCM) stated Resident 50 was moved into the Geri-chair because the resident could not bend her/his knee after the resident broke her/his femur in 10/2025 and remained in the chair because they felt she/he was more comfortable. Staff 4 stated she thought the Geri-chair was considered a Tilt-in-Space chair. She stated she was unsure when Resident 50 was last assessed for head and neck positioning needs. On 4/27/26 at 8:51 AM Staff 8 (Rehabilitation Director) stated there had been no referrals for positioning or therapy assessment when the Geri-chair was introduced and stated he would have wanted to evaluate the resident's positioning needs at that time.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review it was determined the facility failed to ensure staff followed the care plan related to smoking safety and liquid modifications for 2 of 2 sampled residents (#s 9 and 67) reviewed for smoking and dietary modifications. This placed residents at risk for injury. Findings include:1. The facility's 8/2022 Smoking Policy indicated the following:-Smoking is only permitted in designated resident smoking areas, which are located outside of the building. Smoking is not allowed inside the facility under any circumstances. -Resident smoking status is evaluated upon admission and reevaluated quarterly, upon a significant change and as determined by staff.-Any smoking-related privileges, restrictions and concerns are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. -The facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision. -Residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etc., except under direct supervision. Resident 9 was admitted to the facility in 3/2026 with diagnoses including tobacco use. Resident 9's 3/16/26 Smoking and Safety Evaluation revealed the resident used a vape pen (a battery-powered device that heats a liquid into an aerosol mist to be inhaled and typically contains nicotine, flavorings and other chemicals) and was a supervised smoker as she/he did not follow the smoking protocol. Resident 9's 3/19/26 Smoking and Safety Evaluation revealed the resident used a vape pen and was able to smoke independently. Resident 9's 3/24/26 admission MDS revealed the resident was cognitively intact and did not currently use tobacco. A 4/2/26 Letter to Resident 9 written by Staff 1 (Administrator) revealed the resident was found to smoke in her/his room on two different occasions, and as a result, was determined to require supervision when she/he smoked. Resident 9's 4/8/26 Smoking Care Plan revealed the following:-The resident lost her/his smoking privileges as she/he was observed to smoke/vape inside the facility. -Praise the resident for following safety guidelines.-Support the resident's right to smoke by ensuring and supporting her/him access to the designated smoking area on a supervised schedule. -If concerns or complaints about the new smoking schedule were voiced by the resident, validate her/his feelings.-If the resident demonstrated unsafe smoking behavior, notify Staff 1 and Staff 2 (DNS) immediately, and the nurse was to complete a smoking incident report. On 4/20/26 at 1:02 PM, Resident 9 was observed in her/his room bed. Resident 9 stated she/he did not smoke, vape or maintain any smoking material in her/his room or on her/his person. Resident 9 wore a nicotine patch on her/his right arm and stated she/he was trying to quit smoking. No smoking materials were observed in the resident's room or on the resident's person. On 4/24/26 at 9:09 AM, Staff 12 (CNA) stated she did not think Resident 9 required supervision to smoke. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/26 at 9:20 AM, Staff 34 (Agency CNA) stated resident smoking at the facility was a free for all. Staff 34 stated she was unsure if Resident 9 smoked or vaped, and she had to ask the facility's resident care managers to find out about a resident's smoking status. Staff 34 stated she was aware the resident was found to vape indoors two-to-three weeks ago but was unaware of any additional vaping incidents. Staff 34 stated she had never seen information on a resident's smoking status and/or abilities in a care plan. On 4/24/26 at 9:44 AM, Staff 27 (CNA) stated Resident 9 was an independent smoker and kept her/his smoking materials on her/his bed or in her/his nightstand. Staff 27 stated she heard the resident was found vaping in her/his room last week, but she had never observed the resident to vape indoors. On 4/24/26 at 9:58 AM, Staff 33 (LPN) stated Resident 9 previously lost her/his privilege to smoke independently but was now back to being independent with regards to smoking. Staff 33 stated it was a grey area as to where the resident's smoking materials were kept because her/his smoking status had changed so much and she was not familiar with the current status. Staff 33 stated Resident 9 had been caught a few times recently vaping indoors. On 4/24/26 at 10:54 AM, Staff 6 (Social Services Director) stated Resident 9 required supervision to smoke and her/his smoking material were to be securely stored at the nurse's station when not in use. On 4/24/26 at 11:50 AM, Staff 4 (RNCM) stated Resident 9 required supervision to smoke and her/his smoking material was to be secured at the nurse's station when not in use. Staff 4 stated she expected staff to be aware of the resident's current smoking status and acknowledged they were not. On 4/24/26 at 12:11 PM, Staff 1 and Staff 2 (DNS) were present for an interview. Staff 1 stated Resident 9 was determined to require supervision when smoking/vaping approximately two and a half weeks ago after the resident was repeatedly observed to vape indoors. Staff 1 stated he was trying to be fair but structured and balancing resident rights along with safety. Staff 2 stated vaping was classified the same as smoking, and she expected staff to supervise the resident was she/he vaped. Neither Staff 1 or Staff 2 expressed awareness of any issues regarding Resident 9 continuing to vape indoors. 