STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435056	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winner Regional Healthcare Center	805 E 8th St Winner, SD 57580

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A. Based on observation, interview, record review, and policy review, the provider failed to ensure resident safety by not assessing the side rails/grab bars and mattresses on the resident's beds for entrapment (trapped between the rail, mattress, or bedframe spaces) for four of six sampled residents (17, 21, 25, and 26) with loose side rails/grab bars on their beds, five of six sampled residents (6, 14, 17, 21, and 25) with an unsecured mattress on their bed, and one of six sampled residents (17) with a side rail/grab bar that was not indicated for use on the bed. Those failures put those residents at risk for entrapment, injury, or harm.Immediate Jeopardy (IJ) at F689, with a scope and severity of K, began on 5/28/26 at 10:05 a.m. upon observation of resident 14's bed. The bed was unlocked and moved away from the wall; the mattress slid away from the side rail/grab bar with minimal effort, creating a gap of more than five inches. The bed frame did not have mattress guards, which held the mattress in place, preventing the mattress from sliding when a side rail/grab bar was on the bed, putting the resident at risk for entrapment, injury, or harm.Chief executive officer A and director of nursing (DON) B were notified of the IJ on 5/28/26 at 12:45 p.m., and a removal plan was requested. The edited removal plan was received on 5/28/26 at 3:03 p.m. and was accepted on 5/28/26 at 5:10 p.m.The IJ was removed on 5/28/26 at 5:25 p.m. as confirmed by onsite verification by the survey team. After the IJ removal, the severity of non-compliance remained at a G.Current census was: 27Findings include: 1. Observation on 5/27/26 at 9:52 a.m., with resident 6 and resident 14 in their shared room, revealed that a right-side rail/grab bar was attached to each bed. Their mattresses were not securely attached to the beds and created a gap between the side rails/grab bars and the mattresses when the mattresses moved. The gap between resident 14's bed and the side rail/grab bar measured four and a half inches when the mattress slid to the wall when touched. 2. Observation on 5/27/26 at 9:53 a.m. with resident 17 in her room revealed that she had a side rail on the left side of her bed, which was up against a wall in her room. The side rail was loose and could be pulled away from the bed. It was not properly attached to the bed and was held in place with a zip tie. The side rail's bar was not attached to the frame of the bed, was unsecured under the mattress, and could move around. 3. Observation on 5/27/26 at 9:54 a.m., with resident 26 in his room, revealed he had side rails/grab bars on both sides of his bed. The rail/grab bar on the right-handed side of the bed was loose and moved approximately four inches away from the mattress when touched. 4. Observation on 5/27/26 at 10:06 am, with resident 21 in his bed, revealed that he had a rail on the right side of his bed, which was loose, with a four-inch gap between the loose rail and his mattress. The left side of his bed was up against the wall. (continued on next page)

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	10. Review of the maintenance clipboard in the charting conference room revealed there were no resident beds or side rail repair requisitions from 3/18/26 through 5/28/26. 11. Interview on 6/1/26 at 11:56 a.m. with DON B revealed there was no documentation available related to when the side rails were installed on the residents' beds. 12. Interview and review of the maintenance Inspection of Bed Frame w[with]/Mattress and Side Rail Audit on 5/28/26 at 12:04 p.m., with CEO A revealed that the audit was dated 12/06 through 1/13. There was no documentation to identify the year the audit was completed. CEO A thought that maintenance supervisor GG was responsible for assessing the side rails/grab bars, beds, and mattresses for entrapment risk. CEO A stated that maintenance supervisor GG ended his employment on 5/27/26, and CEO A was unable to access information about the installation or inspection of the side rails/grab bars, beds, or mattresses on maintenance supervisor GG's computer. CEO A was unsure if maintenance supervisor GG had inspected the side rails/grab bars, beds, or mattresses, and stated that maintenance supervisor GG was unavailable for an interview. CEO A thought that former maintenance supervisor I completed the bed inspections. There was no maintenance staff member available to interview related to the installation or inspection of side rails/grab bars, beds, or mattresses. 13. Notice of immediate jeopardy (IJ) of F689 was given verbally and in writing on 5/28/26 at 12:45 p.m., to CEO A and DOB B regarding the resident's side rails not being securely attached and the mattresses on residents' beds not being assessed for entrapment risks. Observations made throughout the survey and throughout the long-term care facility from 5/27/26 through 5/28/26 revealed there were several safety concerns related to bedrail installation, maintenance, and bed zone assessments. Residents 17, 21, 25, and 26 had side rail(s)/grab bar(s) that were not securely attached, which created entrapment risks and risk for injury. Resident 25 had a five-inch gap between the top of his mattress and his headboard, which created entrapment risk and risk for injury. Residents 6 and 14 had mattresses that were not securely attached to the bed and created a gap between the side rail/grab bar and the mattress, which created entrapment risks and risk for injury. Resident 17 had a side rail/grab bar that was not indicated for use on that bed, and the side rail/ grab bar was loosely secured to the bed frame with a plastic strap, which allowed the side rail to move away from the mattress and bed frame, creating entrapment risks and risk for injury. The above concerns had the potential to cause serious harm, injury, impairment, or death for residents with side rails on their beds. A plan for the removal of the immediacy was requested at that time. 14. On 5/28/26 at 3:03 p.m., the provider submitted the following IJ removal plan for review, HOW IMMEDIATE JEOPARDY WAS CORRECTED FOR RESIDENTS IDENTIFIED: Immediate jeopardy was identified related to unsafe bed systems, including loose bedrails, gaps creating entrapment (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	of entrapment zones, Immediate reporting and correction process. Education will be completed: Immediately upon IJ identification, During annual competency validation, For all new hires. 15. The immediacy was removed on 5/28/26 at 5:25 p.m. after the survey team verified on-site that the provider had implemented their removal plan through observation, document review, and staff interviews. After the removal of the IJ, the scope and severity of the noncompliance remained at an E. Current census was 27 residents. 16. Review of the provider's revised 1/6/25 Side Rail policy revealed Quarter rails and bed canes [grab bars] that are approved for the beds can be used that are affixed to the bed and evaluated for safety and functioning by maintenance.Maintenance will be notified with side rail evaluations and prn [as needed] for an inspection of the side rail, how it fits the bed, tightness, and to evaluate the mattress for wear and distance from the rail. 17. Review of the provider's undated Bed Safety and Entrapment Prevention Policy revealed that the purpose was To ensure a safe sleeping environment by preventing bedˆrelated accidents, including entrapment, falls, and injury related to bedrails, mattresses, and bed systems. The facility is committed to maintaining all beds, mattresses, and assistive devices in a safe condition. Bed systems will be assessed, maintained, and used in a manner that minimizes the risk of entrapment and injury, in accordance with CMS [Centers for Medicare and Medicaid Services] F689 requirements and FDA [Food and Drug Administration] bed safety guidance. Bedrails will not be used as restraints and will only be utilized when clinically indicated and safe. All beds must: Be in good working condition, Have securely attached side rails or assistive devices (if used), Have a properly fitted mattress, Be compatible with all components (no mixing of incompatible parts), Be free of excessive gaps. All gaps must measure ≤ [less than or equal to] 4.75 inches where applicable. Special attention is given to: Space between mattress and rail, Mattress and headboard/footboard, Split rails and joints. Bedrails will: Only be used when clinically necessary. Require: Assessment prior to use, Care plan documentation, Be removed when: Not used for mobility or positioning, Risk outweighs benefit. Mattresses must: Fit securely within the bed frame, Not slide, shift, or leave gaps, Be secured using: Manufacturerˆapproved systems (e.g., corner brackets or stops), Be replaced if worn or incompatible. Initial and Routine Assessments The following will be completed: On admission, With change in condition, Quarterly and annually, After any bed or mattress change. Assessment includes: Bedrail necessity, Mattress fit and stability, Entrapment zone measurement. Staff Responsibilities: All Staff: Assess need for bedrails, Monitor for signs of entrapment risk, Report hazards immediately. Maintenance: Ensure all beds are properly assembled, Perform repairs and installations, Maintain approved equipment only, Monthly audits on all beds. Administration: Ensure policy compliance, Monitor through [the] QAPI process. B. Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	review, interview, and observation, the provider failed to ensure the safety of one of one sampled resident (5) who was not assessed for her ability to safely drink hot liquids and spilled hot tea on her lap and sustained a hot liquid burn injury, and one of one sampled resident (10) who was not assessed for her ability to safely use her personal coffee maker in her room. Findings include: 1. Review of the provider's 12/23/25 SD DOH FRI report revealed that on 11/19/25, it was reported that resident 5 spilled her hot tea in the dining room, which resulted in a 0.25 centimeter (cm) blister on her right inner thigh, and both inner thighs were red. Bacitracin (an antibiotic ointment) was applied to the blister, and it was covered with a bandage. Resident 5 told a family member that a staff member spilled the hot tea on her. On 12/22/25, resident 5's family member told registered dietitian (RD) H that she thought that a staff member spilled the hot tea on resident 5. On 12/22/25, CEO A and DON B interviewed resident 5, and resident 5 provided inconsistent information about who spilled the hot tea. An unidentified certified nursing assistant (CNA) was interviewed and stated that resident 5 was holding her teacup while the CNA added honey to the hot tea, and then the resident [5] tipped over the cup, into her lap. The unidentified CNA stated she immediately used cloth clothing protectors to absorb the hot tea, took resident 5 to her room, assisted an unidentified nurse to remove resident 5's pants, and cool packs were applied. An unidentified nurse, who the report identified as no longer working at the facility, was interviewed, and there was no change in the above information provided by the unidentified CNA. Dietary manager (DM) G interviewed an unidentified dietary aide who worked on 11/19/25, and the unidentified dietary aide recalled hearing resident 5 cry out, and did not see how the spill occurred. The provider determined that resident 5 spilled her hot tea on her leg. DM G implemented a lid policy, and resident 5 was to have a little water or ice added to her hot beverages, and a lid was to be on the cup when the cup of hot tea was served to resident 5. All hot drinks were to be served with a lid to all residents. The resident or a CNA, upon request by the resident, was the only one that can remove the lid. The lids were not allowed to be removed by the dietary staff members. The temperature on the hot water/coffee machine was not monitored on 11/19/25. The staff were to be trained by 1/5/26 to monitor the temperature of the hot water/coffee machine daily. The temperature of the hot water/coffee machine was monitored after the incident on 11/19/25, and that temperature was in the range of 125-140 degrees Fahrenheit (F). The hot water/coffee machine was inspected and serviced by the coffee company's representative/technician. The provider contacted an unidentified person at the Department of Health and was told that a maximum temperature for hot drinks was not determined by any regulation. Resident 5's blister healed with no residual effect or infection, and her care plan (personalized plan that addresses a resident's care needs, goals, and interventions) was updated to reflect the need for a lid to be used on her hot beverages, and ice was to be added to her tea. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The provider determined the incident was not the result of abuse or neglect. The report indicated that the provider, family, and DON were notified of the incident. 2. Review of resident 5's EMR revealed she admitted to the facility on [DATE]. Her 5/19/26 Brief Interview of Mental Status (BIMS) assessment score was 13, which indicated her cognition was intact. She had a diagnosis of Alzheimer's Disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions). An 11/19/25 nursing progress note revealed Staff reported that resident [5] was in the dining room when she spilled hot tea in her lap. Resident [5] was taken to her room and [her] pants [were] removed immediately. Cool packs [were] applied. Resident [5] has a 0.25 cm blister on [her] right inner thigh. Both inner thighs are red. Bacitracin applied to [the] blister covered with Telfa [a bandage]. [The] provider and family and DON [were] notified. There was an 11/19/25 physician's order for cool packs, Bacitracin, and a bandage to be applied to resident 5's right inner thigh. Resident 5's Skin Observations revealed that on 11/24/25, she had a blister on her right inner thigh that measured 1.5 cm by 0.75 cm, and the leg was tender to touch. On 12/1/25, the Burns spots on [her] inner thighs are peeling. Wound bed [was] pink, no drainage [was] noted. Areas [were] left open to air. On 12/8/25, there were no new skin issues noted.normal skin color, warm to touch. No documentation indicated when the hot liquid burn injury healed. A 12/23/25 progress note written by RD H revealed that she was at the facility on 12/22/25, and resident 5's family member came to her office for follow up regarding the hot liquids in the dining room as discussed during her [resident 5's] care conference on 12/9/25. RD H informed resident 5's family member that DM G adjusted and was monitoring the temperature of the hot water/coffee machine, that the staff members were instructed to add ice to resident 5's hot liquids to cool them, and resident 5 was to have a lid for her hot liquids to reduce the risk of burning herself. RD H reported the conversation to assistant DON C, licensed social worker (LSW) E, and social services designee (SSD) F on 12/22/25 and to DON B and the interdisciplinary team (ADT) at the IDT meeting that morning on 12/23/25. Resident 5's updated 3/10/26 care plan had a focus area that indicated on 11/19/25, resident 5 spilled hot tea on herself, and had a 0.25 cm blister on her right inner thigh. Interventions included that she was able to feed herself after set-up assistance was provided, she had a burn issue with hot tea in the dining room in November 2025, and that she was to have ice added to her hot liquids and a white lid on her cup to decrease the risk of burning herself by hot liquids. There was no documentation that a hot liquid assessment was completed. 3. Observation and interview on 5/27/26 at 8:13 a.m. with resident 5 revealed she had her breakfast of bacon, eggs, toast, and a bowl of oatmeal in front of her. Her hot tea did not have a lid. She answered questions with, yes or no and indicated that she did not have ice in her tea and did not like a lid on her tea. 4. Observation and interview on 5/27/26 at 10:52 a.m. with DM G revealed the water in the hot water/coffee machine was 164 degrees F. She was unsure what the temperatures of the hot water/coffee would have been in November 2025 because they did not monitor the temperatures until 12/24/25, after resident 5 sustained a hot liquid burn injury from her hot tea. She expected the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	member, RD H, assistant DON C, and social services designee (SSD) F attended that care conference. Resident 5's family member discussed her concerns about resident 5's burn injury from her hot tea. 7. Observation and interview on 5/27/26 at 5:11 p.m. in the dining room with resident 5 and contracted travel CNA S revealed resident 5 had a plastic cover on her hot tea. Contracted travel CNA S stated that no residents received ice in their hot beverages, but she would put ice in their hot beverages to cool them, if they asked. All residents were served their hot beverages in a cup with a lid, and the resident or the staff could remove the lid for the resident after it was served. 