| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435045 | A. Building<br>B. Wing | 07/02/2026 |

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| Good Samaritan Society Sioux Falls Village | 3901 S Marion Rd<br>Sioux Falls, SD 57106 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interviews, record review, observation, and policy review, the provider failed to ensure the staff responded promptly to twelve of thirty-one sampled residents (13, 14, 21, 27, 59, 73, 85, 89, 119, 123, 155, and 164) who reported concerns related to extended call light times. Findings include:<br><br>1. Interview on 6/28/26 at 4:03 p.m. with resident 13 revealed that he felt call lights were not answered in a timely manner. He stated, These [call lights] don't get answered.<br><br>2. Review of resident 13's call light response time report (a report of call light usage and time it took for the residents' call lights to be answered by the staff) from 6/1/26 through 6/30/26 revealed that twenty call light response times were more than 20 minutes long, four were more than 30 minutes, one was more than 40 minutes, two were more than 50 minutes, and one response time was greater than 90 minutes.<br><br>3. Interview on 6/29/26 at 2:56 p.m. with resident 59 revealed that he had to wait at least 30 minutes to have his call light answered. He sometimes called the facility phone number to get help. The weekends and holidays had longer wait times, and if a holiday occurred during the weekend, it was worse. Nothing bad had happened to him yet, but he worried and got irritated when he had to wait a long time.<br><br>4. Review of resident 59's electronic medical record (EMR) revealed he admitted to the facility on [DATE]. His 5/7/26 Brief Interview for Mental Status (BIMS) assessment score was 10, which indicated his cognition was mildly impaired.<br><br>His diagnoses included right leg above the knee amputation, anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), major depressive disorder, and Parkinson's disease with dyskinesia (a brain disorder that gradually affects movement, causing symptoms like shaking, stiffness, and slowed motion because the brain loses cells that make dopamine with involuntary, uncontrolled movements).<br><br>His undated care plan indicated he may need the staff's assistance for long distances in his wheelchair. He needed one staff member's assistance with bathing, bed mobility, dressing, grooming, oral care, personal hygiene, and toilet use. He needed two staff members' assistance for transfers using the total body lift (a mechanical lift and sling used to lift a person's full body).<br><br>5. Review of resident 59's call light response time report from 6/1/26 through 6/30/26 revealed he had ten call light response times over 20 minutes long, and one call light response time was 150 minutes long.<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 6. Interview on 6/29/26 at 3:09 p.m. with resident 164 revealed that she has had to wait up to 20 minutes for her call light to be answered. She said, When I have to go to the bathroom, that gets really bad. I end up peeing, and that makes me feel inhumane.<br><br>7. Review of resident 164's EMR revealed she admitted to the facility on [DATE]. Her 6/15/26 BIMS assessment score was 15, which indicated her cognition was intact. Her diagnoses included chronic kidney disease stage 3, history of urinary tract infections (UTIs), and repeated falls.<br><br>Her 7/1/26 care plan indicated she used a wheelchair for mobility. She needed the assistance of one staff member for bathing, bed mobility, dressing, eating, oral care, personal hygiene, toilet use, and transfers. She was to be toileted after each meal and at bedtime to prevent skin breakdown due to incontinence (involuntary urine or bowel leakage) and brief use.<br><br>8.Review of resident 164's call light response time report from 6/2/26 to 6/30/26 revealed she had two call light response times over 20 minutes long.<br><br>9. Interview on 6/30/26 at 9:15 a.m. with resident 21 revealed that about a week ago, resident 21's call light was on for over an hour. She had turned her call light on, and no one came to assist her. Resident 21 went down to breakfast and when she returned, her call light was still on. Resident 21 went to restorative therapy, and when she returned, her call light was shut off. No one came to find out what she needed; someone just turned her call light off. She stated, I am scared no one will answer my call light, when I need help. Her roommate, resident 27, used her call light a lot.<br><br>10. Review of resident 21's EMR revealed her 6/24/26 BIMS assessment score was 15, which indicated her cognition was intact. Her diagnoses included Diabetes Mellitus Type II (a condition involving disruptions in how the body regulates blood sugar), chronic pain syndrome, muscle weakness, and a history of falling.