2. Resident 67 admitted to the facility in 2/2024 with diagnoses including oropharyngeal phase dysphagia (difficulty swallowing). Review of Resident 67's clinical record revealed the following: - The resident was assessed by the SLP on 10/9/25 and was found to aspirate (when food or fluid enters the windpipe to the lungs instead of the stomach) when she/he drank thin liquids and recommended thickened liquids. - A physician order for mildly thick liquid (nectar) consistency was started on 10/9/25. - The 11/7/25 the SLP's ST discharge summary recommended Resident 67 continue receiving thickened liquids. - The 11/21/25 care plan and current Kardex (CNA care plan) instructed facility staff to provide (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 67 with mildly thick (nectar) liquids. - The 2/13/26 Quarterly MDS identifies Resident 67's cognition was moderate impairment. - There was no evidence found a risk assessment to deviate from the diet order or an assessment to independently thicken liquids were completed. On 4/19/26 at 9:55 AM Resident 67 was observed with a water pitcher in front of her/him. Two boxes of single serve thickener packets and one box of hot chocolate packets were visible to be within reach of the resident. Witness 11 (Family Member) reported they have found Resident 67 with thin liquids multiple times and brought the boxes of thickening packets so the resident would have thickener available. On 4/20/26 at 2:30 PM Resident 67 was observed with a mug with a chocolate brown liquid that looked thin. Resident 67 stated an unidentified CNA left her/him with thin hot water, so she/he had just added thickening powder themselves but was having a hard time mixing it and demonstrated the difficulty. A two-inch clump was observed in the mug as the resident attempted to mix in into the liquid. On 4/21/26 at 1:10 PM Staff 45 (CNA) was observed providing Staff 23 (CMA) with a water pitcher that she had been observed filling with ice and water. Staff 23 then handed the water pitcher to Resident 67 without adding thickener. The resident drank from the pitcher and coughed but did not choke. On 4/21/26 at 2:00 PM Staff 24 (CNA) stated Resident 67 was usually good with drinking water from the water pitcher but sometimes would cough. Staff 24 stated she noticed Resident 67 had a water pitcher while assisting Resident 67's roommate with eating lunch and removed it as she left the room. Staff 24 stated Resident 67 drank about one quarter of the water and she had not notified the nurse yet. On 4/21/26 at 2:02 PM Staff 45 stated she was aware Resident 67 required liquids to be thickened and confirmed she gave Staff 23 the ice water without thickening it because she assumed Staff 23 would thicken it before giving it to the resident. Staff 23 stated she had not been trained on thickening liquids. On 4/21/26 at 2:05 PM Staff 23 confirmed she gave Resident 67 the water pitcher without thickening the water because she was unaware the resident had an order for thicken liquids. Staff 23 confirmed she should not have provided the water without thickening it after checking Resident 67's physician orders and care plan. Review of a progress note dated 4/21/26 at 7:09 PM revealed Staff 2 (DNS) found Resident 67 with thin water, which she removed. On 4/22/26 at 9:15 AM Staff 2 stated she was unaware Resident 67 had thickener in her/his room. She confirmed Resident 67 should not have been provided with thin liquids, was not assessed to self-thicken liquids, and additionally found thin liquids in Resident 67's room on 4/21/26. On 4/22/26 at 2:58 PM Staff 47 (Speech Language Pathologist) confirmed Resident 67 aspirated on thin liquids while the resident was on services and staff should not provide Resident 67 with thin liquids. Staff 47 stated Resident 67 was not assessed to self-thicken liquids.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review it was determine the facility failed to ensure residents received appropriate pain management for 1 of 2 sampled residents (#94) reviewed for pain. This placed residents at risk for increased pain. Findings include:Resident 94 was admitted to the facility in 2/2026 with diagnoses including spinal stenosis (a narrowing of spaces within the spine leading to pain), dorsalgia (back pain), anxiety disorder, panic disorder, and opioid dependence. Resident 94's 2/28/26 admission MDS indicated the resident was cognitively intact. Resident 94's 2/24/26 admission orders included the following:Hydrocodone-acetaminophen (an opioid pain reliever) 10 mg - 325 mg oral tablet, give 1 tabs every four hours as needed for pain.Resident 94's 2/2026 MAR indicated the following medication was ordered on 2/24/26 at 10:26 AM:- Hydrocodone-acetaminophen 10 mg - 325 mg oral tablet, give 1 tablet every four hours as needed for pain.- Hydrocodone-acetaminophen 10 mg - 325 mg oral tablet was first administered to the resident on 2/25/36 at 4:25 AM.On 4/21/26 at 1:01 PM Staff 33 (LPN) stated they did not recall Resident 94, the admission, or any issues related to the delivery of hydrocodone-acetaminophen. Staff 33 was unable to provide additional information regarding whether the hydrocodone-acetaminophen prescription was sent to the pharmacy, or why there was a delay in delivery. No documentation by Staff 33 was identified in the medical record to clarify the events surrounding the hydrocodone-acetaminophen prescription and its delivery.On 4/21/26 at 6:26 PM Witness 7 (Complainant) stated Resident 94 was admitted to the facility around noon on 2/24/26. Witness 7 stated the admitting nurse advised Resident 94's hydrocodone-acetaminophen would be delivered to the facility within a few hours of admission. Witness 7 stated at approximately 2:30 AM on 2/25/26 Resident 94 called them in distress indicating she/he was in pain and needed hydrocodone-acetaminophen, and it was not available. Witness 7 stated they contacted the facility, advised the nurse the resident needed pain medication and were told the hydrocodone-acetaminophen prescription had not been sent to the pharmacy. On 4/27/26 at 12:49 PM Staff 36 (CNA) stated