STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425127	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth- Rock Hill	261 S Herlong Ave Rock Hill, SC 29732

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of facility policy, the facility failed to ensure sanitary conditions were maintained in the kitchen by positioning a garbage/refuse cart containing visible waste in close proximity to clean food service items during active tray assembly in one (1) of one (1) kitchen observed. This practice created the potential for contamination of clean trays and plate covers and increased the risk for foodborne illness and infection transmission.Findings include:Record review of facility policy titled, Waste Disposal: Dietary Services last revised 04/11/16 revealed, It is the policy of PruittHealth for the Dietary Department to dispose of waste in an effective manner in order to prevent a breeding place for insects, rodents, and transmission of diseases. This policy applies to all dietary partners employed by PruittHealth. Garbage disposal areas should be separate from food prep areas.Record review of facility policy titled, Dishroom Sanitation last revised 03/22/16 revealed, It is the policy of PruittHealth that the dish room must be maintained in a clean and sanitary condition. Dishwashing and sanitizing procedures will be available in the Dietary Department. This policy applies to all dietary partners employed by PruittHealth. Both full and empty dish racks are to be stored on a dish rack dolly, cart, or under a shelf in the dish room at all times. Dish racks should not be stored on the floor.On 2/17/2026 at 10:36 AM, during a walkthrough of the kitchen and dishwashing area, observation revealed a large trash/garbage cart containing visible waste positioned adjacent to a rack of clean plate covers. The trash cart was open and located next to racks of clean food service tray covers on the kitchen floor near the food service area during active dishwashing.On 2/18/2026 at approximately 10:50 AM, a second observation during lunch tray preparation revealed the same trash/garbage cart containing visible waste positioned adjacent to clean plate covers stored on the kitchen floor. The cart was also located in close proximity to racks of clean food service trays and the active lunch tray assembly area. The Dietitian was observed assisting with tray preparation at the time. The refuse cart remained positioned near clean food service items within the kitchen.During an interview on 2/18/26 at approximately 11:00 AM, the Dietitian stated the trash bin was kept in the kitchen because there was no alternative location to store it while the Kitchen Manager (KM) removed food debris from plates, pre-rinsed soiled dishware, and loaded the high-temperature dishwashing machine.During an interview on 2/19/26 at approximately 12:20 PM, the KM stated he was using the trash bin in that location temporarily for one day because he was working alone. He further stated that normal practice is to dispose of trash in a designated bin and remove it appropriately, and that keeping the bin in that location is not standard procedure. Despite observations made on two separate days, the KM maintained this was not usual practice.During an interview on 2/19/26 at 6:45 PM, the Administrator stated garbage is expected to be stored outside of the kitchen and not maintained on the kitchen floor. Upon review of the observations, she further acknowledged the refuse bin was not appropriately placed and should not have been maintained in that area.

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and review of facility policy, the facility failed to maintain the refuse disposal area in a sanitary and safe manner by failing to ensure dumpster doors remained closed in two (2) of two (2) dumpsters observed. The facility's failure to keep refuse container doors closed had the potential to attract pests and create unsanitary conditions, increasing the risk of environmental contamination.Findings include:Review of facility policy titled, Waste Disposal: Dietary Services, last revised 04/11/2016, revealed, It is the policy of PruittHealth for the Dietary Department to dispose of waste in an effective manner in order to prevent a breeding place for insects, rodents, and transmission of diseases. Garbage disposal areas should be separate from food prep areas.On 2/18/2026 at approximately 10:15 AM, the Housekeeping Supervisor escorted the surveyor to the refuse area and provided a tour of the facility's garbage storage area. Observation revealed two (2) garbage dumpsters with doors open and one cardboard compactor with the black lid flipped over the back of the container, exposing cardboard contents to environmental