<br><br>11. Review of resident 21's call light response time report from 6/1/26 through 6/30/26 revealed she had two call light response times over 20 minutes long, and one call light response time was 127 minutes long.<br><br>12. Review of resident 27's EMR revealed her 5/27/26 BIMS assessment score was 0, which indicated her cognition was severely impaired. Her diagnoses included hemiplegia (complete or severe paralysis of one entire side of the body), and hemiparesis (partial weakness or loss of strength on one side of the body) following a cerebral infarction (stroke) affecting her left side, major depressive disorder, and down syndrome (genetic condition which alters typical development resulting in intellectual disability, development delays and distinct physical characteristics).<br><br>13. Review of resident 27's call light response time report from 6/1/26 through 6/30/26 revealed she had ninety-two call light response times over 20 minutes long, and twenty-nine call light response times over 60 minutes long.<br><br>14. Observation and interview on 6/30/26 at 8:05 a.m. in resident 85's room revealed she was lying in bed, wearing a hospital gown, and had a tracheostomy tube (a tube surgically placed through the neck into the windpipe to allow airflow) and did not require ventilatory support (a machine to breathe for her). She stated that there was a resident down her hallway that CNAs were in her room for two to four hours at a time, and that she and other residents down that hallway have to wait a long time for staff's assistance. Sometimes, when she had to wait a long time for staff to answer her call light, she (continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | needed a nebulizer treatment to loosen her secretions. She did not have any shortness of breath. She was more worried about the other residents having to wait a long time for staff assistance.<br><br>She completed some of the care for her trach by herself, and she took the cap off to clear the secretions around it. When doing this once, the trach came out. Nothing bad happened when that occurred, and the nurse came in right away and replaced it.<br><br>15. Review of resident 85's EMR revealed she admitted to the facility on [DATE]. Her 5/22/26 BIMS assessment score was 15, which indicated her cognition was intact. She had diagnoses of dysphagia (difficulty swallowing), tracheostomy, hypertension (elevated blood pressure), Major Depressive Disorder (a mental health condition that causes a persistent feeling of sadness, emptiness, and loss of interest in activities once enjoyed), atrial fibrillation (irregular heartbeat), and weakness.<br><br>Her 5/26/26 care plan revealed that she had a tracheostomy and sometimes pulled it out when she adjusted it. She required the assistance of one staff member and the sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) to be transferred and one staff member to get dressed and reposition in bed. She required extensive assistance with using the toilet and for personal hygiene care.<br><br>16. Review of resident 85's call light response time report from 6/1/26 to 6/30/26 revealed she had three call light response times over 20 minutes long and one call light response time over 40 minutes long.<br><br>17. Observation and interview on 6/30/26 at 9:53 a.m. in resident 14's room revealed she was lying in bed wearing a hospital gown, and had her left arm and both legs propped up with pillows. She stated that it sometimes took staff hours to answer her call light. She stated that sometimes she needed to have the staff position her legs differently, and she experienced pain when she waited a long time for the staff to answer her call light.<br><br>18. Review of resident 14's EMR revealed she admitted to the facility in October 2025. Her 5/5/26 BIMS assessment score was 15, which indicated her cognition was intact. She had diagnoses of complex regional pain syndrome of the right upper limb (a chronic neurological condition causing severe, persistent pain to her right arm), depression, generalized anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), muscle spasms (a sudden, involuntary contraction of a muscle), and quadriplegia (the partial or total paralysis of all four limbs and torso).<br><br>Resident 14's 6/30/26 care plan indicated that she had chronic pain, and non-pharmacological (non-medicated) interventions to reposition her. She required two staff members to reposition her in bed and total staff assistance with getting dressed and her personal hygiene. She required two staff members and a total body lift (a mechanical lift and sling used to lift a person's full body) to be transferred. She was particular about her care and sometimes required three staff members to assist her.