8. Interview on 6/1/26 at 12:17 p.m. with DON B regarding resident 5's 11/19/25 hot liquid burn injury revealed that she was notified on 12/22/25 that resident 5's family member was stating that resident 5 was burned by a hot liquid and that she thought that a staff member caused the burn injury. DON B was not notified on 11/19/25 that resident 5 received a hot liquid burn injury, and did not expect to be notified because the hot liquid burn injury was not serious enough to require a visit to the emergency room, and the staff thought that resident 5 had spilled her hot tea on herself. CEO A and DON B began their investigation into resident 5's 11/19/25 hot liquid burn injury on 12/23/25. The results of their investigation were entered into the SD DOH reporting system, and then the information was shredded. The provider determined that resident 5 spilled her hot tea on her lap, causing the hot liquid burn injury. Hot liquid safety assessments were not completed on any residents. DM G initiated a policy that all residents were to have lids on their hot tea or coffee, and resident 5 was to have ice added to her hot beverages. Those interventions were added to resident 5's care plan. She was unaware that resident 5 was not provided ice in her hot tea, but resident 5 was allowed to remove the lid from her hot tea. 9. Phone interview on 6/1/26 at 3:53 p.m. with contracted travel CNA U regarding resident 5's 11/19/25 hot liquid burn injury revealed she worked during the evening meal that day. Resident 5 held her teacup up in the air, indicating that she wanted more hot tea and honey. Contracted travel CNA U refilled resident 5's cup and then set it on the table. After she walked away, she heard resident 5 scream that she spilled her hot tea in her lap. She felt that it was a few seconds after she walked away that resident 5 spilled the hot tea. Contracted travel CNA U stated the hot tea pooled in resident 5's lap, she used cloth clothing protectors to soak up the hot liquid, and pushed resident 5 quickly out of the dining room and back to her room to change her pants. She did not think that anyone was near resident 5 when her hot tea spilled. The facility implemented a new policy that all residents were to be served their hot beverages in cups with a plastic lid. They did not use the hot beverage cup lids before the 11/19/25 incident with resident 5. All residents were allowed to have hot beverages, and all residents were required to use the plastic lids. There was no list of residents who were allowed to have the covers removed, but she knew that some residents could remove the lids themselves or ask the nursing staff members to remove the lid for them. 10. Interview on 6/2/26 at 8:25 a.m. with RD H regarding resident 5's 11/19/25 hot liquid burn injury revealed she learned of the injury during resident 5's 12/9/25 care conference. The hot water/coffee machine was serviced by the distributor to ensure the temperature was safe. A hot beverage assessment was considered for resident 5, but the provider's current EMR system did not have one, so that assessment was not completed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident 5 was to have ice added to all of her hot beverages, and the use of plastic lids on all hot beverages was implemented. CNAs were allowed to remove the lids for residents who requested them removed. There were no residents who were not served hot beverages due to the risk of hot liquid burn injuries. The need for ice to be added to resident 5's tea was not on resident 5's meal ticket, but she thought that the staff knew that she needed it. RD H was unaware that ice was not being provided in resident 5's hot beverage, but resident 5 could have the hot beverage cup lid removed from her cup by a nursing staff member when she requested it removed. The temperature of the hot water/coffee machine was not monitored until 12/24/25. She thought that it was determined that resident 5 spilled her own hot tea. 11. Multiple attempts were made throughout the survey to interview resident 5. She answered simple yes-or-no questions, but when as

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure the facility was operated and administered by chief executive officer (CEO) A and director of nursing (DON) B in a manner that ensured quality of life and overall well-being for all 26 residents in the facility.Findings include:1. Observations, interviews, record reviews, and policy reviews throughout the survey from [DATE] through [DATE] and [DATE] through [DATE] revealed CEO A and DON B did not ensure the management, safety, quality of life, and overall well-being of all the residents who lived at the facility.Those were evidenced by a widespread system breakdown to ensure services provided met professional standards and the minimum requirements as it pertained to providing education to residents and residents' representatives to be able to make informed decisions regarding psychotropic medication use, the filing of grievances, the residents' right to be free from abuse and neglect, the right to be free from chemical restraints, investigating and reporting allegations to the South Dakota Department of Health within the required timeframe, resident baseline care plans (personalized plan that addresses a resident's care needs, goals, and interventions within the first 48 hours of admission) completed and offered to the resident or their representative, the updating of care plans to reflect the residents' current care needs, accident hazards identification and mitigation related to entrapment risks for bed side rail use and hot liquid injury, the timeliness of physician visits and complete documentation of the visit, the accountability and securement of controlled medications (medications with risk for abuse and addiction), the pharmacist's medication regimen review, medication accessibility, the removal of expired supplies from use, staff training, and a functioning and effective QAPI (quality assurance and performance improvement) program.2. Interview on [DATE] at 12:31 p.m. with CEO A revealed he had worked at the facility since [DATE]. He was the CEO for the long-term care facility, the clinic, and the attached hospital. He confirmed he was responsible for the daily operations of the facility.3. Review of the providers undated CEO job description revealed, The Chief Executive Officer (CEO) will be responsible for overall administrative management and operation of the hospital, clinics, long-term care program, and related entities under the health umbrella in [redacted name of the town].Leads in educational programs, participates as a teacher and preceptor. Monitors the adequacy and quality of the hospital, clinic, and long-term care medical activities through coordination with the board, management partners [with] the medical and nursing staffs, and enacts policies to assure excellent health care services.4. Review of the provider's undated director of nursing job description revealed The DON plans, organizes, develops, and directs the overall operation of the LTC [long-term care] Nursing Department. Works closely with the Medical Director, and interdisciplinary teams to ensure that a high degree of quality care is maintained in accordance with current federal and state guidance and regulations as well as established policies and procedures.Refer to F552, F585, F600, F605, F609, F655, F657, F689, F700, F712, F755, F756, F761, F865, F944, and F947.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview, record review, and policy review, the provider failed to ensure they identified, investigated, and corrected quality deficiencies, and to initiate or monitor performance improvement projects (PIPs) in response to known areas of concern within their Quality Assurance and Performance Improvement (QAPI) program.Findings include: 1. Interview on 5/28/26 at 5:00 p.m. with CEO A revealed that director of nursing (DON) B managed the facility's QAPI program. He did not routinely attend the long-term care (LTC) QAPI meetings because he was not required to be present. He received a copy of the LTC QAPI meeting minutes and provided that at the general QAPI meeting and again at the board meetings, where he reviewed them. Medical director L was a member of the LTC QAPI committee, attended the meetings when he was able to, and was involved in the policy and procedure process as much as his time allowed. 2. Interview on 6/2/26 at 10:01 a.m. with medical director L revealed that he attended the facility's QAPI meetings quarterly (meaning occurring every three months) when he was able. If he was not able to attend in person, he would attend online. He received a copy of the meeting minutes for review every quarter. 3. Interview on 6/2/26 at 11:48 a.m. with DON B revealed that she was the QAPI Manager and led the QAPI meetings. The facility held quarterly QAPI meetings with committee members, and each committee member was expected to attend and present a report on the information they monitored. She tracked the committee members' attendance. The attendance tracker included the committee member's name, a column for Yes (meaning in attendance), and No (meaning did not attend). She placed a checkmark in the Yes column if the member attended, and a checkmark in the No column if the member did not attend. The QAPI committee implemented PIPs, and the staff were informed of them by their department managers. She acknowledged that potentially harmful systemic issues and concerns were not identified or corrected since the last survey. The staff did not receive training on the elements and goals of the facility's QAPI program. 4. Review of the provider's QAPI meeting attendance records revealed that on 11/23/25 and 3/24/26, CEO A and medical director L did not attend, and there were no other governing board members or facility owner present. On 1/27/26, the attendance record did not have any committee members marked as attending. 5. Review of the provider's QAPI documentation and meeting minutes revealed no PIPs were implemented to address concerns regarding resident safety and quality of care. 6. Interviews throughout the survey confirmed that the QAPI committee did not review or act on the problems that resulted in citations under F600, F605, F609, F689, F700, F755, and F761. There was no evidence that the facility collected safety data, conducted root cause analyses, or monitored corrective actions for the known issues. 7. Review of the provider's undated Chief Executive Officer (CEO) job description revealed that the CEO Leads in educational programs, monitors the adequacy and quality of the medical activities through coordination with the board, management partners, the medical and nursing staff, and enacts policies to assure excellent health care services. Ensures compliance with the regulations and the (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	rules of accrediting bodies by continually monitoring the organization's service delivery and initiating changes as required. Communicates with staff and volunteers to improve service. 8. Review of the provider's revised June 2021 Director of Nursing (DON), Long Term Care (LTC) job description revealed that the DON plans, organizes, develops, and directs the overall operation of the LTC Nursing Department and works closely with the Medical Director, and interdisciplinary team to assure that a high degree of quality care is maintained in accordance with current federal and state guidelines and regulations as well as established policies and procedures of [Facility Name Redacted]. The DON has a primary role in the evaluation and improvement of nursing and other services provided. Provides effective onboarding, education, and training to assure staff competencies, and provides ongoing coaching, mentoring, and performance feedback for staff to succeed. 9. Review of the provider's reviewed October 2025 LTC Quality Assessment Performance Improvement (QAPI) Plan revealed that The QAPI Plan is designed to evaluate, improve, monitor, and measure every activity at [Redacted Facility Name] that affects resident care. The results should be measurable improvement in resident care and optimal utilization of [Redacted Facility Name] LTC Resources. Some goals included, Monitor and continuously improve resident care, find and correct problems in clinical care, improve resident and family satisfaction with services, provide education for staff on quality initiatives and their role, and assure accuracy of resident care documentation. The objectives included, Involve all departments in QAPI activities, and Document QAPI activities in departmental and committee meetings. The LTC QAPI shall be composed of the Administrator [CEO], Director of Nursing [DON], Medical Director (as available), LTC IDT, QAPI Manager, and Pharmacist. The Administrator [CEO] or Director of Nursing will ensure that assigned members of the medical and professional staff participate in the QAPI program and that recommendations for improvement from reports to the LTC QAPI Committee are implemented. The committee shall meet quarterly (more if needed) and shall be responsible for: Reviewing QAPI activities for adequacy and timely completion, Receiving and acting on the quarterly QAPI reports prepared by the QAPI Manager, Identifying opportunities for improvement; implementing initiatives to address problems and documenting follow-up and resolution of problems. The QAPI Manager shall report to the Director of Operations, attend all QAPI Committee meetings, and review reports of various activities. These reports include: quality indicator profiles, resident council, family council, pharmacy drug regimen reviews, family satisfaction surveys, resident abuse files, and incident reports. The QAPI Manager shall perform concurrent monitoring activities of the following: medication records, treatment sheets, incident reports, medication errors, and 24-hour nursing reports. The QAPI Manager will maintain records of all concurrent monitoring activities. Problems affecting resident care are brought to the attention of the QAPI Manager through safety reports, incident reports, survey reports, and resident council minutes. Data will be collected and recorded so that the degree of compliance with achievable goals can be measured. When the cause and scope of a problem are known, corrective action shall be implemented. Alternatives for corrective action include, but are not limited to: In-service Educational Problems, New or Revised Policies and (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procedures, Staffing Changes, and Equipment or Facility Change. The QAPI Committee shall assign problem reassessment and monitoring responsibilities to determine if problems have been resolved or reduced to an acceptable level, and activities shall be documented and should demonstrate measurable improvement in quality of resident care. Refer to F600, F605, F609, F689, F700, F755, and F761.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to ensure the staff educated the resident or the resident's representative of the risks versus benefits of medications or of alternative treatments to make an informed decision for the consent for the use of psychotropic medications (drugs that affects brain activities associated with mental processes and behavior) before they were administered to four of four sampled residents (3, 6, 21, and 32). Findings Include:1. Review of resident 21's EMR revealed he admitted to the facility on [DATE]. His 4/21/26 BIMS assessment score was 3, which indicated his cognition was severely impaired. His diagnoses included Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), dementia with agitation and behavioral disturbance, and neurocognitive disorder with Lewy Bodies (a progressive brain disorder caused by abnormal protein clumps that damage nerve cells that affects thinking, memory, movement, sleep, and behavior), and obstructive sleep apnea (a disorder when your breathing repeatedly stops and starts during sleep because the throat muscles relax, causing the airway to collapse and block airflow). He had a 10/23/25 physician's order to be given one tablet of 15 mg temazepam, a sedative-hypnotic medication that helps the brain relax, making it easier to fall asleep, by mouth every 24 hours as needed at bedtime for insomnia. No documentation indicated that the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or provided their consent for that medication to be administered to resident 21. He had a 10/23/25 physician's order for trazodone 100 mg (an antidepressant medication), one tablet by mouth at bedtime for insomnia. No documentation indicated that the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or provided their consent for that medication to be administered to resident 21. He had 10/24/25 physicians' orders to be given 0.25 ml of lorazepam Intensol oral concentrate, an antianxiety medication, by mouth every two hours PRN for agitation and to be given 0.5 ml of lorazepam by mouth every two hours PRN for agitation. No documentation indicated that the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or provided their consent for that medication to be administered to resident 21. Licensed pharmacist M reviewed resident 21's chart and medication list on 1/26/26, and suggested his lorazepam orders be evaluated by his physician. Licensed pharmacist M indicated in a 5/29/26 review note that resident 21's lorazepam was discontinued by the physician. A 1/30/26 order note for resident 21 indicated that a physician's order was received to discontinue his lorazepam. Review of resident 21's active physician orders indicated that resident 21 continued to be administered his 0.25 ml and 0.5 ml lorazepam Intensol oral concentrate PRN doses as ordered by the physician on 10/24/25. No documentation indicated that the lorazepam doses were ordered to be discontinued on 1/30/26. He had 3/6/26 physicians' orders to be given 1.5 tablets of 1 mg Risperdal, an antipsychotic medication, by mouth in the morning for agitation and 2 mg by mouth every 24 hours PRN, that may be given at bedtime for agitation or anxiety. No documentation indicated that the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or provided their consent for that medication to be administered to resident 21. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	He had 4/2/26 physicians' orders to be given one tablet of 100 mg (1 tablet) sertraline, an antidepressant medication, by mouth in the morning and 50 mg (one-half tablet) at bedtime for depression. No documentation indicated that the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or provided their consent for that medication to be administered to resident 21. He did not have a diagnosis of depression (a mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities). 2. Review of resident 6's EMR revealed he admitted to the facility on [DATE]. His 5/14/26 BIMS assessment score was 5, which indicated his cognition was severely impaired. He did not have a diagnosis of schizophrenia (a chronic and severe brain disorder that affects how a person thinks, feels, and acts), bipolar disorder (a mental health condition characterized by extreme, recurring shifts in mood, energy, and activity levels), anxiety, depression (a serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities), or a severe behavioral disorder. He had an 11/13/25 physician's order for Sertraline HCl oral tablet 100 mg to be administered by mouth in the morning for depression. No documentation indicated that the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 6. He had a 1/23/26 physician's order for Haldol 5 mg (an antipsychotic medication; a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions) give 10 mg by mouth every 6 hours as needed for agitation. That physician's order did not have an end date, a diagnosis for use, and resident 6 needed to be seen by a physician to have that medication reordered on 2/8/26. No documentation indicated that the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 6. He had a 2/20/26 physician's order for Seroquel 25 mg (an antipsychotic medication), one tablet to be administered by mouth two times a day for agitation. The behaviors that Seroquel was ordered to treat were not identified. There was no diagnosis for use identified for that medication. 3. Review of resident 3's EMR revealed she admitted to the facility on [DATE]. Her BIMS assessment score was 11, which indicated her cognition was moderately impaired. Her diagnoses included anxiety disorder and dementia with behavioral disturbance. She had a 7/29/25 physician's order for alprazolamv0.5 mg (an anti-anxiety medication), one tablet to be administered as needed for anxiety. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 3. She had a 5/23/25 physician's order for escitalopram 20 mg (an antidepressant medication), one tablet to be administered every morning for anxiety. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 3. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She had a 12/23/25 physician's order for haloperidol 5 mg one tablet to be administered as needed for agitation. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 3. She had a 12/23/25 physician's order for Seroquel 50 mg, one tablet to be administered at bedtime for behaviors. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 3. She had an 8/7/25 physician's order for trazadone 50 mg, one tablet to be administered at bedtime for sleep. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 3. 4. Review of resident 32's EMR revealed she admitted to the facility on [DATE]. Her 4/22/26 BIMS assessment score was 14, which indicated her cognition was intact. Her diagnoses included dementia with agitation. She had a 4/17/26 physician's order for lorazepam 1 mg (an anti-anxiety medication), one tablet to be administered every eight hours as needed for anxiety. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 32. She had a 4/21/26 physician's order for lorazepam 1 mg, one tablet to be administered two times per day. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 32. She had a 4/16/26 physician's order for mirtazapine 7.5 mg (an antidepressant medication), one tablet to be administered at bedtime for depression. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 32. She had a 4/25/26 physician's order for quetiapine 50 mg (an antipsychotic medication), one tablet to be administered in the afternoon for agitation and dementia with behaviors. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided consent for that medication to be administered to resident 32. She had a 4/21/26 physician's order for olanzapine 10 mg (an antipsychotic medication), one tablet to be administered two times per day for dementia with agitation. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 32. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Interview and EMR review on 6/2/26 at 11:30 a.m. with director of nursing (DON) B revealed the provider did not review the risk versus benefit, educate on alternatives to the psychotropic medications, or have consent forms signed by the resident or the resident's representative before starting or changing resident 21's psychotropic medications. The provider did not have a policy related to psychotropic medications. There was no documentation that resident 21's representative was notified when resident 21 was started on his psychotropic medications. There was no documentation that resident 32's representative was notified when she was started on the lorazepam as needed for anxiety, the mirtazapine, or the quetiapine, because he was difficult to reach by phone. DON B was aware of the regulation related to obtaining the residents' or the residents' representatives' consent for the use of psychotropic medications, but did not implement a process for the review of risks versus benefits, review of alternative treatments or interventions, and obtaining consent for psychotropic medications. 6. Interview on 6/1/26 at 2:33 p.m. with licensed pharmacist M revealed she expected the resident or the resident's representative to be informed of the risks versus benefits of taking a psychotropic medication before the medication was administered or changed. When she made a recommendation, she sent a copy to the resident's physician and DON B. If the physician did not address her recommendation, she did not include it in the following month's review, since she had already mentioned it. Licensed pharmacist M reviewed medication-related diagnoses to ensure that medications had appropriate diagnoses. She acknowledged that residents 21 and 32 did not have a diagnosis for depression but were being treated with an antidepressant. 7. Interview on 6/2/26 at 10:01 a.m. with medical director L revealed that he received resident recommendations from the pharmacist after she reviewed resident charts for gradual dose reductions (GDRs) and monthly medication reviews (MMRs). He reviewed and discussed them with the pharmacist, then submitted an electronic prescription reflecting the changes. Medical director L expected that if he failed to respond to a GDR recommendation, licensed pharmacist M, DON B, or assistant DON C would address him in person immediately. Both the nursing staff and the pharmacist should review the GDRs and MMRs to ensure the orders and reviews were complete. If a medication lacked a diagnosis, he expected the nurse to address the missing diagnosis with their supervisor to obtain the appropriate diagnosis. 8. Interview on 6/2/26 at 12:31 p.m. with chief executive officer (CEO) A revealed he was aware that consent forms were not being completed for psychotropic medications, and that appropriate diagnoses were not documented for resident medications. He was unaware that licensed pharmacist M's recommendations were not reaching medical director L, and, as a result, the provider did not implement them for several months. He acknowledged that pharmacy recommendations regarding psychotropic medication management were not implemented promptly, and residents or their representatives were not informed about their psychotropic medication treatment, including risks, benefits, alternatives, and providing their consent before initiation or continuation of the resident's medications. 9. Review of the provider's 1/12/26 Behavioral Health Management policy revealed, Staff will proactively assess, monitor, and manage behavioral symptoms using individualized, nonpharmacological and clinically appropriate interventions while ensuring resident dignity, safety, and regulatory compliance. The resident's family was to be notified of significant behavioral changes. Residents have the right to participate in care decisions (as able).

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Winner Regional Healthcare Center	805 E 8th St Winner, SD 57580

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to protect the residents' rights to be free of unnecessary medications, specifically psychotropic medications (drugs that affect brain activities associated with mental processes and behavior), for five of five sampled residents (3, 6, 9, 21, and 32) who were administered psychotropic medications without usage order stop dates or documented reasoning for continuation of use of as needed psychotropic medications beyond fourteen days, completed risk versus benefit evaluations for informed consent for use, documented diagnoses for use, documented and physician responses to pharmacy recommendations. Findings include: 1. Review of resident 9's electronic medical record (EMR) revealed she admitted to the facility on [DATE]. Her 2/27/26 Brief Interview of Mental Status (BIMS) assessment score was 3, which indicated her cognition was severely impaired. Her diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities) with agitation. She had a 9/5/25 physician's order to be given 0.25 milliliters (mL) of lorazepam 2 milligrams per milliliter (mg/ml) (an anti-anxiety medication) every two hours as needed (PRN) for agitation or anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). The physician's order did not have a usage end date. Resident 9 did not have a diagnosis of anxiety. Her 5/27/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions)did not indicate she had agitation or anxiety and did not identify any non-pharmacological (without medication) interventions to help her manage agitation or anxiety. 2. Review of resident 3's EMR revealed she admitted to the facility on [DATE]. Her 5/15/26 BIMS assessment score was 11, which indicated her cognition was moderately impaired. Her diagnoses included anxiety disorder and dementia with behavioral disturbance. She had a 12/23/25 physician's order to be given one 5mg tablet of haloperidol (an antipsychotic medication that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions) as needed for agitation. The physician's order did not have a usage end date. She had a 12/23/25 physician's order to be given one tablet of 50 mg Seroquel, (an antipsychotic medication) at bedtime for behaviors. The behaviors that Seroquel was to treat were not identified in that order. Her 5/28/26 care plan had a focus area that indicated she received a psychotropic medication related to behavior management. That focus area did not identify what her behaviors were or non-pharmacological interventions for those behaviors. A focus area indicated she had hallucinations and took the antipsychotic medication olanzapine for anxiety, agitation, and psychosis (a state of losing touch with reality). There were no non-pharmacological interventions for the symptoms of hallucinations, anxiety, agitation, or psychosis. 3. Review of resident 21's electronic medical record (EMR) revealed he admitted to the facility on [DATE]. His 4/21/26 BIMS assessment score was 3, which indicated his cognition was severely impaired. His diagnoses included Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), dementia with agitation and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	behavioral disturbance, and neurocognitive disorder with Lewy Bodies (a progressive brain disorder caused by abnormal protein clumps that damage nerve cells that affects thinking, memory, movement, sleep, and behavior), and obstructive sleep apnea (a disorder when your breathing repeatedly stops and starts during sleep because the throat muscles relax, causing the airway to collapse and block airflow). He had a 10/23/25 physician's order to be given one tablet of 15 mg temazepam, a sedative-hypnotic medication that helps the brain relax, making it easier to fall asleep, by mouth every 24 hours as needed at bedtime for insomnia. Resident 21's temazepam order did not indicate a 14-day stop date or include a physician's evaluation with a rationale for continuing the PRN temazepam beyond 14 days. He had 10/24/25 physicians' orders to be given 0.25 ml of lorazepam Intensol oral concentrate, an antianxiety medication, by mouth every two hours PRN for agitation and to be given 0.5 ml of lorazepam by mouth every two hours PRN for agitation. Those orders did not include 14-day stop dates or physician evaluations with rationales for continuing resident 21's lorazepam PRN doses beyond 14 days. Licensed pharmacist M reviewed resident 21's chart and medication list on 1/26/26 and suggested his lorazepam orders be evaluated by his physician. Licensed pharmacist M indicated in a 5/29/26 review note that resident 21's lorazepam was discontinued by the physician. A 1/30/26 order note for resident 21 indicated that a physician's order was received to discontinue his lorazepam. Review of resident 21's active physician orders indicated that resident 21 continued to be administered his 0.25 ml and 0.5 ml lorazepam Intensol oral concentrate PRN doses as ordered by the physician on 10/24/25. No documentation indicated that the lorazepam doses were ordered to be discontinued on 1/30/26. He had 3/6/26 physicians' orders to be given 1.5 tablets of 1 mg Risperdal, an antipsychotic medication, by mouth in the morning for agitation and 2 mg by mouth every 24 hours PRN, that may be given at bedtime for agitation or anxiety. Resident 21's Risperdal order did not indicate a 14-day stop date, and did not include an evaluation by the physician with a rationale to continue resident 21's PRN Risperdal beyond 14 days. He had a 4/2/26 physicians' orders to be given one tablet of 100 mg sertraline, an antidepressant medication, (1 tablet) by mouth in the morning and 50 mg (one-half tablet) at bedtime for depression. He did not have a diagnosis of depression (a mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities). 4. Review of resident 6's EMR revealed he admitted to the facility on [DATE]. His 5/14/26 BIMS assessment score was 5, which indicated his cognition was severely impaired His diagnoses included type 2 diabetes mellitus, peripheral vascular disease (a circulation disorder characterized by the narrowing, blockage, or spasms of blood vessels outside of the heart and brain), chronic kidney disease (loss of the kidneys' ability to filter waste and excess fluid from the blood), cerebral infarction (stroke), repeated falls, weakness, and tremor (involuntary, rhythmic shaking or trembling movement). He had a 2/20/26 physician's order to be given one tablet of 25 mg Seroquel by mouth two times a day for agitation. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	He had a 1/23/26 physician's order to be given 10 mg of haloperidol by mouth every 6 hours as needed for agitation. That physician's order did not have an end date. He did not have a diagnosis of schizophrenia (a chronic and severe brain disorder that affects how a person thinks, feels, and acts), bipolar disorder (a mental health condition characterized by extreme, recurring shifts in mood, energy, and activity levels), anxiety, depression (a serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities), or a severe behavioral disorder, There was no documentation in resident 6's 5/20/26 care plan that he received an antidepressant or a psychotropic medication. There was a focus area that indicated that he had a behavior of inappropriate touching to [of] female staff. There were no behavior-management or nonpharmacological interventions for those behaviors included in his care plan. 5. Review of resident 32's EMR revealed she admitted to the facility on [DATE]. Her 4/22/26 BIMS assessment score was 14, which indicated her cognition was intact. Her diagnoses included dementia with agitation. She had a 4/16/26 physician's order to be given one tablet of 7.5 mg mirtazapine (an antidepressant medication) at bedtime for depression. Resident 32 did not have a diagnosis of depression. She had a 4/17/26 physician's order to be given one tablet of 1mg lorazepam every eight hours as needed for anxiety. There was no end date included for that PRN medication order. She had a 4/21/26 physician's order to be given one tablet of 1 mg lorazepam two times per day. There was no diagnosis or indication for use identified for that medication. She had a 4/21/26 physician's order to be given one tablet of 10 mg olanzapine two times per day for dementia with agitation and a 4/25/26 physician's order to be given one tablet of 50 mg quetiapine (an antipsychotic medication) administer one tablet in the afternoon for agitation. Olanzapine and quetiapine were in the same drug class. A 4/21/26 progress note from medical director L indicated he spoke with an on-call psychiatrist about resident 32's suicidal ideations who recommended transitioning away from scheduled Seroquel (quetiapine) and switching to scheduled olanzapine. Her 5/28/26 care plan had a focus area of uses psychotropic medications r/t [related to] depression, anxiety, and behavioral management. There were no non-pharmacological interventions identified for that focus area. Her care plan indicated she displayed significant aggressive behaviors, and the intervention was for staff to provide one to one care for her if she poses a risk to herself or others. Potential triggers for her aggressive behavior were not identified. Her history of suicidal thought tiggers or interventions for those thoughts were not identified in her care plan. On 5/21/26, resident 32 had a 2:30 p.m. appointment with a mental health provider related to her prior suicidal thoughts. During that appointment, it was documented that she was, unable to participate in the session due to being asleep and unresponsive to verbal prompting. Review of her May 2026 medication administration record (MAR) indicated that on 5/21/26 at 12:34 p.m. she was administered 5 mg of oxycodone (controlled pain medication with risk fir addiction and abuse) with a reported pain level of three and one tablet of lorazepam 1 mg for agitation. Resident 32 did not have any documented behaviors on 5/21/26. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Interview on 5/28/26 at 9:17 a.m. with registered nurse (RN)(space)Q revealed the nurses were to chart resident behaviors on the residents' MARs or treatment administration records (TAR). The certified nursing assistants (CNAs) would notify the nurse if a resident displayed a behavior. She did not know how the CNAs would know what behaviors the residents had or what the non-pharmacological interventions for those behaviors were. Some of the residents' behaviors and interventions were identified on their care plans, but others were not. 7. Interview on 6/1/26 at 2:33 p.m. with licensed pharmacist M revealed she reviewed the residents' medication regimens monthly. During her reviews, she looked for PRN psychotropic medication orders to check if those medication orders had an end date. If there were no end date, she would send a recommendation to the physician to order an end date for those medications. When she made a recommendation, she sent a copy to the physician and DON B. If the physician did not address her recommendation, she did not include it in the following month's review, since she had already mentioned it. She acknowledged resident 9's PRN lorazepam order did not have an end date. She stated resident 9 was on hospice services previously(comma) and that the medication order was a hospice order. Licensed pharmacist M was unaware of the regulation on end dates for hospice residents. She verified resident 9 was no longer receiving hospice services, but the medication remained on her medication list. She acknowledged haloperidol was an antipsychotic medication that was not to be ordered to be administered PRN for longer than 14 days without being seen and evaluated by a physician and obtaining a new physician's order for that medication. When she completed the residents' monthly medication reviews, she reviewed the medications for each diagnosis and the use of each medication. She did not review the residents' diagnosis list in the EMR to ensure that the diagnosis assigned to the medication was an active diagnosis for that resident. She verified resident 32 did not have an active diagnosis of depression(comma), but her physician's order for mirtazapine indicated it was being used for depression. Licensed pharmacist M was aware that resident 32 had duplicate antipsychotic medication therapy (define). She thought the duplicate therapy was the recommendation of the geriatric psychiatrist, according to medical director L's 4/21/26 progress note. After reviewing that progress note, she stated she previously read the progress note wrong, and medical director L indicated that resident 32 was to be transitioned from quetiapine to olanzapine. She did not recommend continuing that transition in her monthly medication review for resident 32. She acknowledged that resident 21 did not have a diagnosis for depression but was being treated with an antidepressant. 8. Interview on 6/2/26 at 10:01 a.m. with medical director L revealed that he received recommendations from the pharmacist after she reviewed resident charts for gradual dose reductions (GDRs) and monthly medication reviews (MMRs). He reviewed and discussed the recommendations with the pharmacist, then submitted an electronic prescription that reflected the medication changes. Medical director L expected that if he failed to respond to a GDR recommendation, licensed pharmacist M, director of nursing (DON) B, or assistant director of nursing (ADON) C would address that with him in person immediately. He stated that the nursing staff and the pharmacist should review the GDRs and MMRs to ensure the orders and reviews were completed. If a medication lacked a diagnosis, he expected the nurse to address the missing diagnosis with their supervisor to obtain the appropriate diagnosis from him. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Interview on 6/2/26 at 11:30 a.m. with DON B revealed the provider did not review the risk versus benefits, educate on alternatives to the psychotropic medications with the resident or the resident's representative, document that informed consent was obtained, or have written consent forms signed by the resident or the resident's representative before starting or changing resident 21's psychotropic medications. The provider did not have a policy related to psychotropic medications that addressed their use, risks, benefits, alternatives, non-pharmacological interventions, GDRs, PRN use limits, the ongoing need for the medications, and monitoring and safety. DON B acknowledged that there was no documentation that resident 21's representative was notified before he was started on his psychotropic medications. DON B did not implement a process for reviewing risks versus benefits, alternative treatments, or interventions, and obtaining informed or written consent from the resident or their representative for the use of psychotropic medications. 10. Review of the provider's 1/12/26 Behavioral Health Management policy revealed, Staff will proactively assess, monitor, and manage behavioral symptoms using individualized, nonpharmacological and clinically appropriate interventions while ensuring resident dignity, safety, and regulatory compliance. Each resident with behavioral health needs must have an individualized care plan addressing behaviors, identified triggers and early warning signs, specific interventions and staff approaches, and staff must prioritize non-drug approaches. The use of psychotropic medications, Must comply with CMS [Center for Medicare and Medicaid Services] regulations (gradual dose reductions, indications). Use only when clinically necessary and not for staff convenience. Requires: Documented clinical indication, provider order, and monitoring for effectiveness and side effects. 11. Review of the provider's revised November 2024 Drugs: Review of Orders For Discontinuation policy revealed that A procedure whereby the dosage and schedule of medications will be reviewed by physicians. The timeframe for review of orders for continuation or discontinuation will apply to the following categories: Controlled Substances will be discontinued in 30 days, Antibiotics will be discontinued in 7 days, Anticoagulants will be discontinued in 30 days, Colchicine for acute gout attacks will be discontinued in 48 hours, Ketorolac (Toradol) will be discontinued in 5 days, and all other drugs not otherwise ordered for a specific time or number of doses will be discontinued in 60 days. The medication needing review will not automatically discontinue and will remain active until discontinued by the physician. The physician will have three options under this activity, that includes Review, which will reset the review date for the medication, Discontinue, which will discontinue the medication, and Modify, which will modify the medication order and reset the review date. Psychotropic medications were not included in the policy to include PRN (as needed) orders and their 14-day stop dates.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure the residents' care plans (personalized plan that addresses a resident's care needs, goals, and interventions) were reviewed and revised to reflect the current care needs for nine of thirteen sampled residents (3, 5, 6, 9, 14, 18, 21, 22 and 32). Findings include:1. Observation on 5/26/26 at 1:22 p.m. in resident 18's room revealed a nebulizer machine on her bedside table, with a mask and tubing attached and stored on top of the machine. 2. Review of resident 18's electronic medical record (EMR) revealed she was admitted to the facility on [DATE]. Her 3/10/26 Brief Interview of Mental Status (BIMS) assessment score was 05, which indicated her cognition was severely impaired. She had diagnoses included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe (COPD), type 2 diabetes mellitus (a condition involving disruptions in how the body regulates blood sugar), chronic kidney disease (a condition involving the kidneys that are permanently damaged and can't properly filter waste and extra fluid from the blood), and weakness. Resident 18 had 3/10/26 physician orders for Budesonide inhalation suspension 0.5 milligram (mg)/2 milliliters (mL), two times a day, and Combivent Respimat inhalation aerosol solution 100 micrograms (mcg)/act ipratropium-Albuterol, before meals and at bedtime, both for her COPD. Resident 18's comprehensive care plan dated 3/23/26 did not document that she required the use of respiratory treatment and did not indicate her documented diagnosis of COPD. No interventions, measurable objectives, or monitoring related to her COPD, such as respiratory treatments, medications, and cleaning of her nebulizer equipment, were addressed in her care plan. 3. Observation on 5/26/26 at 3:26 p.m. resident 9 was yelling out that she needed to use the restroom. Contracted travel certified nursing assistants (CNA) U and CNA AA brought in a stand aide lift (a manual lift used to assist from a seated to a standing position), assisted resident 9 out of her bed, into the stand aide lift, and rolled the stand aide lift into the bathroom so resident 9 could use the bathroom. 4. Review of resident 9's EMR revealed she was admitted to the facility on [DATE]. Her 2/27/26 Brief Interview of Mental Status (BIMS) assessment score was 3, which indicated her cognition was severely impaired. Her diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities) with agitation, and a stroke (blood flow to the brain is interrupted) resulting in weakness or paralysis of the left side of her body. She had a 9/5/25 physician's order for lorazepam 2 milligrams per milliliter (mg/ml) (an anti-anxiety medication) to be administered 0.25 milliliters (ml) every two hours as needed for agitation or anxiety. The physician's order did not have an end date. Her 5/27/26 care plan did not indicate she had agitation or anxiety or identify any non-pharmacological interventions for agitation or anxiety. Her care plan did not indicate how she transferred out of bed, it did not indicate if she walked or used a wheelchair, and it did not indicate if she required assistance with dressing, bathing, or eating. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Observation on 5/26/26 at 3:30 p.m. of resident 32 in her room revealed she was seated in Broda chair (a specialized, ergonomic medical wheelchair or recliner) in a semi-reclined position. 6. Review of resident 32's EMR revealed she was admitted to the facility on [DATE]. Her 4/22/26 BIMS assessment score was 14, which indicated her cognition was intact. Her diagnoses included dementia with agitation and a stroke resulting in weakness or paralysis affecting the left side of her body. She had been placed on frequent checks and was referred to psychiatry due to her expressions of suicidal thoughts. She had 4/24/26 occupational therapy evaluation completed by occupational therapist DD. It was recommended at that time resident 32 use a Broda chair for positioning. She had a 4/16/26 physician's order for mirtazapine 7.5 milligrams (mg) (an antidepressant medication) one tablet to be administered at bedtime for depression; a 4/17/26 physician's order for lorazepam 1 mg (an anti-anxiety medication) one tablet to be administered every eight hours as needed for anxiety; a 4/21/26 physician's order for lorazepam 1 mg one tablet to be administered two times per day; a 4/21/26 physician's order for olanzapine 10 mg (an antipsychotic medication) one table to be administered two times per day for dementia with agitation; and a 4/25/26 physician's order for quetiapine 50 mg (an antipsychotic medication) administer one tablet in the afternoon for agitation. Her 5/28/26 care plan had a focus area of uses psychotropic medications r/t [related to] depression, anxiety, and behavioral management. There were no non-pharmacological interventions identified within that focus area. Her care plan indicated she had displayed significant aggressive behaviors, and the intervention was to provide one to one care for her if she poses a risk to herself or others. Potential triggers for her aggressive behavior were not identified. Her history of suicidal thoughts was not identified on her care plan nor triggers or interventions for those thoughts. Resident 32's use of a Broda chair to optimize positioning was not identified on her care plan. 7. Observation and interview on 5/26/26 at 3:39 p.m. with resident 22 revealed she had a scoop mattress (a mattress designed with raised, contoured edges and a lower, scooped center) and bed rails/grab bars (bars attached to the bed) on both sides of her bed. She stated that she fell out of bed about a year ago. She could get in and out of bed without assistance, did not use the grab bars, and was unsure why the scoop mattress remained on her bed. 8. Review of resident 22's EMR revealed she was admitted on [DATE]. Her 3/10/26 BIMS assessment score was 15, which indicated her cognition was intact. There was a 4/22/24 physician's order for a Pressure Reducing Mattress: Check Q [each] Week to Ensure Proper Functioning and Placement on Bed at bedtime every Sun[day]. Her 3/11/26 minimum data set (MDS) assessment (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) indicated that she was independent with bed mobility, transfers, and toileting. Her 3/30/26 care plan indicated she required assistance by staff to turn and reposition in Bed., that she used a walker with one assist to go to and from activities and that she required assistance by staff for toileting. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documentation in resident 22's care plan that she required the use of a scoop mattress, the level of assistance that she required to complete bathing and dressing tasks, transfers, or mobility in her room. 9. Interview on 6/1/26 at 2:18 p.m. with DON B regarding resident 22's scoop mattress revealed that no assessment for resident 22's safe use of the scoop mattress had been completed, the use of the scoop mattress was not included in resident 22's care plan, and the provider did not have a policy for the use of the scoop mattress. She did not think a policy or an assessment for the use of a scoop mattress was needed. DON B stated that resident 22's use of a scoop mattress should have been included in the care plan. The scoop mattress was placed on resident 22's bed last year after she fell, at the request of a family member of resident 22. 10. Observation on 5/27/26 at 9:36 a.m. with resident 6 and resident 14 in their shared room revealed that resident 6 was seated upright in a Broda (a specialized, ergonomic medical wheelchair or recliner) chair. Resident 14 was seated in a Broda chair in a semi-reclined position. 11. Review of resident 6's EMR revealed he was admitted to the facility on [DATE]. His 5/14/26 BIMS assessment score was 5, which indicated his cognition was severely impaired. He had an 11/13/25 physician's order for Sertraline HCl oral tablet 100 mg (an antidepressant medication used to treat mental health conditions like major depressive disorder), give 100 mg by mouth in the morning for depression, a 1/23/26 physician's order for Haldol 5 mg (an antipsychotic medication; a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions): give 10 mg by mouth every 6 hours as needed for agitation, and a 2/20/26 physician's order for Seroquel 25 mg (an antipsychotic medication), one tablet by mouth two times a day for agitation. There was no documentation in resident 6's 5/20/26 care plan that he received antidepressant and antipsychotic medication. There was a focus area where he had a behavior of inappropriate touching to [of] female staff. There were no behavior management or non-pharmacological interventions for those behaviors. There was no documentation that he had a mental health diagnosis or a severe behavioral disorder. There was no documentation in that care plan that he required the use of a Broda chair, nor the level of assistance that he required to complete bathing, dressing, transfers, and toileting tasks. 