elements. Specifically, one dumpster had a single door open, and the second dumpster, located closest to the facility, had both side doors open.During the tour of the facility's garbage storage area, the Housekeeping Supervisor stated, Those are supposed to be closed; I think I have some gloves on me. I'll close those, and immediately proceeded to close the dumpster doors. No attempt was made to close the cardboard compactor lid.On 2/18/2026 at approximately 2:48 PM, a second observation of the dumpster visible from a facility hallway window revealed the dumpster door again open.On 2/19/2026 at approximately 3:28 PM, a third observation revealed the same dumpster located outside the facility, within view from a hallway window, with the door open.During an interview on 2/19/2026 at approximately 6:45 p.m., the Administrator stated that dumpster doors are expected to remain closed and that refuse areas should be maintained in a clean and sanitary condition to prevent contamination.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interviews, and record review, the facility failed to maintain 1 of 1 laundry washers in a safe operating condition. Specifically, the facility failed to ensure that 2 filters were cleaned daily for the UniMac washer.Findings include:On 02/18/26 at approximately 10:00 AM, a tour of the laundry room revealed that 2 of 2 filters on the Unimac washer were dusty and filled with black debris. A manufacturer's sign posted below the filters reads, clean filter daily.Review of an Alliance Laundry Systems Washer Manufacturer guidelines revealed: Maintenance End of Day4. If applicable, clean the AC invert drive filter. a. Remove the external plastic cover which contains the filter. b. Remove the foam filter from the cover.c. Wash the filter with warm water and allow air to dry. Filter can be vacuumed clean.During an interview on 02/18/26 at approximately 10:09 AM, the Laundry Assistant, reports that the maintenance department cleans the dryer lint filters and stated she was unaware washer filters were to be cleaned.During an interview on 02/18/26 at approximately 10:15 AM the floor tech/maintenance assistant stated, it was the laundry staff's responsibility to keep dryer and washer filters clean, and he mainly does the facility floors. Floor tech reports he sometimes assists in maintenance as needed, but his job is mainly a floor tech.During an interview on 02/18/26 at approximately 10:30 AM the Laundry Supervisor acknowledged the washer filters are dirty and need cleaning. Laundry supervisor stated she educated staff on how to clean washer filters using a small brush. Laundry supervisor reports she currently does not have a cleaning log sheet for the washer, but will implement a log sheet. Laundry supervisor states that because the facility has 1 washer, maintenance of the washer is a priority.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, record review, and interviews, the facility failed to ensure the Electronic Medical Record (EMR) accurately reflected the Resident's Advance Directives. Specifically Resident (R)23 and (R)128 did not have advance directives that matched their Physician Orders. Findings include: Review of the facility policy titled Advanced Directives: South Carolina last revised on [DATE], revealed, This healthcare center recognizes the right of patients/residents to control decisions related to their medical care. Advanced Directives relate to the provision of care when the patient/resident lacks the capacity to make healthcare decisions. Advanced Directives executed in accordance with state law will be honored by the healthcare center. Procedure: 5. Revocation of Advance Directive: The healthcare center shall enter in the patient/resident's medical record any change in or termination of the advance directive for health care that becomes known to the healthcare center. 1.Review of R128's Face Sheet revealed R128 was admitted to the facility on [DATE], with diagnoses including but not limited to: peripheral vascular disease, heart failure, anxiety disorder, acute kidney failure and plural effusion. Review of R128's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed R128 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicates that she is cognitively intact. Review of R128's Nurses Note dated [DATE], revealed, Patient [R128] decided she wants hospice care. Social Worker informed facility nurse and NP [Nurse Practitioner] as well as hospice staff. It was decided that patient will go under hospice care tomorrow. Review of R128's Physician Orders for February 2026, an order for Full Code. Review of R128's DNR Authorization Form for Patient/Resident with Decision - Making Capacity: States of Florida, North Carolina and South Carolina dated [DATE] revealed resident was informed of and understood the risks and benefits of Cardiopulmonary Resuscitation (CPR) and requested that CPR not be initiated in the event of cardiopulmonary resuscitation. This form was signed by the physician on [DATE]. Review of R128's Care Plan last reviewed/revised on [DATE], revealed, Advanced Directive: Allow Natural Death- Do not attempt resuscitation. Advise patient/resident and or appointed healthcare representative to provide copies to the facility of an updated Advanced Directives, all staff to be made aware of patient/resident wishes. During an interview on [DATE] at 03:30PM with Registered Nurse (RN) 3, revealed, He is familiar with R128. He revealed that the nurse must explain what a DNR is to the resident and/or responsible party. The consent is signed by the resident or responsible party. He further revealed that two physicians sign the DNR paperwork to make it valid. He revealed that R128 has been a DNR for a week. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 04:00PM the MDS Nurse/RN revealed that Social Services usually takes care of the Code orders. When a resident is admitted , we put orders in for a Full Code until all of the paperwork is signed and the orders are written. Social Services gets all of the paperwork done and the code status orders signed. MDS Nurse verified that resident was made a Do Not Resuscitate on [DATE]. MDS Nurse also verified that resident had an active order for a Full Code on [DATE]. MDS nurse stated the Social Worker asked me to put the order in for a Do Not Resuscitate in today and I did. I do not know what happened. It usually does not take that long, and it should not take that long. During an interview on [DATE] at 04:55PM the Director of Nursing (DON) revealed, If we have an order for advanced directives from Hospice or the physician, the nurse should put in the order and Social Services should update the banner. That should occur within 24 hours of obtaining the order or whatever the policy states. This was a failure of the nurse to follow through with Hospice orders when received. Social Services failed to update the banner according to the active advanced directives order for this resident. 2. Review of R23's EMR revealed he was admitted to the facility on [DATE] with diagnoses including but not limited to; hypertension, dementia, insomnia, and depression. Review of R23's Quarterly MDS with an ARD of [DATE] indicated he had a BIMS score of 05 indicated he was cognitively impaired. Review of R23's Physician Orders for February 2026 indicated Full Code, with a start date of [DATE]. Review of R23's banner on his EMR indicated R23 was a DNR. Review of Advance Directives documents attached in the EMR indicated R23's Responsible Party (RP) had elected for R23 to be a DNR on [DATE]. During an interview with Licensed Practical Nurse (LPN)1 on [DATE] at 2:02 PM, she confirmed the process for identifying a Resident's code status. LPN1 was asked to view R23's orders in which she confirmed R23's code status did not match between the orders and what was located on the banner in the EMR. She stated the expectation would be for the orders to be audited and accurate. During an interview with Social Services on [DATE] at 3:42 PM, she confirmed that either Social Services or the Nurse collects advance directives data. She stated only the Nurses can change orders, but the banner and care plan can be updated by Social Services. She confirmed the inaccuracy in code status documentation for R23. During an interview on [DATE] at 4:04 PM, the Director of Nursing (DON) stated she had been made aware of the discrepancies and it was her expectation that the medical record was accurate. During an interview with the Administrator on [DATE] at 9:10 AM, she stated it is her expectation that the medical record is accurate and processes will be implemented to ensure this.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility policy and interviews, the facility failed to ensure written notification of the bed hold policy, including reserve bed payment requirements, was provided to the resident and/or the resident's representative for one of one Resident (R)1 reviewed for hospitalization.Findings Include:Review of the facility policy titled, Bed Hold Authorization Form: South Carolina last revised 12/6/22 revealed, Two notices related to the healthcare center's bed hold policy will be issued. The first notice of bed hold policies is given during this admission, which is well in advance of any transfer. The second notice, which specifies the duration of the bed hold policy will be issued at the time of any transfer. In cases of emergency transfer, notice ?at the time of transfer' means that the family and/or