<br><br>19. Review of resident 14's call light response time report from 6/1/26 to 6/30/26 revealed she had twenty-three call light response times over 20 minutes long, nine call light response times over 30 minutes long, four call light response times over 40 minutes long, one call light response time over 60 minutes long, one call light response times were over 80 minutes long, and one call light response time of 112 minutes long.<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 20. Interview on 6/30/26 at 10:38 a.m. with resident 73 revealed that he had waited 45 minutes to get his call light answered. He would get anxious when he had to wait a long time for his call light to be answered because he was blind and unable to see anyone to get help.<br><br>21. Review of resident 73's EMR revealed he admitted to the facility on [DATE]. His 5/7/26 BIMS assessment score was 15, which indicated his cognition was intact.<br><br>His diagnoses included legal blindness, sensorineural hearing loss (a permanent type of hearing loss caused by damage to the inner ear), retention of urine, and weakness.<br><br>His 7/1/26 care plan indicated he required one staff member's assistance for wheelchair mobility, bathing, bed mobility, dressing, grooming, eating, oral care, personal hygiene, and toilet use. He required two staff to assist him with transfers. He had an indwelling urinary catheter (flexible tubing inserted into the bladder to drain urine).<br><br>22. Review of resident 73's call light response time report from 6/1/26 to 6/30/26 revealed he had four call light response times over 20 minutes long.<br><br>23. Interview on 6/30/26 at 2:30 p.m. with certified nursing assistant (CNA) D revealed that the staff were expected to answer the residents' call lights within five minutes. She carried a radio that alerted her when the residents' call lights were turned on, and monitors located in the hallway near the ceiling alerted the staff of the activated call lights.<br><br>24. Observation and interview on 6/30/26 at 3:05 p.m. of resident 155's call light with activity assistant II revealed that she turned on resident 155's call light and was waiting for the staff to transfer resident 155 to her wheelchair. Activity assistant II would then take resident 155 to an activity. Activity assistant II indicated that both CNAs that were assigned to resident 155's hallway were in resident 14's room.<br><br>25. Observation on 6/30/26 at 3:06 p.m. in resident 14's room revealed that certified medication aide (CMA) KK and CNA LL were assisting resident 14 with personal hygiene care.<br><br>26. Observation and interview on 6/30/26 at 3:24 p.m. revealed that CMA KK answered resident 155's call light. Activity assistant II reported she had to wait almost every day for a long time for staff to transfer a resident for her so she could take them to the activity, and stated, Now the activity is over. There was a teaching cooking activity in the main dining room that resident 155 missed. She said she turned resident 155's call light on about five to seven minutes before talking to her on 6/30/26 at 3:05 p.m.<br><br>27. Interview on 6/30/26 at 3:27 p.m. with CNA LL and CMA KK revealed CNA LL started working at the facility in March 2026 and CMA KK started in November 2025. Resident 14 required two staff members to assist her with part of her care. Her morning care could take up to three hours, and her afternoon care took about an hour. Two staff members would be in her room for about 30 to 45 minutes. CNA LL and CMA KK were scheduled to work the 600 hall, and they did not have an extra CNA to help that day.<br><br>They notified the nurse before going into resident 14's room to help answer call lights. Neither CNA LL or CMA KK had used a radio to communicate with other staff members since they began working at the facility due to there not being enough radios available.<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 28. Observation and interview on 6/30/26 at 3:40 p.m. with registered nurse (RN) FF and licensed practical nurse (LPN) GG revealed that they were sitting in the nurses' station. RN FF was assigned to work on the 500 hall, and LPN GG was assigned to work on the 600 hall. They did not carry radios and stated that there were two radios in the charging station at the nurses' station, which were usually turned on and would alert them if a call light was activated. They used the monitors hanging in the hallways to alert them if a residents call light was activated, which they could not see from the nurses' station. They verified that CNA LL and CMA KK notified them that they went into resident 14's room. They thought the CNAs on the 500 hall would help watch the 600 hall's call lights since both CNAs were in with resident 14. They used to carry radios, but they either got lost or quit working. When they were in a resident's room, they did not know when another resident's call light was on. They were expected to answer the residents' call lights within the first few minutes or to at least inform the resident that someone was coming to assist them.