12. Review of resident 14's EMR revealed he was admitted to the facility on [DATE]. His 5/14/26 BIMS assessment score was 13, which indicated his cognition was intact. There was no documentation in resident 14's 4/15/26 care plan that he required the use of a Broda chair, nor the level of assistance that he required to complete bathing, dressing, transfers, and toileting tasks. 13. Observation on 5/28/26 10:30 a.m. with resident 5, certified nursing assistant (CNA) AA, and CNA EE revealed that resident 5 was transferred from her wheelchair to the bathroom with a stand aid lift (a mechanical lift used to assist from a seated to a standing position), and there were no side rails/grab bars (bars attached to the bed) on her bed. 14. Review of resident 5's EMR revealed she was admitted on [DATE]. There was a 3/19/25 physician's order side rails to promote independence and increase safety, and a physician's order Ok to use Purwick catheter system [a non-invasive, external urine management (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	system] due t[o] incontinence, which was discontinued on 12/12/25. Her 3/10/26 care plan indicated she was able to transfer with supervision, that she required the use of a full body lift with staff assistance for her safety, and that restorative therapy was working on resident 5's request to use a stand lift. Her care plan also indicated that she used side rails/grab bars on her bed for her safety, and she used a Purwick catheter system due to incontinence. Her 5/19/26 MDS assessment indicated her BIMS assessment score was 13, which indicated her cognition was intact, and that she was dependent with toileting tasks, and required substantial/maximal assistance with bathing and dressing. There was no documentation in resident 5's care plan that indicated the level of assistance she required to complete bathing, dressing tasks or toileting tasks. 15. Review of resident 21's EMR revealed he was admitted to the facility on [DATE]. His 4/21/26 BIMS assessment score was 03, which indicated his cognition was severely impaired. His diagnoses included Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), dementia (a group of symptoms affecting memory, thinking, and social abilities) with agitation and behavioral disturbance, neurocognitive disorder with Lewy Bodies (a progressive brain disorder caused by abnormal protein clumps that damage nerve cells that affects thinking, memory, movement, sleep, and behavior), and obstructive sleep apnea (a disorder when your breathing repeatedly stops and starts during sleep because the throat muscles relax, causing the airway to collapse and block airflow). He had a 10/23/25 physician's order for donepezil 10 milligram (mg) one tablet by mouth in the morning for his dementia. Resident 21's care plan, dated 10/23/25, had an intervention with the incorrect dose for that medication. The intervention listed the medication as Donepezil HCL 100 Mg PO BID. The dose on the care plan had an extra zero, indicating it was 100 mg instead of the physician's ordered 10 mg, and the care plan reflected that he should receive it twice daily rather than once daily. He had physicians' orders dated 10/24/25 for lorazepam Intensol oral concentrate 0.25 milliliters (mL) (an antianxiety medication) by mouth every two hours PRN (as needed) for agitation and for 0.5 mL by mouth every two hours PRN for agitation. Resident 21's care plan, dated 10/23/25, had an intervention with the incorrect dose for that medication. The intervention listed the medication as Lorazepam 0.5 mg-1 mg Q [every] 2 HRS [hours] PRN. He had physicians' orders dated 3/6/26 for Risperdal 1mg (an antipsychotic medication that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions), give 1.5 mg (1.5 tablets) by mouth in the morning for agitation and 2 mg by mouth every 24 hours PRN, may give at bedtime for agitation or anxiety. Resident 21's care plan, dated 10/23/25, had an intervention with the incorrect dose for that medication. The intervention listed the medication as Risperdal 2 Mg PO [by mouth] at HS [bedtime]. He had physicians' orders dated 4/2/26 for sertraline 100 mg (an antidepressant medication), 1 tablet by mouth in the morning and 50 mg (1/2 tablet) at bedtime for depression (a mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities). Resident 21's care plan, dated 10/23/25, had an intervention with the incorrect dose for that medication. The intervention listed the medication as Sertraline 100 Mg BID [twice daily]. He did not have a diagnosis (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of depression. Resident^21's care plan dated 10/23/25 continued to include interventions and referral to hospice services, despite the resident's hospice services being discontinued on 1/16/26. The facility did not update the care plan to reflect resident 21's current status and needs, and did not address goals and interventions to include the risks associated with psychotropic medication use. Resident 21's 10/23/25 care plan was not individualized or person^centered related to his psychotropic medications. 16. Review of resident 3's EMR revealed she was admitted to the facility on [DATE]. Her 5/15/26 BIMS assessment score was 11, which indicated her cognition was moderately impaired. Her diagnoses included anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and dementia with behavioral disturbance. She had a 7/29/25 physician's order for alprazolam 0.5 milligrams (mg) (an anti-anxiety medication), one tablet to be administered as needed for anxiety. The physician's order did not have an end date. She had a 12/23/25 physician's order for haloperidol 5 mg (an antipsychotic medication; a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions), one tablet to be administered as needed for agitation. The physician's order did not have an end date, and she needed to be seen by a physician to have this reordered on 1/6/26. She had a 12/23/25 physician's order for Seroquel 50 mg (an antipsychotic medication), one tablet to be administered at bedtime for behaviors. The behaviors that the Seroquel was ordered to treat were not identified. Her 5/28/26 care plan had a focus area stating she received psychotropic medication related to behavior management. That focus area did not identify what her behaviors were or non-pharmacological interventions for those behaviors. A focus area stated she had hallucinations and indicated she was taking olanzapine (an antipsychotic medication) for anxiety, agitation, and psychosis (a state of losing touch with reality). She did not have a physician's order for this medication. She did not have a diagnosis of psychosis or hallucinations, and there were no non-pharmacological interventions for these symptoms identified in her care plan. 17. Interview and EMR review on 5/28/26 at 9:17 a.m. with registered nurse (RN) Q revealed she would expect the care needs of each resident to be in their care plan. The care plans should include the assistance the resident requires for transfers, dressing, eating, and toileting. The nurses charted resident behaviors on the residents' medication administration record (MAR) or treatment administration record (TAR). The certified nursing assistants (CNA)s would notify the nurse if a resident had displayed a behavior. She did not know how the CNAs would identify what behaviors the residents had or what the non-pharmacological intervention for that behavior was. She acknowledged some of the residents' behaviors and interventions were identified in their care plans, but others did not. 18. Interview on 6/1/26 at 11:38 a.m. with CNA S revealed that she knew the level of assistance that a resident needed to complete bathing, dressing, and transfers because that information was on the resident's care plan in the EMR. She expected a resident's care plan to contain information about a resident's behaviors and interventions or solutions to manage those behaviors. She indicated that a (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's care plan had all the information she needed to care for the residents, including their cognitive status, if the resident required special equipment for transfers and positioning. There was also a note on each residents bathroom door that indicated how a resident transferred. She thought that DON B or assistant DON C updated the care plan if there was a change in how she was to care for or transfer a resident. 19. Interview on 6/1/26 at 12:17 p.m. with DON B revealed that the facility used an external Minimum Data Set (MDS) company to complete resident care plans when MDS assessments (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) were completed. She stated that the company was responsible for updating the resident's care plan. She was unaware that the care plans for residents 3, 5, 6, 9, 14, 18, 21, 22, and 32 were neither person-centered nor up to date with those residents' individual needs. DON B said she would email the external MDS company if she became aware that something needed to be added to or updated on a resident's care plan. DON B and ADON C were responsible for updating resident care plans. DON B stated that the care plans should have contained information on the resident's physical ability or the level of assistance they require to complete bathing, dressing, toileting, and transfer tasks She expected the CNAs to use the residents' care plan to know what care each resident required. The CNA's daily assignment sheet also included information on the level of assistance and equipment needed to transfer a resident. She expected the residents' use of a Broda chair and side rails to be included in the care plan. She expected monitoring for the use of antidepressant and psychotropic medications, the resident's behaviors, and non-pharmacological approaches to be included in the resident care plan. 20. Review of the provider's revised February 2020 Care Plans: Preliminary, Comprehensive and Reviews policy revealedAn interdisciplinary team, in coordination with the resident and his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident. Each discipline enters their portion of the comprehensive care plan into PointClickCare EMR [an electronic medical record] and works with the interdisciplinary team members to maintain a care plan for each resident. PointClickCare shall always have the most updated care plan for each resident. Care plans are revised as changes in the resident's condition dictates and reviewed at least quarterly. The Comprehensive Care Plan is designed to: Incorporate identified problem areas and risk factors. Enhance the optimal functioning of the resident. CNA [certified nursing assistant] staff, Day/Night, shall be responsible for reviewing and revising their drop sheets to reflect care. Changes in the resident's condition must be reported to the RN [registered nurse] MDS [minimum data set] coordinator so that a review of the resident's assessment and care plan can be made. Daily care and documentation must be consistent with the resident's care plan. The Care Planning Committee/Team is responsible for keeping care plans on a current status and for periodic review and updating of care plans. 21. Review of the provider's 1/12/26 Behavioral Health Management policy revealed, Staff will (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure physician's orders, in accordance with the provider's policy, were obtained before bed rails/grab bars (bars attached to the bed) were installed for two of ten sampled residents (6 and 26), alternatives to the bed rails/grab bars were attempted before the bed rails/grab bars were installed, the risks versus benefits of bed rails/grab bars were reviewed with the resident, or the resident's representative, entrapment zone assessments were completed, and a consent for the bed rails/grab bars were obtained for seven of ten (6, 14, 17, 21, 22, 25, and 26) who had bed rails/grab bars on their bed. Findings include:1. Observation and interview on 5/26/26 at 3:39 p.m. with resident 22 revealed she had a scoop mattress (a mattress designed with raised, contoured edges and a lower, scooped center) and bed rails/grab bars (bars attached to the bed) on both sides of her bed. She stated that she fell out of bed about a year ago. She could get in and out of bed without assistance, did not use the grab bars, and was unsure why the scoop mattress remained on her bed. 2. Review of resident 22's electronic medical record (EMR) revealed she admitted on [DATE]. Her 3/10/26 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. There was a 4/22/24 physician's order for a Pressure Reducing Mattress: Check Q [each] Week to Ensure Proper Functioning and Placement on Bed at bedtime every Sun[day], and a 4/23/24 physician's order for Bilateral bed rails for repositioning and safety while in bed. There was no documentation to indicate when resident 22's side rail/grab bars or scoop mattress were installed on her bed. There was no documentation that alternatives were attempted before the recommendation or installation of the side rail/grab bars or scoop mattress, that the risks versus benefits of side rail/grab bars or scoop mattress were reviewed with the resident or the resident's representative, or a consent for the side rail/grab bars or scoop mattress was obtained before the installation of the side rail/grab bars or scoop mattress on resident 22's bed. There was no documentation that resident 22's safety for the use of the scoop mattress, or the risk for entrapment, had been assessed. The quarterly side rail/grab bar assessments completed did not assess for resident 22's risk of entrapment. 3. Interview on 6/1/26 at 2:18 p.m. with DON B regarding resident 22's scoop mattress and bed rails/grab bars revealed that no assessment for resident 22's safe use of the scoop mattress had been completed, the use of the scoop mattress was not included in resident 22's care plan, and the provider did not have a policy for the use of the scoop mattress. She did not think a policy or an assessment for the use of a scoop mattress was needed. Resident 22's use of a scoop mattress should have been included in the care plan. DON B thought that the scoop mattress and bed rails/grab bars were placed on resident 22's bed last year after she fell, at the request of a family member of resident 22. 4. Observation on 5/27/26 at 9:53 a.m., with resident 6 and resident 14 in their shared room revealed that both of their beds had right-side side rails/grab bars. The mattresses were not securely attached to the beds and created a gap between the side rail/grab bar and the mattress when the mattresses moved. The gap between resident 14's bed and the side rail/grab bar measured four and a half inches (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	when the mattress slid to the wall when touched. 5. Review of resident 6's EMR revealed he was admitted to the facility on [DATE]. His 5/14/26 BIMS assessment score was 5, which indicated his cognition was severely impaired. There was no documentation that a physician's order was obtained for the use of a side rail/grab bar on his bed, when the side rail/grab bar was installed on his bed, that alternatives were attempted before the recommendation or installation of the side rail/grab bar, that the risks versus benefits of side rail/grab bars were reviewed with the resident or the resident's representative, or that a consent for the use of the side rail/grab bar was obtained before the installation of the side rail/grab bar on resident 6's bed. Quarterly side rail assessment documentation started on 11/17/25. The 2/20/26 quarterly assessment was completed on 5/27/26, and the 5/12/26 quarterly assessment was completed on 5/28/26. The completed quarterly side rail/grab bar assessments did not assess for resident 6's risk of entrapment. 6. Review of resident 14's EMR revealed he was admitted to the facility on [DATE]. His 5/14/26 BIMS assessment score was 13, which indicated his cognition was intact. He had a 2/24/26 physician's order OK for side rails. There was no documentation of when the side rail/grab bar was installed on his bed, that alternatives were attempted before the recommendation or installation of the side rail/grab bar, that the risks versus benefits of side rail/grab bars were reviewed with the resident or the resident's representative, or that a consent for the use of the side rail/grab bar was obtained before the installation of the side rail/grab bar on resident 14's bed. The quarterly side rail/grab bar assessments completed did not assess for resident 14's risk of entrapment. 7. Observation on 5/27/26 at 9:53 a.m. with resident 17 revealed that she had a side rail on the left side of her bed, which was the side of the bed that was up against a wall in her room. The side rail loose and could be pulled away from the bed. It was not properly attached to the bed and was held in place with a zip tie. The side rail was not appropriate for use on that bed. The bar to which the side rail was attached was not attached to the frame of the bed, was loose and unsecured under the mattress, and could move around. 