undersigned parties, not to include the healthcare center, is provided with written notification within 24 hours of the transfer. The requirement is met if the patient/resident's copy of the notice is sent with other papers accompanying the patient/resident to the hospital.On 2/19/26 at approximately 8:58 AM, a closed record review revealed R1 was admitted to the facility on [DATE] and transferred via EMS to the hospital on 1/5/26. The resident did not return to the facility following the transfer.Further review of the closed record revealed no documentation demonstrating that written notification of the facility's bed hold policy was provided to R1 or the resident's representative at the time of transfer, sent with transfer paperwork, or issued within 24 hours as required by facility policy.During an interview on 2/19/26 at approximately 3:50 PM, the Social Services Worker stated she was unable to locate documentation of a bed hold notification for R1 and would need to conduct further review.During an interview on 2/19/26 at approximately 6:45 PM, the Administrator confirmed that neither she nor the Social Services Worker were able to locate or provide documentation demonstrating that written notice of the facility's bed hold policy had been provided to R1 or the resident's representative at the time of transfer or thereafter. The Administrator stated the nurse who discharged the resident had two additional discharges that same day and described it as a busy day.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on review of facility policy, record reviews and interviews, the facility failed to complete the admission Minimum Data Set (MDS) within 14 calendar days after admission for Resident (R)130 1 of 1 residents reviewed for comprehensive assessment and timing.Findings include: Review of the facility policy titled, MDS Assessment Accuracy, revealed, Policy Statement: It is the policy of this healthcare center that each Minimum Data Set (MDS) reflect the acuity and the medical status of each patient/resident in accordance with acceptable professional standards and practices. The assessment will be scheduled to accurately account for the acuity and complexity of the patient/resident. Each Assessment Reference Date (ARD) will be chosen to capture services rendered and reflect an accurate clinical profile of each patient/resident.Review of R130's Face Sheet revealed the facility admitted R130 on 01/30/26 with diagnoses including but not limited to: displaced intertrochanteric fracture of left femur, dementia, encephalopathy, dysphagia, and cerebral infarction.Review of R130's admission MDS located under the MDS tab in the EMR revealed MDS 02/05/26 In Process.During an interview conducted on 02/19/26 at 4:38 PM the MDS Nurse revealed [R130's] admission MDS has not been completed. It should have been completed by now. During an interview conducted on 02/19/26 at 05:15 PM the Director of Nursing revealed, they know better than that. The MDS nurse schedules the completion dates for the MDS. She should make sure they are completed on time.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to initiate a baseline care plan related to therapy services and wound care for Resident (R)123 one of three residents reviewed for wound care. Findings include:Review of the facility's policy titled, Care Plans, revised 10/21/25, revealed Procedure: New admission Baseline Plan of Care 1. Upon a new admission, a baseline care plan will be developed by the admitting nurse/nurses in conjunction with the other IDT, the patient/resident and/or patient/resident representative. The baseline care plan should be initiated in 24 hours and will be completed and implemented within 48 hours of admission. Review of R123's Face Sheet revealed R123 was admitted to the facility on [DATE], with diagnoses including but not limited to: cellulitis of left lower limb, type 2 diabetes mellitus with diabetic neuropathy, and cerebral palsy.Review of R123's admission Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 01/25/26 coded the resident as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R123 is cognitively intact.Review of R123's Baseline Care Plan located under Care Plan tab in the EMR, revealed a baseline care plan was not initiated 01/19/26 for wound care or therapy services.On 02/19/26 at 01:05PM interview with MDS nurse revealed that she is familiar with R123 and she has a surgical cite that will not heal. The MDS nurse verified that there is no care plan for addressing R123's wound progress or treatments. MDS nurse verified that R123 should have a care plan that addresses the resident's wound.On 02/19/26 at 05:55PM interview with the Director of Nursing revealed that the MDS nurses and the IDT team should initiate the baseline care plan within twenty-four or forty-eight hours after a resident is admitted . They dropped the ball here.