Resident 94 was in pain on 2/25/26 and was agitated the night of admission to the facility and the resident requested pain medication several times which they reported to the nurse. Staff 36 stated Resident 94 was upset because her/his hydrocodone-acetaminophen was not available when she/he was told it would be at the time of admission. Staff 36 stated the resident also called Witness 7 twice and reported she/he was in pain and needed her pain medication and had not received it. Staff 36 stated they were unsure what time Resident 94 began requesting pain medication but believed it was early in their shift, which began at 10:00 PM.On 4/22/26 at 5:24 PM Staff 37 (RN) stated the night of Resident 94's admission they received a call from Witness 7 requesting pain medication for the resident reporting she/he had called them from her/his room upset and in pain. Staff 37 stated Resident 94 had admitted to the facility earlier that day with orders for hydrocodone-acetaminophen for pain control, but the prescription had not been sent to the pharmacy, and therefore resident's pain medication was not available for administration. Staff 37 requested a prescription from the on-call provider and a pull-code (a code for secure access) from the pharmacy to access the facility's backup supply of hydrocodone-acetaminophen. Staff 37 administered Resident 94 her/his first dose of hydrocodone-acetaminophen on 2/25/26 at 2:25 AM.On 4/24/26 at 10:35 AM Staff 3 (LPN-Resident Care Manager) and Staff 4 (RNCM) stated the resident was admitted to the facility from home without a hard copy of the hydrocodone-acetaminophen prescription. Staff 4 stated in such cases the admitting nurse should have requested a STAT (immediate) prescription from the on-call provider for Resident 94's hydrocodone-acetaminophen for delivery as soon as possible and ideally within four hours. Staff 3 and Staff 4 stated there should have been diligent follow-up by the floor nurse and documentation reflecting the cause of any delay and the status of the prescription delivery, especially given Resident 94's diagnoses. Staff 3 acknowledged there was no record of follow-up on the hydrocodone-acetaminophen prescription in Resident 94's medical record and the medication was not readily available to the resident upon request.

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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 it was determined the facility failed to ensure appropriate provisions for dialysis care were implemented and timely post-dialysis assessments were completed for 1 of 1 sampled resident (#7) reviewed for dialysis. This placed residents at risk for delayed treatment. Findings include:The facility's 2/2023 Hemodialysis Catheters (a flexible, plastic tube inserted into a large vein, typically in the neck, chest or groin used to provide access for filtering blood in patients with kidney failure) - Access and Care of Policy revealed the following:a. Care immediately following dialysis treatment:-The dressing change is done in the dialysis center post-treatment.-If the dressing becomes wet, dirty, or not intact, the dressing shall be changed by a licensed nurse trained in this procedure. -Mild bleeding from the access site can be expected. Apply pressure to the site and contact the dialysis center for instructions.-If there is major bleeding from the site, apply pressure to access site and contact emergency services and dialysis center. b. Documentation is to be completed by the nurse every shift and should include the location of the catheter, condition of the dressing, any interventions needed, if dialysis was done during the shift, any part of the report from the dialysis nurse post-dialysis being given and observations post-dialysis. Resident 7 was admitted to the facility in 3/2026 with diagnoses including dependence on renal dialysis (a life-sustaining medical procedure that acts as an artificial kidney, filtering waste products, excess salt and fluid from the blood when the kidneys have failed). Resident 7's 3/31/26 admission MDS revealed the resident was cognitively intact and received dialysis while a resident at the facility. Resident 7's 3/2026 Physician Orders revealed the following:-Monitor bruit and thrill (signs of turbulent, rushing blood flow, often indicating a narrowed artery or a functioning dialysis fistula [a surgically created connection, typically in the arm or wrist, that joins an artery directly to a vein to provide access for hemodialysis], signs and symptoms of bleeding, hypotension, nausea, chest pain, unsteady gait, fatigue, seizure, leg cramps, fluid imbalance, headache and/or infection. If noted, document in a progress note and notify the physician of abnormalities every shift. -Send vital signs, the MAR and documentation of the time of the last meal consumed with the resident to the dialysis center in the morning every Monday, Wednesday and Friday. A review of Resident 7's 4/2026 TAR and 4/2026 Dialysis Communication Forms revealed the following: -Monitor bruit and thrill, signs and symptoms of bleeding, hypotension, nausea, chest pain, unsteady gait, fatigue, seizure, leg cramps, fluid imbalance, headache and/or infection. If noted, document in progress notes and notify physician of abnormalities every shift: missing day shift documentation on 4/3/26, 4/4/26, 4/5/26, 4/10/26 and 4/11/26.