<br><br>LPN GG stated that resident 85 had a tracheostomy tube that typically only needed to be suctioned after her nebulizer treatments and did not typically have respiratory problems. Resident 85's tracheostomy tube had fallen out once before and that thankfully the nurse manager was really close and she came back and put one in. The staff does not know what a resident needs when they turn their call light on, and it could be an emergency.<br><br>29. Interview on 6/30/26 at 4:10 p.m. with CNA MM and CMA JJ revealed they were working on the 500 hall and were not watching for the call lights on the 600 hall. CNA MM had worked at the facility for three weeks, and CMA JJ had worked at the facility for five days, and was still on orientation. They did not carry a radio or know if they were expected to. They knew when a resident's call light went off because there was a single beep from the monitor in the hallway, and the room number would be displayed on it. If they were in a resident's room, they did not always hear the beep when another resident turned their call light on.<br><br>30. Interview on 6/30/26 at 4:15 p.m. with CNA HH revealed he was working the 500 hall. Everyone was supposed to carry the radio, but he did not grab one. When a resident's call light was turned on, the monitor screen in the hallway would make a single beep, and display on the screen. Sometimes the beep could be heard when in a resident's room if the door was not closed. He was not sure if radios were programmed to alert all staff of all call lights or if it was specific to the hallway they were working. The monitor screen on the 500 wing showed call lights for residents on the 500 wing. The monitor screen at the end of the 500 hall and to the 600 hall showed both the 500 and 600 hall call lights. Door alarm alerts went to the radios as well.<br><br>31. Interview on 7/1/26 at 8:30 a.m. with CNA D revealed she had worked at the facility since 2019 and worked on the 300 hall. She felt a resident's call light should be answered within three to five minutes. She did not have a radio on her and observed the monitors hanging in the hallways for residents' call lights.<br><br>32. Interview on 7/1/26 at 8:38 a.m. with LPN E revealed she had worked for the facility for about two years and worked on the 300 hall. She expected the residents' call lights to be answered within ten minutes in ideal situations.<br><br>33. Interviews on 7/1/26 at 10:07 a.m. at the resident council meeting revealed resident 123 stated, there were some wait times for call lights but mostly because there were other residents that needed more help and they would take up more of the staff's time. Call lights have been brought up at resident council, and [the] staff were doing what they could, but it seems like it could take a while to<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | get a call light answered. Resident 89 indicated that she had waited two hours one morning for staff assistance before she took herself to the bathroom.<br><br>34. Observation and interview on 7/1/26 at 2:14 p.m. with resident 119 revealed that his call light was on, he was lying in bed, and was using the bedpan. He said his call light had been on for a long time. He was waiting for the staff to help him off the bedpan and then he wanted to go play Bingo. An activity assistant was waiting outside his door to assist him to Bingo.<br><br>35. Observation on 7/1/26 at 2:23 p.m. revealed resident 119's call light was answered by CNA HH.<br><br>36. Interview on 7/1/26 at 2:30 p.m. with CNA HH revealed he just started his shift at 2:15 p.m. and was working the 500 hall. He was not aware that resident 119 was using the bedpan. CNA LL was working the 500 hall with him.<br><br>37. Interview on 7/1/26 at 2:34 p.m. with CNA LL revealed she did not have a radio, and she was not aware resident 199 was on the bedpan. The other CNA just went home after the change of shift.<br><br>38. Interview on 7/1/26 at 4:00 p.m. with resident 119 revealed his call light is on for a long period of time, more often than I like. Nothing bad happened when he had to wait for the staff, but it made him feel like he was not important.<br><br>39. Review of resident 119's EMR revealed he admitted to the facility on [DATE]. His 6/5/26 BIMS assessment score was 14, which indicated his cognition as intact. He had diagnoses of acquired absence of the right knee, dysphagia, hyperkalemia (elevated potassium [electrolytes]), End Stage Renal Disease (permanent kidney failure), essential hypertension (elevated blood pressure), Major Depressive Disorder, type 2 diabetes (a condition involving disruptions in how the body regulates blood sugar) with hyperglycemia (high blood sugar), and weakness.