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, record review, observations, and interviews, the facility failed to ensure a care plan was completed and implemented for Resident (R)2 related to activities for one of three residents reviewed for care plans. Findings include: Review of the facility's policy titled, Care Plans, with a revised dated of 10/21/25 revealed 2. A comprehensive person-centered care plan will be developed by the interdisciplinary team for each patient/resident within seven days after the completion of the comprehensive assessment. 3. The comprehensive person-centered care plan is developed to include measurable goals and timeframes to meet a patient/resident's medical, nursing and psychosocial needs, the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial needs that are identified in the comprehensive assessment. Review of R2's Face Sheet located in the Electronic Medical Record (EMR) revealed R2 was admitted to the facility on [DATE] with diagnoses including but not limited to; diabetes, hypertension, and dysarthria. Review of R2's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/25/25 indicated she has a Brief Interview of Mental Status (BIMS) score of 15, indicating she is cognitively intact. During an interview on 02/17/26 at 11:43 AM, R2 stated she was unaware of what activities the facility provided. She states that no one has ever came and offered her to attend activities. She stated, I hear things going on out there, but no one has invited me yet. Observation of R2's room indicated no presence of an activities calendar. Review of R2's Assessments, located in the EMR revealed no Activities assessment was completed. Review of R2's care plan did not indicate activities, or the need for activities as a problem. During continuous observations of R2 on 02/17/26, 02/18/26, and 02/19/26, R2 remained in her room, in bed with no activities in place, other than her television. During an interview with the Activities Director (AD) on 02/19/26 at 8:53 AM, she stated on admission, she typically does an assessment and then visits daily throughout the facility. She stated she is the only one in the Activities department, so often time she utilizes volunteers. When asked to provide documentation related to R2's assessments and R2's activity attendance, the AD was unable to locate the documents. Upon reviewing the EMR, the AD stated she must've missed this resident and acknowledged R2 did not have any assessments or care plans relative to activities. During an interview with the Administrator on 02/19/26 at 9:10 AM, she stated it is her expectation for all residents to have activities assessments completed within 48 hours of admission and care plans as required, so that their likes and dislikes can be honored.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility's policy, record review, observations, and interviews, the facility failed to ensure a dependent resident (R)83 received adequate Activities of Daily Living (ADL) care to match her preferences.Findings include:Review of the facility's policy titled, Documentation: Charting Activities of Daily Living (ADLs) with a reviewed date of 11/17/25 indicated, It is required for Activities of Daily Living (ADL) care given by Certified Nursing Assistants and Nurses to be documented under Care Assist in patient's/resident's Electronic Healthcare Record (EHR). For the healthcare centers not utilizing EHR, all documentation will be completed using the CNA ADL Flow Sheet Form.Review of the facesheet located on the EHR indicated R83 was admitted to the facility on [DATE] with diagnoses including but not limited to urinary tract infection, cognitive communication deficit, type 2 diabetes and hypertension.Review of R83's admission Minimum Data Set (MDS) assessment dated [DATE] indicated R83 has a Brief Interview for Mental Status (BIMS) score of 3, indicating she was cognitively impaired. Review of Section F of the MDS indicated F0400: Interview for Daily Preferences: C. how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? Was answered as 2. Somewhat important.Review of R83's care plan indicated the problem category, ADLs Functional Status/Rehabilitation Potential ADL Decline related to recent hospitalization and muscle weakness with a start date of 01/01/26. Approaches were listed as Ensure resident's hair is combed. Provide assistance when needed. Provide showers per schedule.During a telephone interview with R83's Responsible Party (RP) on 02/17/26 at 12:15 PM, she indicated R83 has not had a shower or her hair washed since admission, she has only been offered a bed