-No evidence was found to indicate the time of the resident's last meal consumed was communicated to the dialysis center. On 4/19/26 at 12:48 PM, Resident 7 was observed to sit on the bed in her/his room. Resident 7 stated not all nurses assessed her/him when she/he returned from dialysis. On 4/20/26 at 4:34 PM, Resident 7 returned to the facility following dialysis. Resident 7 was observed to wheel her/himself to the nurse's station and hand her/his Dialysis Communication Form to Staff 30 (RN). Staff 30 informed the resident she would pass the form to her/his nurse. Resident 7's access site was covered by her/his jacket, and Staff 30 was not observed to perform a post-dialysis assessment of the resident. Resident 7 independently returned to her/his room in her/his wheelchair. Observations on 4/20/26 between 4:34 PM and 5:10 PM revealed a nurse did not complete a post-dialysis assessment of Resident 7 upon her/his return from dialysis. On 4/20/26 at 5:10 PM, Staff 31 (LPN) stated she was the nurse responsible for the care of Resident 7. Staff 31 stated nurses were expected to complete a post-dialysis assessment of Resident 7 as soon as she/he returned from dialysis, but she was unable to do so as she was on break when the resident returned. Staff 31 stated Staff 30 should have completed the assessment when the resident returned from dialysis, but since Staff 30 did not, she would complete Resident 7's post dialysis assessment as soon as she finished checking resident blood sugars. On 4/20/26 at 5:15 PM and 4/27/26 at 9:49 AM, Staff 30 stated post-dialysis assessments should be completed immediately upon a resident's (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	return from dialysis. Staff 30 stated she did not complete a post-dialysis assessment for Resident 7 on 4/20/26 following her/his return from dialysis because these assessments were usually completed by the nurse who was assigned to the resident. On 4/22/26 at 9:40 AM, Staff 32 (LPN) stated he completed resident post-dialysis assessments as soon as possible, which included checking vital signs and the access site to ensure it was not bleeding.On 4/24/26 at 10:47 AM, Staff 33 (LPN) stated she completed resident post-dialysis assessment within the hour of the resident's return from dialysis. Staff 33 reviewed Resident 7's 4/2026 TAR and 4/2026 Dialysis Communication Forms and stated documentation of the time of the resident's last meal was not being communicated to the dialysis center. On 4/24/26 at 11:36 AM, Staff 3 (LPN-Resident Care Manager) stated she was unsure of the timeframe as to when resident post-dialysis assessments should be completed. On 4/24/26 at 12:31 PM, Staff 2 (DNS) stated resident post-dialysis assessments should be completed upon a resident's return from dialysis. Staff 2 stated Resident 7's post-dialysis assessment on 4/20/26 was not timely. Staff 2 further stated she expected staff to follow physician orders with regards to dialysis care and confirmed the time of Resident 7's last meal was not being communicated to the dialysis center, and she could not provide an explanation for the missing documentation on the resident's 4/2026 TAR.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on observation, interview and record review it was determined the facility failed to ensure residents who were trauma survivors received trauma-informed care for 3 of 3 sampled residents (#s 8, 41 and 49) reviewed for trauma-informed care. This placed residents at risk for re-traumatization and a decrease in their quality of life. Findings include:The facility's 8/2022 Trauma-Informed and Culturally Competent Care Policy revealed the following: -Universal screening of residents, which includes a brief, non-specialized identification of possible exposure to traumatic events will be performed.-The initial screening will be utilized to identify the need for further assessment and care. -Assessment involves an in-depth process of evaluation of the presence of symptoms, their relationship to trauma, as well as the identification of triggers. -Individualized care plans will be developed that address past trauma in collaboration with the resident and family as appropriate. 1. Resident 8 was admitted to the facility in 2/2026 with diagnoses including PTSD (post-traumatic stress disorder). A 2/4/26 History & Physical Hospital Note revealed Resident 8 had a history of attempted suicide and experienced PTSD as a result of an attempted strangulation by her/his spouse. Resident 8's 2/12/26 Social Services Evaluation indicated the following:-The resident had an experience that was so upsetting that it changed her/him emotionally, spiritually, physically or behaviorally. -A trauma care plan was needed. Resident 8's 2/17/26 admission MDS revealed the resident was able to make her/himself understood and understand others without difficulty. Resident 8's 2/17/26 Care Plan revealed the following:-The resident had a history of physical, emotional or mental distress due to changes in her/his living situation. -Staff were to initiate increased supervision or close visual supervision per policy if the resident exhibited behaviors that presented a significant risk and notify the physician. -The resident's medications were to be reviewed with her/his physician to determine if there was a need to change the current medication regimen. No evidence was found in Resident 8's clinical record to indicate the resident's past history of trauma and/or triggers which could cause re-traumatization were identified or assessed. On 4/19/26 at 1:40 PM, Resident 8 was observed in her/his room and sat in her/his wheelchair. Resident 8 stated she/he experienced trauma but was unable to provide any additional information or details. On 4/27/26 at 9:29 AM, Staff 27 (CNA) stated she was unaware if Resident 8 experienced any trauma or any potential triggers that could cause re-traumatization. Staff 27 stated this information was found in the resident's care plan. On 4/27/26 at 9:32 AM, Resident 8 was observed in her/his room in bed. Resident 8 stated she/he had experienced trauma and religious literature and talks really helped to not dwell on the past. Resident 8 further stated she/he felt more comfortable working with women instead of men but no one at the facility had asked her/him about her/his care preferences. On 4/27/26 at 9:39 AM, Staff 30 (RN) stated she was unaware of any trauma history for Resident 8, (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but she would look in the resident's care plan to find information on potential trauma triggers. On 4/27/26 at 9:59 AM, Staff 34 (Agency CNA) stated she was unaware if Resident 8 experienced any trauma or of any potential triggers that could cause re-traumatization. Staff 34 