<br><br>Resident 119's 6/18/26 care plan indicated he required supervision and touching assistance with repositioning in bed, dressing, and personal hygiene care. He required extensive assistance with using the bathroom. Staff were to offer him the bedpan for using the bathroom. He transferred using the total lift. He had falls on 11/21/25, 12/12/25, and 12/26/25, and the staff was to remind him to use his call light for assistance.<br><br>40. Review of resident 119's call light response time report from 5/30/26 to 6/30/26 revealed he had 18 call light response times over 20 minutes long, and 6 call light response times were over 30 minutes long.<br><br>41. Interview on 7/1/26 at 2:35 p.m. with CNA N revealed that she felt the resident's call lights should be answered within five to ten minutes.<br><br>42. Interview on 7/1/26 at 2:45 p.m. with CNA M revealed that he felt an appropriate time for a resident's call light to be answered was two minutes.<br><br>43. Interview on 7/1/26 at 2:58 p.m. with director of nursing (DON) B revealed she expected the resident's call lights to be answered within 20 minutes. She expected the staff to wear radios while working for communication between staff and for notifications of the call lights, and to observe the monitors in the hallways for activated call lights. She was aware of the residents' call light concerns, and educated the staff at every staff meeting to check in with the residents to ensure there were no<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | emergencies, and to let them know the staff will return to assist them.<br><br>44. Interview on 7/1/26 at 3:00 p.m. with contract travel RN L revealed that she expected a call light to be answered within two to three minutes.<br><br>45. Observation on 7/1/26 at 3:55 p.m. in the 600 hall revealed there was a call light on, it showed on the monitor screen in the 600 hall and on the monitor where halls 600 and 500 met. The call light did not show on the 500 hall monitor screen.<br><br>46. Review of the provider's 7/8/25 Call light policy revealed the purpose was To ensure residents always have a method of calling for assistance. To promptly answer resident's call light. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on the observation, interview, and record review, the provider failed to ensure medications were securely stored in three of ten observed medication carts by registered nurse (RN) V, RN FF, and certified medication aide (CMA) Z. Findings include:1. Observation on 6/30/26 at 2:10 p.m. in the 700 hallway outside of resident 75's room revealed there was an opened bottle of liquid Amoxicillin-Pot Clavulanate Oral Suspension (an antibiotic) for resident 181 on top of the medication cart. There were no staff members present.<br><br>2. Observation on 6/30/26 from 2:10 p.m. to 2:13 p.m. revealed that CMA X, activities assistant W, and two unidentified visitors walked past the medication cart that had the open bottle of resident 181's unsecured antibiotic medication on top of it.<br><br>3. Observation and interview on 6/30/26 at 2:13 p.m. with clinical care leader (CCL) S revealed that she removed the bottle of antibiotic medication from the top of the medication cart and was going to return the medication to the refrigerator. RN V was the nurse assigned to that medication cart, and CCL S was unsure how long the antibiotic medication was left on top of the medication cart.<br><br>CCL S expected RN V to have returned the antibiotic medication to the refrigerator or taken it with her when she left the medication cart.<br><br>4. Interview on 6/30/26 at 2:15 p.m. with CMA X revealed that she was not administering any medications that day and was not aware that there was an antibiotic medication left on top of the medication cart when she had walked past that medication cart earlier.<br><br>5. Interview on 6/30/26 at 2:27 p.m. with registered nurse RN V when she returned to the medication cart revealed she acknowledged that she had left resident 181's antibiotic medication on top of the medication cart and forgot to return the antibiotic medication to the refrigerator. She wondered where it went and was unaware that CCL S had returned that medication to the refrigerator.<br><br>6. Review of resident 181's electronic medical record (EMR) revealed she had a 6/30/26 physician's order for Amoxicillin-Pot Clavulanate Oral Suspension. Reconstituted 400-57 MG[milligrams]/5ML[milliliter] (Amoxicillin & Pot Clavulanate) Give 6.2 ml via [by] NG-Tube [nasogastric tube] two times a day for Acute cystitis without hematuria [a bladder infection without blood in the urine].<br><br>7. Observation on 7/1/26 at 8:21 a.m. of RN FF preparing medications for resident 47 revealed that there was a bottle of Fluticasone nasal spray for resident 89 on top of the medication cart. RN FF prepared resident 47's medications, which included pills and a bottle of Polyethylene Glycol (a laxative). She locked the medication cart, left the bottle of Polyethylene Glycol and the Fluticasone nasal spray sitting on top of the medication cart, walked into the dining room, gave resident 47 her medications, and walked back to the medication cart that was in the hallway.<br><br>8. Observation on 7/1/26 at 8:39 a.m. of RN FF preparing medications for resident 150 revealed she prepared the medications, locked the medication cart, left the bottle of Polyethylene Glycol and Fluticasone nasal spray on top of the medication cart, walked into the dining room, gave resident 150 her medications, and walked back to the medication cart that was in the hallway.<br>(continued on next page) |