bath.During observations of R83 on 02/17/26 at 12:10 PM and 02/18/26 at 9:45 AM, she was observed lying in bed, dressed in a hospital gown. Her hair appeared greasy and unkempt. An interview was attempted with no success.During an interview with Certified Nursing Assistant (CNA)1 on 02/17/26 at 4:16 PM, he stated, We only give showers when we have enough staff. We are short-staffed so no one is getting a shower today. The last time I gave a shower was last Thursday, I believe. It's hard to give showers if no one is here, and that's always. We have a schedule, but it's not followed so we do what we can.During a tour with CNA1 on 02/17/26 at 4:17 PM revealed a shower room on unit with a functioning shower. He stated half of the room was being used for storage. There was one additional shower room. There are three in total, but one is currently being worked on.During an interview with Licensed Practical Nurse (LPN)1 on 02/17/26 at 4:45 PM, she provided shower sheets. Review of the shower sheets from 01/26/26-02/18/26 indicated no dates had been signed off as showers given. LPN1 stated CNAs are also supposed to document in Point of Care (POC) if showers were given.During a second interview with LPN1 on 02/18/26 at 10:00 AM, she stated the nurses usually make the assignments for the CNAs. On the shower sheets, whomever is highlighted indicates who gets a shower on that day. The CNAs should sign off once given. If a resident refuses, staff should alert the Nurse so that it can be documented. She confirmed there was no documentation of R83's showers or having her hair washed. There were also no documented refusals for showers or hair washing.Review of R83's POC ADL log for 01/01/26-02/18/26 indicated under bathing, BED or PART. LPN1 confirmed this meant either a bed bath or partial bath. If a shower had been given, it would indicate SHOWER.Review of the Unit 2 Shower Schedule posted at the Nurses' station did not indicate when R83 was scheduled for showers.During an interview with the Director of Nursing (DON) on 02/18/26 at 4:04 PM, she stated it is her expectation for the Unit Managers to manage the floor staff. They are responsible for ensuring residents are receiving what they need and for CNAs to ensure documentation is adequate.During an interview with the Administrator on 02/19/26 at 9:10 AM she stated, We have had some staffing challenges. We do not use agency staff. The expectation is that residents receive a shower at least three times a week. Due to staffing, we offer showers at least once a week, but we ensure everyone gets a bed bath. This will be made a priority. We have other staff working in other areas who are certified as CNAs that we may pull to assist.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, record review, observations, and interviews, the facility failed to assess Resident (R)2 for the needs and/or provide activities that met her interests.Findings include: Review of the facility's policy titled, Activities Program, with a reviewed date of 11/17/25 revealed, Policy Statement: The Health Care Center provides an ongoing program of Activities designed to meet the physical, mental, and psychosocial well-being of each resident while offering a rich array of activities to the residents of the center.Procedure: 7. After reviewing the Activities Assessment & Preferences for Customary Routine & Activities in the EHR, the IDT designates specific activities for individual residents in the resident's care plan based on their likes/dislikes, preferences, and impairments. 8. The Activity Participation will be recorded by the Activities Director/Assistant or designee in the EHR. Participation will be completed for each resident per each activity. R2 was admitted to the facility on [DATE] with diagnoses including but not limited to; diabetes, hypertension, and dysarthria. Review of R2's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/25/25 indicated she has a Brief Interview of Mental Status (BIMS) score of 15, indicating she is cognitively intact. Review of Section F: Preference for Customary Routine and Activities indicated the response of Somewhat important for the following questions:A. how important is it to you to have books, newspapers, and magazines to read? B. how important is it to you to listen to music you like? C. how important is it to you to be around animals such as pets? D. how important is it to you to keep up with the news? E. how important is it to you to do things with groups of people? F. how important is it to you to do your favorite activities? G. how important is it to you to do things with groups of people? H. how important is it to you to participate in religious services of practices? During an interview on 02/17/26 at 11:43 AM, R2 stated