further stated she found the resident was more receptive to care when it was provided in a sweet and gentle manner and tasks were thoroughly explained. On 4/27/26 at 10:10 AM, Staff 35 (CNA) stated he was unaware if Resident 8 experienced any trauma or of any potential triggers that could cause re-traumatization. Staff 35 stated the resident did experience episodes of increased anxiety when she/he rubbed her/his hands and complained of not being able to sleep. On 4/27/26 at 10:22 AM, Staff 6 (Social Services Director) stated all residents with a history of trauma should have a trauma-informed care plan in place. Staff 6 stated she was unaware of Resident 8's diagnosis of PTSD or her/his history of trauma. Staff 6 stated she did not reapproach the resident about her/his trauma after her/his initial trauma screen to identify possible trauma triggers, did not talk to the resident's family about her/his trauma history or create a trauma-informed care plan. 2. Resident 49 was admitted to the facility in 9/2025 with diagnoses including schizophrenia (a chronic, severe brain disorder affecting how a person thinks, feels and behaves). Resident 49's 9/23/25 Hospital Psychiatric Evaluation revealed the following:-The resident had a hoarding disorder (a mental health condition characterized by a persistent difficulty discarding possessions, regardless of their actual value, leading to severe clutter that compromises living spaces).-The resident experienced food insecurity, hoarded food, lived in unsanitary conditions and was homeless in the last year. Resident 49's 1/30/26 Social Services Evaluation revealed the following:-The resident had an experience that was so upsetting it changed her/him emotionally, spiritually, physically or behaviorally. -The resident felt angry/had angry outbursts in response to stressful events. -A trauma care plan was not needed. Resident 49's 4/4/26 Quarterly MDS revealed the resident was severely cognitively impaired and experienced episodes of disorganized thinking (fragmented, illogical or disjointed thoughts often manifesting as incoherence or rapid shifting between unrelated topics), inattention and hallucinations. On 4/20/26 at 1:14 PM, Resident 49 was observed in her/his room and sat in her/his wheelchair. The resident had an unpleasant body odor and her/his clothes appeared dirty. The foot of the resident's bed was covered with her/his personal belongings, and the resident wore a necklace of permanent markers that covered the front on her/his chest. The resident was unable to answer any questions related to her/his trauma history as her/his speech was disorganized (incoherent, illogical or rambling speech). On 4/21/26 at 11:56 AM, Staff 27 (CNA) stated she was unsure if Resident 49 had a history of trauma but thought the resident may have been in the military. Staff 27 stated taking things from people was her/his thing, but she was unsure of why the resident took things from others. On 4/21/26 at 1:13 PM, Staff 34 (Agency CNA) stated you can tell [she/he] likes to hoard but was unsure if Resident 49 had a history of trauma. Staff 34 stated the resident was very territorial, (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refused to change her/his clothes and bathe and was very particular at mealtimes. Staff 34 stated a resident's trauma history and potential trauma triggers were found in the resident's care plan. On 4/21/26 at 7:22 PM, Staff 17 (LPN) stated Resident 49's trauma triggers included being touched or when a person touched any of her/his belongings. Staff 17 further stated information on a resident's trauma history and trauma triggers were found in the resident's care plan. On 4/22/26 at 9:02 AM, Witness 10 (Friend) stated Resident 49 had a history of being homeless, hoarding and living in unsanitary conditions. Witness 10 stated he was unsure if Resident 49 served in the military, but the resident had talked about previous military experiences. On 4/22/26 at 10:28 AM, Staff 3 (LPN-Resident Care Manager) stated she was unaware of Resident 49's history of being homeless but that would actually explain some of the behaviors the resident exhibited at the facility. On 4/22/26 at 11:27 AM, Staff 6 (Social Services Director) stated all residents with a history of trauma should have a trauma-informed care plan in place. Staff 6 stated she was aware of some of Resident 49's past traumas, including food insecurity and being homeless. Staff 6 acknowledged she did not create a care plan specific to trauma-informed care for the resident, and she should have. 3. Resident 41 was admitted to the facility in 7/2025 with diagnoses including PTSD (Post-Traumatic Stress Disorder). Review of the 7/9/25 Social Services Evaluation revealed a trauma care plan was needed because Resident 41 had a trauma history, which included past physical assault, assault with a weapon, and war zone combat trauma and the resident reported having disturbing thoughts, images, or dreams and she/he would avoid certain situations to avoid remembering the traumas. Resident 41's 7/28/25 admission MDS revealed the resident was able to make her/himself understood and understand others without difficulty. Review of Resident 41's 7/21/26 Care Plan revealed no evidence trauma related care planning was completed. On 4/19/26 at 11:09 AM Resident 41 stated that she/he had PTSD bad because of her/his Vietnam War combat and war related injuries. The resident indicated triggers included talking about the trauma, dreams, and pain from injuries sustained during the war, which was why it was important to the resident that pain and psychotropic medications were not reduced or discontinued. Interviews on 4/21/26 at 11:27 AM with Staff 11 (CNA), 4/22/26 at 3:28 PM with Staff 41 (CNA), and 4/23/26 at 11:05 AM with Staff 24 (CNA) stated they were unaware of Resident 41's trauma history. They stated they would look in the care plan but were unaware of Resident 41's signs or symptoms or possible triggers. On 4/23/26 Staff 6 (Social Services Director) stated if a resident admits with a diagnosis of PTSD or has past traumas a trauma care plan was created. She confirmed was aware of the resident's trauma and she did not develop a trauma care plan for Resident 41 but should have.