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| Good Samaritan Society Sioux Falls Village | 3901 S Marion Rd<br>Sioux Falls, SD 57106 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 9. Interview on 7/1/26 at 8:40 a.m. with RN FF revealed that she left the Fluticasone nasal spray on top of the medication cart so she would not forget to administer it to resident 89, who was eating. RN FF stated, It is not a medication. She was not supposed to leave the Polyethylene Glycol bottle on her medication cart unsecured.<br><br>10. Observation and interview on 7/2/26 at 8:43 a.m. in the 200 hallway with RN/clinical nurse leader I and CMA Z revealed an unlocked medication cart with no medication aide or nurse attending it. The medication cart drawers were easily opened. RN/clinical nurse leader I witnessed the medication cart being unlocked and agreed that the medication cart should have been locked while unattended. CMA Z returned to the medication cart and reported that she thought she had locked the medication cart. She agreed that the medication cart should have been locked while it was unattended.<br><br>11. Interview on 7/2/26 at 10:00 a.m. with director of nursing (DON) B revealed that she expected medications to be locked in the medication cart and not left on the medication carts unattended, so residents would not be able to have access to them. She expected medications that needed to be refrigerated to be placed back in the refrigerator after they were used. She stated, There are confused residents everywhere.<br><br>12. Review of the provider's 3/30/26 Medications: Acquisition Receiving Dispensing and Storage policy revealed that medications will be stored in a locked medication cart, drawer or cupboard. All medications will be stored in accordance with manufacturers' recommendations. |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, observation, and policy review, the provider failed to protect the resident's rights to dignity and respect for one of thirtyˆone sampled residents (145) who was told by registered nurse (RN) (QQ) to ?stop talking' when asking her about his medications.Findings include:1. Observation on 7/1/26 at 8:44 a.m. of resident 145 sitting in his wheelchair in the hallway talking to RN QQ revealed he asked RN QQ, What time should I be getting my meds [medications]? RN QQ replied, They are at 8:00 a.m., but I am behind today. Resident 145 said, Well, I want to know what I get and when I get them. RN QQ said, I'm behind, and this isn't the time, so stop talking. Resident 145 then sat in his wheelchair in the hallway and waited until RN QQ gave him his morning medications at 8:50 a.m.2. Review of resident 145's electronic medical record (EMR) revealed he admitted to the facility on [DATE]. His 6/3/26 brief interview for mental status (BIMS) assessment score was 12, which indicated his cognition was moderately impaired.His diagnoses included dependent personality disorder (a long-lasting mental health condition where a person has an excessive need to be taken care of and relies heavily on others for emotional and physical support), anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), obsessive-compulsive disorder (a chronic mental health condition where a person has unwanted, repeated thoughts (obsessions) and feels driven to perform repetitive actions or mental rituals (compulsions) to ease the distress), malignant neoplasm of the brain (is a harmful tumor made of cancer cells that grow and spread inside the brain), schizoaffective disorder (a serious mental illness with symptoms of impaired reality perception, mood swings, disorganized thinking, and altered behavior), and bipolar type.His undated care plan indicated he had impaired thought processes related to his mental illnesses and a history of brain cancer. The care plan's interventions directed the staff to use communication techniques that enhance interactions, allow for adequate time for him to respond, repeat as necessary, do not rush, and request feedback clarification from him to ensure his understanding. The staff were to face him when they were speaking to him, make eye contact, and to explain all procedures, treatments, and medications.4. Interview on 7/1/26 at 2:45 p.m. with certified nursing assistant (CNA) M