she was unaware of what activities the facility provided. She states that no one has ever came and offered her to attend activities. She stated, I hear things going on out there, but no one has invited me yet. Review of R2's Assessments, located in the EMR revealed no Activities assessment was completed. Review of R2's care plan did not indicate activities, or the need for activities as a problem. During continuous observations of R2 on 02/17/26, 02/18/26, and 02/19/26, R2 remained in her room, in bed with no activities in place, other than her television. During an interview with the Activities Director on 02/19/26 at 8:53 AM, she stated on admission, she typically does an assessment and then visits daily throughout the facility. She stated she is the only one in the Activities department, so often time she utilizes volunteers. When asked to provide documentation related to R2's assessments and R2's activity attendance, the AD was unable to locate the documents. Upon reviewing the EMR, the AD stated she must've missed this resident and acknowledged R2 did not have any assessments or care plans relative to activities. During an interview with the Administrator on 02/19/26 at 9:10 AM, she stated it is her expectation for all residents to have activities assessments completed within 48 hours of admission and care plans as required, so that their likes and dislikes can be honored.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide snacks for 2 residents, reviewed R 8 and R22.Findings include:Review of facility policy titled Nourishments, revision date 10/18/2017.Procedures: 2. Dietary will stock each nourishment kitchen with a variety of food and beverage items. (i.e., peanut butter, crackers, soup, ice cream, cereal, milk, or other beverages).Review of facility policy titled, Bedtime (HS) Snacks, revision date 06/20/2022. Procedures:2. Nursing staff will offer the HS snacks to all patients/residents (with the exception of patients/residents not receiving oral nutrition) at bedtime. An observation on 2/18/26 at approximately 4:19 P.M., observation revealed a family friend providing a snack to R 13, the resident was seated in the common area in front of the nurses' station. The family friend was observed holding a cup containing what appeared to be Chex Mix and pretzels.An observation on 02/19/2026 of 3 of 3 nourishment rooms revealed the following:Unit 1 cupboard at approximately 8:50 AM 1 12 boxes of Fieldstone Fudge Rounds, 5-Fieldstone Oatmeal Creme Pies in the cupboard. Refrigerator contained 9- Shasta [NAME], 6 8ozShasta Diet Ginger [NAME].Unit 2 cupboard at approximately 8:56 AM - 2 six pack 4-ounce apple sauce in the cupboard. Refrigerator contained 1 Glucerna.Unit 3 cupboard at approximately 9:03 AM - 5 Fieldstone Fudge Rounds in cupboards. Refrigerator contained 3 8oz Shasta Diet Ginger [NAME], 3 8. oz Shasta [NAME].An observation on 02/19/2026 of 3 of 3 nourishment rooms revealed the following:Unit 1 cupboard at approximately 5:04PM1 12 count Fieldstone Oatmeal Creme Pies, 1 -12 count Fudge Round, 2 loose Fieldstone Oatmeal Creme Pies, 2 loose Fieldstone Fudge Rounds, 1 60 count 2 pk Oreos in cupboard. Refrigerator contained 11- 8oz Shasta [NAME], 7 8oz Shasta Diet [NAME], 7 8oz Shasta Ginger [NAME], and a variety of supplements (i.e., Glucerna).Unit 2 cupboard at approximately 5:19 PM 60/2count Oreos, 2 12 pack Fieldstone Fudge Rounds, 5 loose Fieldstone Fudge Rounds, 12 6 count Toasty Peanut butter Crackers, 9 4 oz [NAME] Apple Sauce.Refrigerator contained 7 8oz Zero sugar Shasta ginger [NAME], 4 8oz Shasta Zero sugar [NAME], 2 8 oz Shasta ColasUnit 3- cupboard at approximately 5:24 PM: 14 Lance Toasty Peanut butter crackers, 16 Fieldstone Oatmeal Creme Pies, 5 Fieldstone Fudge Rounds.Refrigerator contained 24 8oz Shasta Ginger [NAME], 3 8oz Shasta Diet ginger [NAME].Review of R 8 Minimum Data Set, MDS-section C reveals Brief Interview for Mental Status, BIM score of 15. Review of MDS section F Preferences for Customary Routine and Activities; Section 0400 reveals very important to have snacks available between meals.Review of R 22 Minimum Data Set, MDS-section C reveals Brief Interview for Mental Status, BIM score of 13. Review of section F Preferences for Customary Routine and Activities; Section 0400 reveals very important to have snacks available between meals.Review of facility mealtimes reveals the following:Unit 1 Breakfast 7:00 AM, Lunch 11:30 AM, Dinner 5:00 PMUnit 2 (early small cart) Breakfast 7:10 AM, Lunch 11:40 AM, Dinner 5:10 PMUnit 2 (large cart) Breakfast 7:30 AM, Lunch 12:00 PM, Dinner 5:30 PMUnit 3 (early small cart) Breakfast 7:20 AM, Lunch 11:50 AM, Dinner 5:20 PMUnit 3 (large cart) Breakfast 7:40 AM, Lunch 12:10 PM, Dinner 5:40 PM Based on an