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on observation, interview and record review it was determined the facility failed to identify and ensure a resident with a diagnosed substance use disorder and/or mental health disorder received necessary behavioral health care and services for 2 of 2 sampled residents (#s 9 and 49) reviewed for smoking and dementia care. This placed residents at risk for unaddressed behavioral and emotional needs and a decrease in their quality of life. Findings include: 1. Resident 9 was admitted to the facility in 3/2026 with diagnoses including psychoactive substance dependence (a chronic condition where an individual requires a substance, such as alcohol, nicotine or drugs to function normally), other stimulant use (the consumption of illicit, prescription or over-the-counter substances that increase alertness and energy) and sedative, hypnotic or anxiolytic abuse (the misuse of central nervous system depressants for euphoric effects or beyond their prescribed purpose, leading to addiction, coma or death).Resident 9's 3/10/26 Hospital History & Physical revealed the resident had a diagnosis of polysubstance abuse disorder, which included abuse of opioids, benzodiazepines and methamphetamine. The History & Physical further revealed the resident reported using each of these drugs daily prior to her/his hospitalization. No evidence was found in Resident 9's 4/2026 Care Plan to indicate she/he had a diagnosis of substance use disorder (SUD) or interventions to help staff identify the signs and symptoms of substance use or to manage and treat the resident's addiction through individualized and person-centered approaches. On 4/24/26 at 9:09 AM, Staff 12 (CNA) stated she thought Resident 9 had a drinking problem but was not aware of any additional substance abuse concerns for the resident. Staff 12 stated she hoped information about a resident with a known SUD could be found in the resident's care plan. On 4/24/26 at 9:20 AM, Staff 34 (Agency CNA) stated she knew Resident 9 drank alcohol but was unaware of any additional substance abuse concerns for the resident. Staff 34 stated there were times when the resident was so drowsy that she/he could barely wake up. Staff 34 did not indicate an understanding of what she was supposed to do on these occasions when she could not rouse the resident as she stated she was unsure of the resident's baseline. On 4/24/26 at 9:44 AM, Staff 27 (CNA) stated she thought the facility admitted a lot of residents with diagnoses of SUDs, but she was unaware if Resident 9 had a diagnosis of SUD. On 4/24/26 at 9:58 AM, Staff 33 (LPN) stated she thought Resident 9 had a diagnosis of SUD and interventions related to the resident's substance use and what staff should be on the lookout for should be in the resident's care plan. Staff 33 stated there had been instances when she had to hold the resident's scheduled medications because the resident appeared sedated. Staff 33 stated these instances when the resident appeared sedated were observed after the resident returned from being out of the facility. On 4/24/26 at 10:33 AM, Resident 9 was observed in her/his room and sat in her/his wheelchair. Resident 9 stated she/he had a history of substance abuse but did not provide any additional information regarding this topic. Resident 9 stated she/he had been offered treatment and therapy groups, but was not interested. On 4/24/26 at 10:54 AM, Staff 6 (Social Services Director) stated residents who had a diagnosis of SUD should have a care plan in place and further stated she was unware Resident 9 had a history of drug abuse. On 4/24/26 at 12:12 PM, Staff 2 (DNS) stated care plans should include individualized interventions related to the resident's diagnosed conditions, including SUD, and acknowledged Resident 49's care plan lacked behavioral interventions. 2. Resident 49 was admitted to the facility in 9/2025 with diagnoses including schizophrenia (a chronic, severe brain disorder affecting how a person thinks, feels and behaves, causing a disconnection from reality) and dementia.Resident 49's 4/4/26 Quarterly MDS revealed the resident was severely cognitively impaired, exhibited the behavior of rejecting care and experienced episodes of disorganized thinking (fragmented, illogical or disjointed thoughts often manifesting as incoherence or rapid shifting between unrelated topics), inattention and hallucinations. A 4/6/26 Progress Note completed by Staff 44 (Physician Assistant-Certified) indicated the following:-Resident 49 (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	experienced a recent behavioral escalation, which included aggression, paranoia and altercations.-The resident demonstrated significant paranoid ideation and disorganized thought process during her examination of the resident. -The resident required frequent reorientation related to her/his severe dementia. Resident 49's 4/20/26 Care Plan revealed the resident experienced hallucinations, delusions and/or paranoia related to her/his diagnosis of schizophrenia, had hoarder tendencies and stole items from staff and the facility. Interventions included the following:-Document the resident's hallucinations, delusions and paranoia when it occurred.-Listen to the resident when she/he verbalized what occurred.-Consult with family to determine if these experiences were common in the resident's past, and if so, what the treatment was for these perceptions.-Stress reducing interventions included: to take items back that she/he took, example blankets, creams, etc. -The resident needed reassurance and support by staff for all bathing activities. -Monitor the resident's antipsychotic medications.