8. Review of resident 17's EMR revealed she was admitted to the facility on [DATE]. Her Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. Her diagnoses included contracture, cerebral palsy, weakness, and dependence on a wheelchair. There was an 8/7/19 physician's order for side rails for positioning, and a 3/5/24 physician's order for left-side quarter bed rail for repositioning and safety. Resident 17 had an Alarm/Side Rail/Restraint Consent for Use dated 9/9/22 on file; it was signed by a former DON, but the consent was not signed by resident 17. A Side Rail Use Assessment was completed on 3/16/19, but it was not signed by resident 17. Quarterly side rail assessments were completed on 10/6/25, 1/20/26, and 4/1/26. No other quarterly assessments were provided prior to the 10/6/25 side rail assessment. There was no documentation to indicate when resident 17's side rail was installed on her bed. There was no documentation that alternatives were attempted before the recommendation or installation of the side rail, that the risks (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	entrapment risk. 13. Observation on 5/27/26 at 12:05 p.m. with resident 21 out of his bed, revealed that he had a half-rail on the right side of his bed, and the left side of his bed was up against the wall. The half-rail on the bed was loose. The gap between the loose right half-rail and his mattress measured five inches when the mattress was pushed to the wall, and the loose rail was pulled out from the bed. There was a 4.5-inch gap between his headboard and the head of the mattress when the mattress was pushed to the foot of the bed. 14. Review of resident 21's EMR revealed he was admitted to the facility on [DATE]. His 4/21/26 BIMS assessment score was 03, which indicated his cognition was severely impaired. His diagnoses included Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), dementia (a group of symptoms affecting memory, thinking, and social abilities) with agitation and behavioral disturbance, and neurocognitive disorder with Lewy Bodies (a progressive brain disorder caused by abnormal protein clumps that damage nerve cells that affects thinking, memory, movement, sleep, and behavior), and obstructive sleep apnea (a disorder when your breathing repeatedly stops and starts during sleep because the throat muscles relax, causing the airway to collapse and block airflow). There was a 12/22/25 physician's order for Siderails and fall mat for safety and to promote independence. Quarterly side rail assessments were completed on 10/31/25 and 4/20/26. No quarterly side rail assessment was completed in January 2026, and no other quarterly side rail assessments were provided prior to the 10/31/25 side rail assessment. There was no documentation indicating that consent to install the side rail for resident 21 was obtained. There was no documentation to indicate when resident 21's side rail was installed on his bed. There was no documentation that alternatives were attempted before the recommendation or installation of the side rail, that the risks versus benefits of the side rail were reviewed with the resident or the resident's representative. There was no documentation that resident 21's safety for the use of the siderail or the risk for entrapment had been assessed. The quarterly side rail assessments completed did not assess for resident 21's risk of entrapment. 15. Interview on 5/28/26 at 10:05 a.m., with DON B revealed she was unaware that the side rail/grab bars and mattresses needed to be assessed for entrapment risks. She was unsure if maintenance assessed the rails or mattresses for entrapment risk in any zones. She stated that when a resident or their representative requested a side rail/grab bar, the therapy department would assess the resident using a checklist, which did not contain resident risk for entrapment, interventions tried, or obtain resident consent for the use of the side rail/grab bar. She thought that if a resident wanted a side rail/grab bar, they could request one, and one would be provided. She expected the nurse assigned to the resident that day to obtain a physician's order and complete a quarterly assessment when it was due to be completed. 16. Interview on 6/1/26 at 11:56 a.m. with DON B revealed there was no documentation available related to when the side rails were installed on residents' beds. 17. Review of the provider's undated Bed Safety and Entrapment Prevention Policy revealed: The policy did not indicate when it was developed, reviewed, or approved. The purpose was To ensure a safe sleeping environment by preventing bedˆrelated accidents, including entrapment, falls, and injury related to bedrails, mattresses, and bed systems. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility is committed to maintaining all beds, mattresses, and assistive devices in a safe condition. Bed systems will be assessed, maintained, and used in a manner that minimizes the risk of entrapment and injury, in accordance with CMS F689 requirements and FDA bed safety guidance. Bedrails will not be used as restraints and will only be utilized when clinically indicated and safe. All beds must: Be in good working condition, Have securely attached side rails or assistive devices (if used), Have a properly fitted mattress, Be compatible with all components (no mixing of incompatible parts), Be free of excessive gaps. All gaps must measure ≤ 4.75 inches where applicable. Special attention is given to: Space between mattress and rail, Mattress and headboard/footboard, Split rails and joints. Bedrails will: Only be used when clinically necessary. Require: Assessment prior to use, Care plan documentation, Be removed when: Not used for mobility or positioning, Risk outweighs benefit. Mattresses must: Fit securely within the bed frame, Not slide, shift, or leave gaps, Be secured using: Manufacturerˆapproved systems (e.g., corner brackets or stops), Be replaced if worn or incompatible. Initial and Routine Assessments The following will be completed: On admission, With change in condition, Quarterly and annually, After any bed or mattress change. Assessment includes: Bedrail necessity, Mattress fit and stability, Entrapment zone measurement. Staff Responsibilities: All Staff: Assess need for bedrails, Monitor for signs of entrapment risk, Report hazards immediately. Maintenance: Ensure all beds are properly assembled, Perform repairs and installations, Maintain approved equipment only, Monthly audits on all beds. Administration: Ensure policy compliance, Monitor through QAPI process. 18. Review of the provider's revised 1/6/25 Side Rail policy revealed Quarter rails and bed canes that are approved for the beds can be used that are affixed to the bed and evaluated for safety and functioning by maintenance. A side rail assessment will be completed by therapy and/or nursing when there is a desire expressed by the resident or [a] need [is] reported by the nursing staff. Physicians['] orders will be obtained prior to placing the side rail on the bed. A side rail assessment form will be completed quarterly and prn [as needed] by the MDS [minimum [NAME] set] coordinator or designee. and prn for use or desired change. Resident and/or family education is provided with new orders received from [the] physician for side rail use.Maintenance will be notified with side rail evaluations and prn for an inspection of the side rail, how it fits the bed, tightness, and to evaluate the mattress for wear and distance from the rail. Continued use of the side rail will be reviewed with the family quarterly and prn [with] changes in condition. The Director of Nurses or designee will be contacted when there is a determination that a side rail order is being requested.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and admission packet review, the provider failed to ensure that residents were seen by a physician at least once every 30 days for the first 90 days after admission for two of four sampled residents (3 and 6), and at least once every 60 days thereafter for one of four sampled residents (9). Findings include:1. Review of resident 9's electronic medical record (EMR) revealed she was admitted to the facility on [DATE]. Resident 9's January 2025 through May 2026 physician's visit documentation revealed she was seen by medical director L on 1/14/25 and then not seen by a physician in the facility until 4/18/15. There were 94 days between the two physician's visits. After the 4/18/25 physician's visit she did not have a physician's visit until 8/14/25. There were 118 days between the two physician's visits. On 10/16/25 resident 9 was seen by medical director L, there were no signed physician's orders for that visit. She had physician's visit with medical director L on 12/12/25 and then did not have another physician's visit until 4/21/26. There were 130 days between those two physician's visits. 2. Review of resident 3's EMR revealed she was admitted to the facility on [DATE]. Resident 3's January 2025 through May 2026 physician's visit documentation revealed she was not seen by a physician until 3/18/25, 96 days after she was admitted to the facility. 3. Review of resident 6's EMR revealed he was admitted to the facility on [DATE]. Review of resident 6's November 2025 through May 2026 physician's visit documentation revealed he was seen by medical director L on 12/12/25, 1/22/25, 3/24/25, and 5/13/26. There were 61 days between his 1/22/25 and 3/24/25 physician visits. 4. Interview on 6/2/26 at 10:01 a.m. with medical director L revealed his physician rounds schedule was organized by director of nursing (DON) B and assistant DON C and he saw the residents according to the schedule that DON B and assistant DON C made for him. Each physician visit he completed he signed a physician's order and completed a progress note for that resident's visit. He was aware that a newly admitted resident needed to be seen by a physician every 30 days for the first 90 days and then every 60 days after that. 5. Interview and EMR review on 6/2/26 at 11:12 a.m. with DON B resident 9 was not seen in March 2025 because she had been in the hospital from [DATE] through 3/4/25. March physician's rounds were on 3/11/25, and she thought the hospitalization replaced resident 9's physician visit. She verified that resident 9 had not been seen by a physician from April 2025 through August 2025, in December 2025, or April 2026. She acknowledged that the time between those physician's visits did not meet the required every 60-day physician visits. There was no documentation to support resident 3 was seen after she was admitted to the facility on [DATE] until she was seen on 3/18/25. She acknowledged resident 3 was not seen every 30 days for the first 90 days after her admission to the facility to meet the required physician visits. 6. A policy related to physician visits was requested on 6/2/26 at 9:20 a.m. from DON B and was not received by the end of the survey. 7. Review of the provider's undated admission Packet revealed, Physician Services (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the first ninety (90) days after the resident's admission to the facility, a physician must see the resident at least every thirty (30) days. After that, a physician will see the resident at least once every sixty (60) days.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, record review, and policy review, the provider failed to ensure proper medication storage practices for one of one resident medication refrigerators in one of one medication storage room. Specifically, expired medications and supplies were not discarded as required; temperatures in the resident medication refrigerator were not consistently monitored and documented; and unlabeled resident beverages were stored in the resident medication refrigerator with resident medications. Findings include: 1. Observation and interview on 5/27/26 at 3:31 p.m. of the medication storage room with contracted travel registered nurse (RN) V revealed that the door was locked and that she used a key to enter. She stated that she held the key to the medication storage room for her shift and that every nurse had access to the medication room key during their shifts at the facility. The resident's medication refrigerator contained the resident's personal beverages and their medications stored together. Resident 5's Trulicity 3mg/0.5ml syringe box was wet, as two boxes of opened, unlabeled wine boxes were stored above the medications. One box of wine was leaking from the spicket. Contracted travel RN V acknowledged that the cardboard medication container for resident 5's medication was wet. There was an unlabeled 12-pack of beer stored in the refrigerator as well. Additionally, a clear plastic bag containing three boxes of influenza vaccine Adjuvanted on the bottom shelf was wet. The following expired medications and supplies were stored on shelves in the medication storage room: Eight boxes of COVIDˆ19 Antigen Rapid Tests (5ˆtest kits), expired 9/2/25 One box (50 per box) Bionix lighted ear curettes, expired 11/7/25 Twentyˆfour boxes of COVIDˆ19 Antigen Rapid Tests (2ˆtest kits), expired 11/11/25 Nine PureWick female external catheters, expired 4/28/26 Five syringes of Influenza vaccine adjuvanted lot #407253, expired 5/6/26 Eight syringes of Influenza vaccine adjuvanted lot #407257, expired 5/13/26 Contracted travel RN V acknowledged that the medications and supplies had expired and should have been removed from the medication storage room during the last monthly check. She acknowledged that residents' personal food and drinks should not be stored in the medication refrigerator due to the risk of contamination. She acknowledged that resident 5's medication container was compromised from the leaking wine spicket. Contracted travel RN V stated that controlled medications waiting to be destroyed were stored in the locked cupboard in the medication storage room. She was unsure of the medication destruction process. 2. Observation and interview on 5/27/26 at 4:14 p.m. with assistant director of nursing (ADON) C in the medication storage room revealed that outdated medications and supplies in the medication storage room were checked by night shift nurses the last day of the month, and nurses were expected to complete a fax request to the pharmacy to notify them that medications and supplies had expired and needed to be replaced. The resident medication refrigerator temperatures were to be monitored by the nurses every shift. She acknowledged that resident 5's cardboard medication container was wet from a leaking wine box stored above the medications. She was unsure if the resident's personal food and drinks could be stored in the medication refrigerator. ADON C acknowledged that two boxes of wine and a 12-pack of beer were not labeled with the resident's name or the date the wine boxes were opened. 3. Observation and interview on 5/27/26 at 4:19 p.m. with director of nursing (DON) B, in the medication storage room, revealed that temperatures should be monitored once or twice a day, but she was unsure. She acknowledged that no temperature log was maintained for May 2026. Temperature logs for February, March, and April 2026 were reviewed and revealed numerous missing temperature readings. She stated that the controlled medications were locked in a 2-door cupboard and that she, ADON C, and the scheduled working nurses had access to the key. DON B said that controlled medications were destroyed together by ADON C and licensed pharmacist M every one to two weeks. She said the controlled medications awaiting destruction were not counted each shift. 4. Review of the provider's resident medication refrigerator temperature log revealed that The temperature of patient medication refrigerators is to be (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	monitored and documented daily. Store the medications under proper conditions as soon as possible and contact the pharmacy to determine if the potency of any of the medications has been affected, and recommendations for use or disposal. If pharmacy recommends, dispose of open multiple-use vials of medication. Defrost immediately if needed. Notify maintenance for recommendation regarding repair/maintenance/replacement. Document the actions taken in the space provided on the back of this sheet. The February 2026 temperature log had missing temperature documentation on days 2, 6-7, 11-15, 18, 20-21, and 24-27.The March 2026 temperature log had missing temperature documentation on days 4-7, 14, 18-21, and 26-28. The April 2026 temperature log was missing temperature documentation every day except days 5 and 6. 5. Interview on 5/28/26 at 8:40 a.m. with RN Q revealed she was concerned about the number of controlled medications awaiting destruction. She reported there were numerous controlled medications in the locked cupboard in the medication storage room awaiting destruction with licensed pharmacist M and ADON C. RN Q stated that the controlled medications had been in the cupboard for several weeks, waiting to be destroyed. 