interview on 02/18/2026 at 4:17 PM with Certified Nursing Assistant (CNA) [NAME] stated that snacks are usually distributed at approximately 2:00 P.M. and 7:00 PM, and snacks are labeled with residents whose names have been identified as wanting snacks.When asked what occurs between scheduled snack times, the CNA stated that staff may go to the kitchen if nothing is available in the nourishment room and that leftover snacks are sometimes available.The CNA stated there are designated residents who receive snacks and that staff utilize a list of resident names for snack distribution.When asked whether residents who are not on the designated list are offered snacks, the CNA did not state that snacks are routinely offered to those residents and reiterated that there are specific residents identified on the snack list.Based on (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview on 02/18/2026 at approximately 2:17 PM during the Resident Council Meeting, R 8 reports that residents do not get offered snacks at night.Based on an interview on 02/18/2026 at approximately 2:21 PM during Resident Council Meeting R 22 reports she asks for snacks at night and is told there are no snacks, or asks and does receive snacks. R 22 stated she has stopped asking for snacks because she does not receive them and has started purchasing from the canteen up front. Based on an interview on 02/18/2026 at approximately 4:19 PM with a family friend of R13, stated that if she does not bring snacks, the resident would not receive one. She further revealed that R13 does not eat large meals and relies on snacks, and that without snacks, R13 typically does not eat well.Based on an interview on 02/18/2026 at 4:25 PM with the Dietitian, the kitchen closes at 8:00 PM, and residents do not receive additional snacks until the kitchen reopens the following day. The Dietitian stated that if snacks are not available in the nourishment room after the kitchen closes, residents would have to wait until the next day.Based on an interview on 02/19/2026 at 8:45 AM with the DON stated that resident snacks come out twice a day, between meals. DON reports that snacks are offered to residents and that snacks should always be available day and night. DON stated her expectations for resident snacks: Snacks should be available for residents when and as they want them, even when I want a snack at home, it does not matter what time it is. This is their home.The facility failed to meet the nutritional needs and snack preferences of the residents

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review and interviews, the facility failed to ensure appropriate infection control practices were followed related to urinary catheter care for one of two Residents (R) 120 reviewed for catheter care. Specifically, the facility failed to prevent a resident's urinary drainage bag from being placed directly on the floor, creating a potential risk for contamination and infection. Findings include:Review of R120's Face Sheet revealed, the facility admitted R120 on 02/16/26 with diagnoses including but not limited to; urinary tract infection, type 2 diabetes mellitus and Alzheimer's disease. Review of R120's orders reveal Catheter Dx: Chronic Urinary Retention. Indwelling urinary catheter #16 FR 10cc bulb.An observation on 02/17/26 at 01:40 PM of R120 revealed resident lying in bed watching television. Bed was in low position. Catheter bag noted resting on floor.During an observation on 02/17/26 at 04:50 PM revealed resident lying in bed watching television. Bed was in low position. Catheter bag noted resting on floor.During an interview on 02/17/26 at 04:55 PM with Licensed Practical Nurse (LPN) 2 confirmed that resident's catheter bag was resting on the floor.During an observation on 02/18/26 at 11:00 AM revealed resident lying on floor beside her bed. Catheter bag noted resting on floor.During an interview with the unit manager on 02/18/26 at 12:00 PM it was revealed that R120 broke the hook that hangs the bag on the floor when she fell and that is why the catheter bag was on the floor on 02/17/26. The unit manager revealed that she could not explain why the catheter bag was observed on the floor on 02/18/26. The unit manager revealed that she was replacing the privacy bag for R120 and the new privacy bag would keep R120's catheter bag off of the floor.During an interview on 02/18/26 at 01:15 PM with the Director of Nursing revealed, it is common sense. The nurses and the Certified Nursing Assistants (CNA)s know that the catheter bag should always remain off of the floor.During an interview on 02/19/26 at 06:15 PM with the administrator revealed that there is no policy related to catheter care or infection control in regard to a catheter.