-Psych consult as needed. No evidence was found in Resident 49's clinical record to indicate an individualized and person-centered care plan was developed to support the behavioral health care needs of the resident. On 4/20/26 at 1:14 PM, Resident 49 was observed in her/his room and sat in her/his wheelchair. The resident had an unpleasant body odor and her/his clothes appeared dirty. The foot of the resident's bed was covered with her/his personal belongings, and the resident wore a necklace of permanent markers that covered the front of her/his chest. The resident was unable to answer any questions related to her/his mood or psychosocial well-being as her/his speech was disorganized (incoherent, illogical or rambling). On 4/21/26 at 11:26 AM, Staff 31 (LPN) stated Resident 49 refused care all of the time, but her/his cooperation was dependent upon the way you approach. Staff 31 stated the resident was more likely to refuse care when staff were bossy and/or in a rush. On 4/21/26 at 1:13 PM, Staff 34 (Agency CNA) stated Resident 49 refused to change her/his clothing, and if you pushed the resident a little to change her/his clothes, the resident would yell. Staff 34 stated establishing trust with the resident was very important, and she did not want to agitate the resident or have her/him loose trust in her, so she did not approach the resident to change her/his clothes. Staff 34 stated the resident liked to hoard, and took items that did not belong to her/him, especially pens. Staff 34 stated she did not confront the resident when she/he took items that did not belong to her/him because her/his behaviors worsened. Staff 34 stated a lot of the house staff knew to avoid confrontation with the resident and to remove items that did not belong to her/him from the resident's room when not present. On 4/21/26 at 1:53 PM, Staff 44 (Physician Assistant-Certified) stated Resident 49 had abnormal thought processes and recently experienced an increase in paranoid thinking and behaviors, including hoarding and throwing things at people. Staff 44 stated the resident's behaviors were off and on since her/his admission to the facility, and something would set [her/him] off, and we don't know why. On 4/21/26 at 7:22 PM, Staff 17 (LPN) stated Resident 49 was very particular and felt like building repour and continuity was important when working with the resident. Staff 17 stated the resident refused to change clothes or shower and thought her/his refusals were due to his/her mental illness. Staff 17 stated the resident did not like people messing with her/his stuff, and you can't leave anything out and around or the resident would take it. Staff 17 stated she thought information on the resident's behaviors and related interventions were found in the resident's care plan. On 4/21/26 at 4:43 PM, Staff 40 (CNA) stated Resident 49 got violent if you touched her/his belongings, including items the resident had taken from others. Staff 40 stated the resident took stacks of cups, papers and pens that belonged to the facility staff as well as her/his roommate's belongings, and staff needed to retrieve the items when the resident was not looking. Staff 40 stated she observed staff confront the resident after she/he had taken a pen that did not belong to her/him and the resident went crazy. Staff 40 stated the resident was calm and cooperative when staff didn't have an attitude and took the time to talk to and get to know her/him. Staff 40 stated the care plan should tell us everything about the resident, including behaviors and interventions, but was unsure if Resident 49's care plan contained interventions to help staff with the resident's behaviors. Staff 40 stated Resident 49 did not do well when her/his routine was changed. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff 40 stated CNAs were constantly changing sections so Resident 49 was always working with different staff, which negatively impacted the resident. On 4/22/26 at 9:02 AM, Witness 10 (Friend) stated Resident 49 hoarded food, stole from others and refused care daily. Witness 10 stated having a consistent routine helped the resident and thought continuity in staff would help to mitigate the resident's behaviors. On 4/22/26 at 9:45 AM, Staff 32 (LPN) stated Resident 49 was verbally and physically aggressive, and her/his behaviors increased when staff directed any accusations towards the resident. Staff 32 stated interventions to address resident behaviors were found in the resident's care plan. Staff 32 stated it would be beneficial for Resident 49 to work with consistent CNAs but currently CNAs rotated sections every day. On 4/22/26 at 10:28 AM, Staff 3 (LPN-Resident Care Manager) and Staff 2 (DNS) were present for an interview. Staff 3 stated Resident 49 had trust issues, refused all personal care, hoarded various items, such as the facility's cups and permanent markers, and became verbally aggressive when repeatedly approached by staff with a question or direction. Staff 3 stated the resident tolerated a few staff and her/his behaviors were improved with certain male staff. Staff 2 (DNS) stated care plans should include individualized interventions to meet the behavioral needs of residents and acknowledged that Resident 49's care plan lacked behavioral interventions.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review it was determined the facility failed to ensure a medication error rate of less than five percent during medication administration for 2 of 10 sampled residents (#s 74 and 82) reviewed for medication administration. The facility's medication administration error rate was 11.11%. This place residents at risk for subtherapeutic dosing and uncontrolled blood sugars. Findings include: The 2016 insulin aspart (NovoLog) FlexPen manufacturer Guide to Using Your NovoLog FlexPen indicated the insulin pens should be primed with two units of insulin prior to each administration to ensure the correct dose was delivered. 