revealed that dignity was treating the residents with respect, giving them options to help them live comfortably, listening to their concerns, and treating them fairly. If the staff were busy, they needed to find the time to ensure they did not rush the residents. Rushing made mistakes happen.5. Interview on 7/1/26 at 4:06 p.m. with RN QQ revealed that dignity meant giving respect, comfort, and privacy to the residents. Treat them as you would like to be treated. She did not consider the staff telling a resident to stop talking to be treating them with dignity.6. Interview on 7/2/26 at 9:11 a.m. with the director of nursing (DON) B revealed that treating a resident with dignity meant respecting everything about them, as the facility was their home. If the resident asked for something, the staff should get it or educate the resident about their request. Telling a resident to stop talking was not treating them with dignity.7. Interview on 7/2/26 at 9:25 a.m. with administrator A revealed that she would refer to the facility's dignity policy to determine what the dignity expectations were. She did not consider telling a resident to stop talking to be treating them with dignity.8. Review of the provider's reviewed 12/18/25 resident dignity policy revealed the location will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The interdisciplinary team will assist all staff members in maintaining the dignity of every resident. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and policy review, the provider failed to follow standard food safety practices to ensure that one of one licensed practical nurse (LPN) (K) performed hand hygiene (washing hands with soap and water or using hand sanitizer) when she assisted four of four sampled residents (23, 51, 147, and 161) to eat the evening meal, and that one of one cook (P) wore a hairnet over his beard while preparing food in the main kitchen.Findings include:1. Observation on 6/29/26 from 5:21 p.m. to 5:31 p.m. in the 400-hall dining room revealed LPN K did not perform hand hygiene before she assisted residents 23, 51, 147, and 161 at the supper table with their food.<br><br>She placed a spoon in resident 23's hand, touched his leg and shoulder, and added the pudding onto his plate from the container.<br><br>At 5:25 p.m., LPN K handed resident 161 her silverware and bowls to begin eating.<br><br>At 5:27 p.m., LPN K assisted resident 51 and fed her a spoonful of food.<br><br>At 5:29 p.m., LPN K assisted resident 147 with his supper. She touched resident 147's clothing protector, wheelchair, and his thumb that was in his mouth, before she used his fork to give him a bite of food.<br><br>At 5:31 p.m., LPN K picked up resident 51's silverware and helped her take another bite of food. LPN K then touched the top of the cranberry juice glass to give resident 51 a drink. LPN K went back to resident 147 and continued using his fork to give him bites of food.<br><br>2. Interview on 7/1/26 at 4:06 p.m. with RN QQ revealed that expected hand hygiene to be completed in between helping residents eat their food.<br><br>3. Observation on 7/1/26 at 10:00 a.m. of cook P in the main kitchen revealed that he was preparing raw chicken and did not have a hairnet covering his beard.<br><br>4. Interview on 7/1/26 at 10:50 a.m. with cook P revealed that he was not wearing a hairnet over his beard and he should have been. He usually had his beard covered while he prepared food and that he had made a mistake.<br><br>5. Observation on 7/1/26 at 12:40 p.m. of cook P at a food preparation table in the kitchen revealed he was preparing food without a hairnet covering his beard.<br><br>6. Interview on 7/1/26 at 12:42 p.m. with systems chef O revealed that he expected the staff with beards to have them covered with a hairnet anytime they were preparing food.<br><br>7. Interview on 7/2/26 at 8:46 a.m. with infection preventionist (IP) C revealed that she expected the staff to perform hand hygiene in between assisting residents to eat in the dining room.<br><br>8. Observation on 7/2/26 at 9:35 a.m. outside of the kitchen entry door revealed there was a bin with bold lettering indicating HAIRNETS and a sign on the door that stated, HAIR RESTRAINT[S] ARE REQUIRED AT ALL TIMES IN THE KITCHEN.<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 9. Review of the provider's 6/10/26 Employee Hygiene and Dress Code- Food and Nutrition Services revealed a purpose of To promote a professional appearance, safety, and sanitation. The section regarding hairnets stated 1. Hairnets or hair restraints and beard nets or beard restraints are used: a. When cooking, preparing, assembling food or ingredients. This includes dish room and storage areas.<br><br>10. Review of the provider's 6/8/26 reviewed hand hygiene policy revealed the purpose is to prevent the spread of infection to residents/patients/clients, employees, and visitors through hand hygiene practices. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, and policy review, the provider failed to ensure the staff followed infection prevention and control practices by one of one certified medication aid (CMA) (KK) and one of one certified nursing assistant (LL) who did not wear a gown or perform hand hygiene (wash hands with soap and water or sanitize hands) while providing care to one of one sampled resident (14) on enhanced barrier precautions (EBP) (glove and gown use when providing contact care). Findings Include:<br><br>1. Observation on 6/30/26 at 3:06 p.m. in resident 14's room revealed she had a magnet on her door frame that indicated she required EBP. When the surveyor went into her room, CNA LL and CMA KK had gloves on, did not have gowns on, and were providing care to resident 14. Resident 14 was lying partially on her left side, and her nephrostomy tube (a flexible tube surgically inserted into the kidney to drain urine) was clipped and hanging on the right side of the bed. CNA LL and CMA KK placed an incontinence (involuntary urine or bowel leakage) brief under resident 14.<br><br>CNA LL removed her gloves, discarded them in the trash can, did not perform hand hygiene, put on a clean pair of gloves, and assisted CMA KK with repositioning resident 14 and situating her pillows to her comfort. CMA KK removed her gloves, discarded them in the trash can, did not perform hand hygiene, situated the resident's bedside table, handed resident 14 her tablet and phone, and brushed resident 14's hair. CMA KK put on a clean pair of gloves, grabbed the garbage bag from the trash can and the bag of used linens, and left the residents' room. CMA KK placed the bag of garbage and dirty linens in the dirty utility room, removed her gloves, discarded them in the trash can, and sanitized her hands.<br><br>2. Interview on 6/30/26 at 3:27 p.m. with CMA KK and CNA LL revealed that with residents who were on EBP, the staff needed to wear a gown when completing perineal (private area between the legs) care, and not when they repositioned the resident. They verified they did not wear gowns when completing perineal care for resident 14 and they should have. They did not perform hand hygiene every time they removed their gloves in resident 14's room. They were supposed to perform hand hygiene before and after resident personal care, when they removed their gloves, and before putting on a new pair of gloves.<br><br>3. Review of resident 14's electronic medical record (EMR) revealed she admitted to the facility 10/27/25. Her 5/5/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. Her diagnoses included calculus of the kidney with calculus of the ureter (kidney stones), and quadriplegia (the partial or total paralysis of all four limbs and torso).<br><br>Resident 14's 6/30/26 care plan indicated she was on EBP and the staff were to don [put on] gown and gloves when performing high contact care activities including: dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking and changing [her incontinence brief], device care and/or use, and wound care. She had a right-sided nephrostomy tube due to a history of kidney stones. She required two staff members to reposition her in bed, assist her with dressing, and personal hygiene, and to transfer her with a total body lift (a mechanical lift and sling used to lift a person's full body).<br><br>4. Interview on 7/2/26 at 10:00 a.m. with director of nursing (DON) B revealed she expected the staff to wear gowns and gloves during all high-contact resident care for residents who were on EBP, which was indicated on the magnet on the resident's door frame.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 5. Review of the provider's 4/30/26 Standard, Enhanced Barrier, and Transmission-Based Precautions policy revealed that the purpose of the policy was to prevent the spread of infection and communicable diseases to residents/patients, employees, and visitors through infection prevention and control practices.<br><br>EBP. refer to the use of a gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug-resistant organisms (MDROs) to staff hands and clothing. EBP is used for residents with indwelling medical devices.<br><br>High-contact resident care activities include transfers, dressing, assisting during bathing, providing hygiene, changing briefs or assisting with toileting,.changing linens, indwelling medical device care or use., and wound care.<br><br>6. Review of the provider's 11/13/25 Hand Hygiene policy revealed that the purpose of the policy was to establish hand hygiene as the single most important factor in preventing the spread of disease-causing organisms to patients and personnel in healthcare settings. The staff were to perform hand hygiene before going into a resident's room, before performing a clean task, after removing their gloves, and when leaving the room. |