1.Resident 74 was admitted to the facility in 2/2022 with diagnoses including type 2 diabetes mellitus (a chronic condition affecting the body's ability to control blood sugar levels).Resident 74's 6/2024 Physician Orders included the following:- insulin aspart (a rapid acting insulin) 100 unit/ml - give 7 units with meals for type 2 diabetes mellitusOn 4/21/26 at 7:08 AM Staff 31 (LPN) was observed to administer insulin aspart to Resident 74 and did not prime the insulin pen prior to administration. On 4/21/26 at 7:08 AM Staff 31 acknowledged they did not prime the insulin pen and expressed it was not part of their practice. On 4/23/26 at 4:22 PM Staff 2 (DNS) was notified Resident 74's insulin pen was not primed prior to administration. Staff 2 stated they expected all nursing staff to prime insulin pens prior to insulin administration.2. Resident 82 was admitted to the facility in 1/2026 with diagnoses including type 1 diabetes mellitus (a chronic condition in which the body cannot make insulin).Resident 82's 4/2026 Physician Orders indicated the following:1. insulin aspart (a rapid acting insulin) 100 unit/ml - give 3 units with meals related to type 1 diabetes mellitus2. insulin aspart 100 unit/ml - give per sliding scale before meals and at bedtime related to type 1 diabetes mellitus.On 4/21/26 at 7:21 AM Resident 82 was observed leaving the dining room and confirmed she/he had already eaten breakfast.On 4/21/26 at 7:21 AM Staff 31 was observed to administer insulin aspart 6 units (3 units scheduled and 3 units per sliding scale) to Resident 82.On 4/21/26 at 7:21 AM Staff 31 acknowledged Resident 82 received both scheduled and sliding scale doses of insulin aspart after his/her meal.On 4/23/26 at 4:22 PM Staff 2 (DNS) stated insulin was expected to be administered before or with meals as ordered, and acknowledged Resident 82's insulin was not administered in accordance with the ordered timing.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview it was determined the facility failed to ensure a functional and comfortable environment for 1 of 1 resident rooms reviewed for lighting. This placed residents at risk for diminished quality of life and quality of care. Findings include:The facility's 2/2021 Homelike Environment Policy revealed comfortable and adequate lighting is provided in all areas of the facility to promote a safe, comfortable and homelike environment. The lighting design emphasizes sufficient general lighting in resident-use areas, task lighting as needed and night lighting to promote safety and independence. Resident 9 was admitted to the facility in 3/2026 with diagnoses including quadriplegia (paralysis affecting all four limbs and the torso). Resident 9's 3/24/26 admission MDS revealed the resident was cognitively intact. On 4/23/26 at 7:32 AM, Resident 9 was observed in bed in the room she/he shared with two additional residents. A curtain was pulled to the left of the resident's bed and another one at the foot of the bed to divide the room space and to allow for privacy. No light switch, light fixture or lamp was visible on Resident 9's portion of the room. A light fixture was observed on the ceiling of the room located on the other side of the pulled curtain at the foot of the resident's bed. Resident 9 stated she/he had not had her/his own light since she/he had been in this room, and she/he wanted her/his own light, especially to use at night to be able to watch television and to just be able to have a dim light. Resident 9 further stated it sucks at night because everyone gets woken up because they have to use my roommate's light to change me. On 4/24/26 at 9:20 AM, Staff 34 (Agency CNA) stated all of the CNAs at the facility did not like light situation in Resident 9's room. Staff 34 stated Resident 9 did not have access to a light in her/his portion of the room. Staff 34 further stated she woke up Resident 9's roommates when she turned on the shared light and that was why one of her/his roommates slept with a pillow covering her/his head. On 4/24/26 at 9:44 AM, Staff 27 (CNA) stated Resident 9's room had only one light which was located outside of the resident's portion of the room. Staff 27 stated she felt unsafe when she assisted the resident with transfers or personal hygiene because of the light situation in the room. Staff 27 further stated she frequently woke up one of the resident's roommates and the other roommate slept with a blanket over her/his head because of the lack of lighting in the room. On 4/24/26 at 9:58 AM, Staff 33 (LPN) stated the limited lighting in Resident 9's room posed a safety concern for all three residents who shared the room. On 4/24/26 at 12:03 PM, Staff 1 (Administrator) and Staff 7 (Maintenance Director) were present for an interview. Staff 1 stated each resident was to have their own light that they could independently access. Staff 1 stated Resident 9 was provided with a lamp because of the lighting situation in her/his room. Staff 1 and Staff 7 stated they were unaware the lamp was not available in Resident 9's room.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on interview and record review it was determined the facility failed to the ensure the Direct Care Staff Daily Report (DCSDR) postings were accurate and complete for 28 of 49 days reviewed for staffing. This placed residents and the public at risk for inaccurate and incomplete staffing information. Findings include:The facility's Staffing, Sufficient and Competent Nursing Staff policy, dated 8/2022, indicated the direct care daily staffing numbers were posted in the facility for every shift. A review of the facility's DCSDR postings revealed the following: From 3/1/26 through 4/19/26, 49 days were reviewed and revealed 28 days when licensed nurse staff hours were inaccurate or the postings had missing/incomplete information including no census and inaccurate recording of licensed nursing hours on 3/1/26, 3/2/26, 3/3/26, 3/4/26, 3/5/36, 3/6/26, 3/7/26, 3/8/25, 3/9/26, 3/14/26, 3/16/26, 3/17/26, 3/20/26, 3/29/26, 3/30/26, 3/31/26, 4/3/26, 4/5/26, 4/6/26, 4/7/26, 4/11/26, 4/13/26, 4/14/26, 4/15/26, 4/16/26, 4/17/26, 4/18/26 and 4/19/26. On 4/23/26 at 9:40 AM, Staff 22 (Staffing Coordinator) reviewed the 3/1/26 through 4/19/26 DCSDR postings and verified the reports were inaccurate or incomplete on the days identified.