6. Observation and interview on 5/28/26 at 11:46 a.m. with ADON C in the medication storage room, and the controlled medications revealed that the controlled medications were locked in a cupboard in the medication storage room. Numerous controlled medications were stored in the cupboard, and the cupboard was disorganized and did not have a clear system of order. The controlled medication disposition forms were not stored with the medications, requiring ADON C to search through the cupboard to match each medication with its corresponding form.She stated that the controlled medications were to be counted and then destroyed at least every one to two weeks. ADON C stated that she and licensed pharmacist M were usually the ones who counted and destroyed the controlled medications together, and that they had not done so in over 2 weeks. She acknowledged that controlled medications awaiting destruction were not counted daily for their accountability, and multiple staff nurses having access to them was a potential risk for diversion. She stated that all medications were destroyed in the RX Destroyer (a liquid, ready-to-use chemical drug destruction product that begins deactivating drugs upon contact with it). Review of destruction logs revealed that she and licensed pharmacist M last counted together on 3/14/26. She acknowledged that the controlled medications had not been destroyed by her and licensed pharmacist M for over two months. The cupboard contained the following unreconciled controlled medications awaiting destruction for residents 7, 8, 11, 13, 32, and 100:Resident 7: Eight tablets of lorazepam 0.5 mg Six tablets of lorazepam 0.5 mg Six tablets of lorazepam 0.5 mg PRN 29 mL of lorazepam Intensol 2 mg/mL Two tablets of diazepam 10 mg 25 mL of morphine sulfate oral solution 20 mg/mLResident 8: 21 mL of lorazepam Intensol oral concentrate 2 mg/mL 75 tablets of hydromorphone 2 mg 26 mL of morphine sulfate 100 mg/5 mL 15 tablets of morphine sulfate ER 60 mg 15 tablets of morphine sulfate ER 60 mg Resident 11: One tablet of buprenorphine 2 mgResident 13: 15 tablets of hydrocodone/APAP 5-325 mg 26 tablets of tramadol 50 mg 22.5 mL of morphine sulfate 20 mg/mL Nine fentanyl 25 mcg/hr patchesResident 32: Three tablets of haloperidol 5 mg One tablet of lorazepam 1 mgResident 100: 28.5 mL of morphine sulfate oral solution 20 mg/mL Five fentanyl 25 mcg/hr patches 29.25 mL of lorazepam Intensol oral concentrate 2 mg/mLUnknown Two unidentified light-orange pills, stored in an unlabeled clear plastic medication cup 7. Interview on 5/28/26 at 12:28 p.m. with ADON C revealed that DON B reported to her that DON B found medications on the floor in former resident 8's room, but she was unsure of the exact date. She stated that DON B said the medication was brought to resident 8 by a family member or friend. ADON C acknowledged that the medication was not documented on a controlled log sheet, was stored without identification, and that she had no record of it being stored in the medication room cupboard. 8. Interview on 5/28/26 at 1:45 p.m. with DON B in the medication storage room revealed that she acknowledged that resident 5's cardboard medication container was wet and that two boxes of unlabeled, opened wine above were likely what had leaked onto the medication. She removed both open boxes of wine, placed them in the sink, and stated she would discard them. She removed a 12-pack of beer from the door of the medication refrigerator that was (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not labeled with a resident's name. She acknowledged that residents' personal food and beverages should not be stored in the medication refrigerator but should be placed in the hospitality refrigerator behind the nurses' station. She expected nursing staff to complete a thorough check of the medication storage room for expired medications and supplies monthly and dispose of them. She acknowledged that controlled medications awaiting destruction were not counted each shift for accountability, that every nurse who worked a shift had access to the keys for both the medication storage room and the cupboard. She agreed that the controlled medications had not been destroyed by ADON C and licensed pharmacist M for over two months. Additionally, she said that maintenance had access to the medication storage room and acknowledged there was potential for drug diversion. , 9. Interview on 6/1/26 at 2:32 p.m. with licensed pharmacist M revealed she had been with the facility for one year and completed resident chart reviews, managed daily medication refills, and destroyed controlled medications with ADON C. She said that three months ago, she and ADON C changed to routinely destroying medications every other Tuesday to limit the number of controlled medications stored for destruction. Prior to that change, it was the facility contacting the pharmacy to come and destroy the controlled medications when needed. She said that RX Destroyer was used for the destruction of the controlled medications. Licensed pharmacist M was unsure whether another RN could destroy medications with her if ADON C was not available, and said she would have to ask DON B. She stated that she was at the facility frequently but did not have keys or access to the medication room or the locked cupboard that stored the controlled medications awaiting destruction. She was unsure if the controlled medications awaiting destruction were reconciled every shift until destroyed. She stated that there was concern for potential diversion when numerous people had access to keys. Licensed pharmacist M said that it was the nurses' responsibility to go through the medication room and carts for expired meds and supplies, and acknowledged that resident food and beverages should not be stored in the medication refrigerator. She acknowledged that waiting over 2 months to destroy controlled medications was not good practice and was a concern for potential drug diversion as well. She stated that she had not been involved in the facility's pharmacy policymaking. 10. Interview on 6/2/26 at 11:48 a.m. with DON B revealed that the unidentified medication that was stored in the locked cupboard in the medication room belonged to former resident 8 and was Dilaudid 2mg (an opioid medication used to treat moderate to severe pain) tablets that were brought in from home by his family or a friend. She acknowledged that the medication was not documented on a controlled log sheet, was stored in the cupboard unidentified, and she had no record of it being in the medication room cupboard. DON B didn't think about the medication being counted and destroyed because it was not a medication from the facility. She did not remember whether she documented the medication information in resident 8's EMR. 11. Interview on 6/2/26 at 12:31 p.m. with chief executive officer (CEO) A revealed that he expected nursing to go through the medication room monthly to check for expired medications and supplies and dispose of them. He stated that the controlled medications should be counted and then destroyed by licensed pharmacist M and ADON C when necessary. He was not aware that the controlled medications were not destroyed on a routine basis. He was not aware that the controlled medications had not been destroyed for over two months. He acknowledged that nursing staff have access to the keys to the medication storage room and the locked cupboard containing controlled medications awaiting destruction. He also confirmed that maintenance has a key and access to the medication storage room. 12. Medication storage, resident medication refrigerator, drug diversion, consultant pharmacist, and pharmacy services policies were requested between 5/27/26 and 6/2/26 during the survey; the facility did not have those policies for review. 13. Review of the provider's revised August 2018 Outdated Drug Control policy revealed that Outdated medications will not be dispensed for patient use or allowed to remain in the dispensing area of the pharmacy or in patient areas. Pharmacy personnel will check medications for dated items and remove all outdated packages from the shelves monthly. Nursing stations and medication stock areas will be checked monthly for outdated items and replaced. All outdated inventory will be removed and replaced (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	by the pharmacy.14. Review of the provider's reviewed September 2018 Drug Disposition and Destruction policy defined the Procedure for proper disposition of medicines, which are discontinued because of the discharge or death of a resident; the drug is outdated; a drug is found that is not identifiable to a resident; the prescription is discontinued or changed; or destruction of a partial dose is required. Schedule II, III and IV drugs [controlled medications] (medications with risk for abuse and addiction) will be destroyed by a pharmacist and a registered nurse (RN). Discontinued medications (excluding Schedule II, III, and IV drugs) may be kept up to one month after the discontinued date. Destroy medications immediately if: resident was discharged or has expired. Discontinued Schedule II, III, and IV drugs will be secured, and then destroyed as soon as the pharmacist is available. Drugs with the exception of morphine oral solution and fentanyl patches, will be crushed and mixed in kitty litter in med room by the pharmacist and an RN and discarded. Morphine oral solution and fentanyl will be flushed down the toilet. Unless otherwise instructed, flush tablets, capsules, liquids, and contents of vials and ampules down the toilet. If a drug is found that cannot be readily identified to a resident, the drug will be taken to a pharmacist for identification. If the drug cannot be traced to a resident, it will be destroyed. An attempt will be made to identify the resident and why the drug was not properly administered. A documentation note will be written in the resident's medical record (Medication Reconciliation Form) by the person responsible for destroying the medications. The note will be signed by those persons destroying the medications. The drug disposition record must contain, as a minimum, the following information: date destroyed, name of the drug, dosage of drug, prescription number (if any), the quantity destroyed, method of destruction, and signatures of witnesses. Completed drug disposition records must be forwarded to medical records for the resident's medical record.15. Review of the provider's undated admission Packet revealed that with food and beverages, Family and friends may bring in food and non-alcoholic beverages as approved by the physician's ordered diet. Please report any food and beverages brought in. Alcoholic beverages are permitted only with a doctor's order and are kept in the medication room. Refrigerator space is available for small food and drink items in the facility nourishment room.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to have a system in place to identify medication irregularities, report those irregularities to the physician, and for the physician to address the identified irregularities for four of four sampled residents (3, 6, 21, and 32) on psychotropic medications (drugs that affect brain activities associated with mental processes and behavior). Findings include:1. Review of resident 3's electronic medical record (EMR) revealed she was admitted to the facility on [DATE]. Her 5/15/26 Brief Interview of Mental Status (BIMS) assessment score was 11, which indicated her cognition was moderately impaired. Her diagnoses included anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and dementia (a group of symptoms affecting memory, thinking, and social abilities) with behavioral disturbance. She had a 12/23/25 physician's order for haloperidol 5 milligrams (mg) (an antipsychotic medication; a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions), one tablet to be administered as needed for agitation. The physician's order did not have an end date, and she needed to be seen by a physician to have this reordered on 1/6/26. She had a 12/23/25 physician's order for Seroquel 50 mg (an antipsychotic medication) one tablet to be administered at bedtime for behaviors. The behaviors the Seroquel was ordered to treat were not identified. 2. Review of resident 3's 1/1/25 through 5/1/26 monthly medication reviews and gradual dose reduction (GDR; systematic dose reduction over time to determine if the condition could be managed with a lower dose or discontinuation of the medication) recommendations revealed there were no recommendations made by the pharmacist to resident 3's physician regarding resident 3's haloperidol physician's order did not have an end date on the order or that the physician's order for Seroquel did not have a diagnosis or an identified behavior for which it was prescribed to treat. 3. Review of resident 32's EMR revealed she was admitted to the facility on [DATE]. Her 4/22/26 BIMS assessment score was 14, which indicated her cognition was intact. Her diagnoses included dementia with agitation. She had a 4/16/26 physician's order for mirtazapine 7.5 mg (an antidepressant medication) one tablet to be administered at bedtime for depression. Resident 32 did not have a diagnosis of depression. She had a 4/17/26 physician's order for lorazepam 1 mg (an anti-anxiety medication) one tablet to be administered every eight hours as needed for anxiety. There was no end date on that physician's order. She had a 4/21/26 physician's order for lorazepam 1 mg one tablet to be administered two times per day. There was no diagnosis or indication for use identified for this medication. She had a 4/21/26 physician's order for olanzapine 10 mg (an antipsychotic medication) one tablet to be administered two times per day for dementia with agitation and a 4/25/26 physician's order for quetiapine 50 mg (an antipsychotic medication) administer one tablet in the afternoon for agitation. Olanzapine and quetiapine were in the same drug class. A 4/21/26 progress note from medical (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	director L indicated he had spoken with an on-call psychiatrist about resident 32's suicidal ideations and that psychiatrist recommended transitioning away from scheduled Seroquel (quetiapine) and switching to scheduled olanzapine. 4. Review of resident 32's 5/29/26 monthly medication review revealed licensed pharmacist M documented, There are no medication-related concerns at this time. The monthly medication review identified that the physician ordered psychotropic medications as mirtazapine 7.5 mg at bedtime, olanzapine 10 mg two times per day, lorazepam 1 mg two times per day, and quetiapine 25 mg three times per day as needed. Quetiapine will require 2 GDR [gradual dose reduction] attempts prior to 4/27 (Jul, Nov). PRN [as needed] use should be limited to 14 days and will require reassessment. Therapy changed to Olanzapine 10 mg BID [two times a day] given with lorazepam 1 mg BID per geriatric psychiatry recommendation. The monthly medication review did not address that the indication for use of mirtazapine was depression and resident 32 did not have a diagnosis of depression in her EMR. It did not address the as needed lorazepam that did not have an end date on the physician's order or the scheduled lorazepam not having a diagnosis on the physician's order. It identified quetiapine as being ordered to be given three times per day as needed, and the physician's order was for it to be administered daily in the afternoon. The monthly medication review did not identify the duplicate therapy of olanzapine and quetiapine or the psychiatrist recommended a transition from quetiapine to olanzapine. 5. Review of resident 21's EMR revealed he was admitted to the facility on [DATE]. His 4/21/26 Brief Interview of Mental Status (BIMS) assessment score was 3, which indicated his cognition was severely impaired. His diagnoses included Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), dementia (a group of symptoms affecting memory, thinking, and social abilities) with agitation and behavioral disturbance, and neurocognitive disorder with Lewy Bodies (a progressive brain disorder caused by abnormal protein clumps that damage nerve cells that affects thinking, memory, movement, sleep, and behavior), and obstructive sleep apnea (a disorder when your breathing repeatedly stops and starts during sleep because the throat muscles relax, causing the airway to collapse and block airflow). He had a 10/23/25 physician's order for temazepam 15 milligrams (mg), a sedative-hypnotic medication that helps the brain relax, making it easier to fall asleep, one tablet by mouth every 24 hours PRN (as needed) at bedtime for insomnia (a sleep disorder with trouble falling asleep, staying asleep, or waking too early). Resident 21's EMR did not document a 14-day stop date from initiation and did not document a physician evaluation with a rationale for continuing resident 21's temazepam beyond 14 days. No physician response was documented for a GDR for that medication. He had a 10/23/25 physician's order for trazodone 100 mg (an antidepressant medication), one tablet by mouth at bedtime for insomnia. Resident 21's EMR did not document a physician evaluation with a rationale for continuing resident 21's trazodone, and no physician response was documented for a GDR for that medication. He had physicians' orders dated 10/24/25 for lorazepam Intensol oral concentrate 0.25 milliliters (mL) (an antianxiety medication) by mouth every two hours PRN (as needed) for agitation and for 0.5 mL by mouth every two hours PRN for agitation. Resident 21's EMR did not document 14-day stop dates from the initiation of both doses, nor did it document evaluations by the physician with rationales for continuing Resident 21's lorazepam doses beyond their 14-day limits. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed pharmacist M completed monthly Drug Regimen Reviews (DRRs) on 1/26/26, 2/27/26, 3/30/26, 4/29/26, and 5/29/26. A request to evaluate resident 21's lorazepam orders was suggested on 1/26/26 by licensed pharmacist M. The 5/29/26 review note completed by licensed pharmacist M indicated that resident 21's lorazepam was discontinued by the physician. A 1/30/26 order note for resident 21 indicated that a physician's order was received to discontinue his lorazepam. Review of resident 21's active orders revealed that resident 21 continued his lorazepam Intensol oral concentrate 0.25 mL by mouth every two hours PRN and lorazepam 0.5 mL by mouth every two hours PRN, both for agitation, and remained active since 10/24/25. No documentation was found indicating that the lorazepam doses were discontinued on 1/30/26. He had physicians' orders dated 4/2/26 for sertraline 100 mg (an antidepressant medication), 1 tablet by mouth in the morning and 50 mg (1/2 tablet) at bedtime for depression (a mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities). He did not have a diagnosis of depression. 6. Review of resident 6's EMR revealed he was admitted to the facility on [DATE]. His 5/14/26 BIMS assessment score was 5, which indicated his cognition was severely impaired. His diagnoses included type 2 diabetes mellitus (a condition involving disruptions in how the body regulates blood sugar), peripheral vascular disease (a circulation disorder characterized by the narrowing, blockage, or spasms of blood vessels outside of the heart and brain), chronic kidney disease (loss of the kidneys' ability to filter waste and excess fluid from the blood), cerebral infarction (stroke), repeated falls, weakness, and tremor (involuntary, rhythmic shaking or trembling movement). He had an 11/13/25 physician's order for Sertraline HCl oral tablet 100 mg (an antidepressant medication used to treat mental health conditions like major depressive disorder), give 100 mg by mouth in the morning for depression. Resident 6 had a 1/23/26 physician's order for Haldol 5 mg (an antipsychotic medication; a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions): give 10 mg by mouth every 6 hours as needed for agitation. That physician's order did not have an end date, and he needed to be seen by a physician to have this reordered on 2/8/26. There was no diagnosis for use identified for this medication. He had a 2/20/26 physician's order for Seroquel 25 mg (an antipsychotic medication), one tablet by mouth two times a day for agitation. The behaviors that Seroquel was ordered to treat were not identified. There was no diagnosis for use identified for this medication. Review of resident 6's 11/17/25 through 5/29/26 DRRs and gradual dose reduction recommendations revealed that on 11/17/25, the DRR did not address that he took an antidepressant medication and did not have a diagnosis of depression in his EMR. On 12/29/25, the DRR indicated there were no medication-related concerns at this time. The DRR did not address that he took antidepressant medication and did not have a diagnosis of depression in his EMR. On 1/28/26, the DRR indicated there were no medication-related concerns at this time. The DRR did not address that he took antidepressant and antipsychotic medication and did not have a diagnosis of depression, or another mental health disorder, agitation, or anxiety in resident 6's EMR. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/27/26, the pharmacist's recommendation included The following medication-related concern has been identified: 1) Evaluation of PRN psychotropic medication: [Resident 6] has an active orders for Haloperidol 10 mg Q6H [every six hours] PRN agitation/anxiety. Per CMS [Centers for Medicare & Medicaid Services] guidelines, non-pharmacological interventions are prioritized and use of PRN psychotropic medications is limited to 14 days. Evaluation by a physician is required to extend use beyond 14 days. Provider contacted to complete the risk-benefit evaluation for ongoing use. The DRR did not address that resident 6 took antidepressant and antipsychotic medication, and he did not have a diagnosis of depression, or another mental health disorder, agitation, or anxiety in his EMR. There was no documentation that the provider followed up on the pharmacist's recommendation. On 3/30/26, the pharmacist's recommendation included The following medication-related concern has been identified: 1) Gradual Dose Reduction: [Resident 6] is currently taking Sertraline 100 mg QAM [every morning] for depression. Per CMS guidelines, this medication requires GDR attempts with the intent of utilizing [the] lowest possible effective/optimal dose. Provider contacted to complete a Gradual Dose Reduction Risk-Benefit Evaluation. There was no documentation that the provider followed up on the pharmacist's recommendation. The 3/30/26 DRR did not address that he took antidepressant and antipsychotic medication, and he did not have a diagnosis of depression, or another mental health disorder, agitation, or anxiety in his EMR. The DRR did not address the as-needed Haldol that did not have a supporting diagnosis or end date on the physician's order. On 4/29/26, the pharmacist's recommendation included that there were no medication-related concerns identified at this time. The DRR did not address that he took antidepressant and antipsychotic medication and did not have a diagnosis of depression, or another mental health disorder, agitation, or anxiety in his EMR. The DRR did not address the as-needed Haldol that did not have a supporting diagnosis or end date on the physician's order, or the need for a GDR of the scheduled Sertraline. On 5/29/26, The following medication-related concern has been identified: 1) Gradual Dose Reduction: [Resident 6] is currently taking Sertraline 100 mg QAM [every morning] for depression. Per CMS guidelines, this medication requires GDR [gradual dose reduction] attempts with the intent of utilizing [the] lowest possible effective/optimal dose. Provider contacted to complete a Gradual Dose Reduction Risk-Benefit Evaluation. This was noted, and the physician declined the GDR. The DRR did not address that he did not have a diagnosis of depression, or another mental health disorder, agitation, or anxiety in his EMR. The DRR did not address the as-needed Haldol that did not have a supporting diagnosis or end date on the physician's order. 7. Interview on 5/27/26 at 2:43 p.m. with director of nursing (DON) B revealed the provider did not have a policy related to psychotropic medications. 8. Interview and EMR review on 6/1/26 at 2:33 p.m. with licensed pharmacist M revealed she reviewed the residents' medication regimen monthly and was responsible for completing the residents' monthly medication review and making recommendations to the physician for the required gradual dose reduction. During her reviews she looked for psychotropic medications that were prescribed as needed to be sure the medication had an end date. If there was no end date, she would (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	send a recommendation to the physician to place an end date on those medications. She acknowledged haloperidol was an antipsychotic and could not be ordered to be administered as needed for longer than 14 days without being seen by a physician and a new physician's order obtained. When she completed the residents' monthly medication reviews, she reviewed the medications to be sure there was a diagnosis associated with the medication. She did not review the residents' diagnoses list in the EMR to be sure the diagnosis assigned to the medication was a diagnosis that resident had. She verified resident 32 did not have a diagnosis of depression but her physician's order for mirtazapine indicated it was being used for depression. Licensed pharmacist M was aware resident 32 had duplicate therapy related to her antipsychotic medications. She thought the duplicate therapy was the recommendation of the geriatric psychiatrist, according to medical director L's 4/21/26 progress note. After reviewing the progress note, licensed pharmacist M stated she had read the progress note wrong previously and medical director L had documented that resident 32 was to be transitioning from quetiapine and switching to olanzapine. She had not made the recommendation to continue with the transition from quetiapine to olanzapine in her monthly medication reviews. 9. Interview on 6/2/26 at 10:01 a.m. with medical director L revealed he received the monthly medication reviews and the gradual dose recommendations from licensed pharmacist M in a secure envelope each month. When he receives the monthly medication reviews and gradual dose recommendations, he reviews them and responds to them if needed. If he had a question related to the monthly medication review or gradual dose reduction recommendation he would talk with pharmacist M in person. If the monthly medication review or the gradual dose recommendation required a new prescription, he would submit the new prescription electronically to the pharmacy and the provider. Medical director L acknowledged he had not responded to a gradual dose reduction recommendation submitted by licensed pharmacist M for resident 6. He expected that if he missed a monthly medication review or gradual dose recommendation, licensed pharmacist M or someone in the nursing department would immediately notify him that it was missed. He expected licensed pharmacist M and someone in the nursing department to review the monthly medication reviews and the gradual dose reduction recommendations to ensure they are completed each month. 10. Interview and EMR review on 6/2/26 at 11:30 a.m. with DON B revealed the provider did not review the risk versus benefit of psychotropic medications, educate on alternatives to the psychotropic medications, or have consent forms signed by the resident's representative prior to starting or changing resident 21's psychotropic medications. There was no documentation that resident 21's representative was notified when he was started on his psychotropic medications. DON B was aware of the regulation related to the consent for the use of psychotropic medications, but had not implemented a process for the review of risk versus benefits, review of alternative treatments or interventions, and consent for psychotropic medications. 11. Interview on 6/2/26 at 12:31 p.m. with CEO A revealed that he was aware the facility lacked a process for residents' use of psychotropic medications, was unaware that consent forms were not being completed for their use, and was unaware that appropriate diagnoses were not consistently documented. He was unaware that licensed pharmacist M's recommendations were not reaching medical director L, and, as a result, the provider did not implement them for several months. He (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	acknowledged that resident diagnoses were not consistently documented in resident records, pharmacy recommendations regarding psychotropic medication management were not implemented in a timely manner, and residents or their representatives were not informed about their psychotropic medication treatment, including risks, benefits, alternatives, and consent prior to initiation or continuation of their medications. 12. Review of the provider's revised November 2024 Drugs: Review of Orders For Discontinuation policy revealed that A procedure whereby the dosage and schedule of medications will be reviewed by physicians. The timeframe for review of orders for continuation or discontinuation will apply to the following categories: a. Controlled Substances =30 days. b. Antibiotics = 7 days. c. Anticoagulants = 30 days. d. Colchicine for acute gout attack = 48 hours e. Ketorolac (Toradol) = 5 days. f. All other drugs not otherwise ordered for a specific time or number of doses = 60 days. The medication needing review will not automatically discontinue and will remain active until discontinued by the physician. The physician will have three options under this activity: 1. Review – this will reset the review date for the medication. 2. Discontinue – this will discontinue the medication. 3. Modify – this will modify the medication order and reset the review date. Psychotropic medications were not included in the policy to include PRN (as needed) orders and their 14-day stop dates. 13. Review of the provider's 1/12/26 Behavioral Health Management policy revealed, Staff will proactively assess, monitor, and manage behavioral symptoms using individualized, nonpharmacological and clinically appropriate interventions while ensuring resident dignity, safety, and regulatory compliance. The use of psychotropic medications, Must comply with CMS [Center for Medicare and Medicaid Services] regulations (gradual dose reductions, indications). Use only when clinically necessary and not for staff convenience. Requires: Documented clinical indication, provider order, and monitoring for effectiveness and side effects. 14. Review of the provider's 12/30/25 Facility Assessment Tool revealed, Our facility has an excellent consultant that does thorough chart reviews, makes appropriate suggestions, he is (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	instrumental in helping with medication audits and accuracy. 15. A Monthly Medication Review and a Gradual Dose Reduction policy were requested on 6/2/26 at 9:20 a.m. and was not received by the end of the survey.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, interview, and policy review, the facility failed to ensure timely destruction of controlled medications (medications with risk for abuse and addiction) for six of six sampled residents (7,8,11,13, 32, and 100) and failed to ensure that the controlled medications awaiting destruction were stored with restricted access and maintained under proper accountability procedures in one of one medication storage room.Findings include:1. Observation and interview on 5/27/26 at 3:31 p.m. of the medication storage room with contracted travel registered nurse (RN) V revealed that the door was locked and that she used a key to enter. She stated that she held the key to the medication storage room for her shift and that every nurse had access to the medication room key during their shifts at the facility. The resident's medication refrigerator contained resident's personal beverages and their medications stored together. Resident 5's Trulicity 3mg/0.5ml syringe box was wet, as two boxes of opened, unlabeled wine boxes were stored above the medications. One box of wine was leaking from the spicket. Contracted travel RN V acknowledged that the cardboard medication container for resident 5's medication was wet. There was an unlabeled 12-pack of beer stored in the refrigerator as well. Additionally, a clear plastic bag containing three boxes of influenza vaccine Adjuvanted on the bottom shelf was wet. The following expired medications and supplies were stored on shelves in the medication storage room: Eight boxes of COVIDˆ19 Antigen Rapid Tests (5ˆtest kits), expired 9/2/25 One box (50 per box) Bionix lighted ear curettes, expired 11/7/25 Twentyˆfour boxes of COVIDˆ19 Antigen Rapid Tests (2ˆtest kits), expired 11/11/25 Nine PureWick female external catheters, expired 4/28/26 Five syringes of Influenza vaccine adjuvanted lot #407253, expired 5/6/26 Eight syringes of Influenza vaccine adjuvanted lot #407257, expired 5/13/26 Contracted travel RN V acknowledged that the medications and supplies had expired and should have been removed from the medication storage room during the last monthly check. She acknowledged that residents' personal food and drinks should not be stored in the medication refrigerator due to the risk of contamination. She acknowledged that resident 5's medication container was compromised from the leaking wine spicket. Contracted travel RN V stated that controlled medications waiting to be destroyed were stored in the locked cupboard in the medication storage room. She was unsure of the medication destruction process. 2. Observation and interview on 5/27/26 at 4:14 p.m. with assistant director of nursing (ADON) C in the medication storage room revealed that outdated medications and supplies in the medication storage room were checked by night shift nurses the last day of the month, and nurses were expected to complete a fax request to the pharmacy to notify them that medications and supplies had expired and needed to be replaced. The resident medication refrigerator temperatures were to be monitored by the nurses every shift. She acknowledged that resident 5's cardboard medication container was wet from a leaking wine box stored above the medications. She was unsure if the resident's personal food and drinks could be stored in the medication refrigerator. ADON C acknowledged that two boxes of wine and a 12-pack of beer were not labeled with the resident's name or the date the wine boxes were opened. 3. Observation and interview on 5/27/26 at 4:19 p.m. with director of nursing (DON) B, in the medication storage room, revealed that temperatures should be monitored once or twice a day, but she was unsure. She acknowledged that no temperature log was maintained for May 2026. Temperature logs for February, March, and April 2026 were reviewed and revealed numerous missing temperature readings. She stated that the controlled medications were locked in a 2-door cupboard and that she, ADON C, and the scheduled working nurses had access to the key. DON B said that controlled medications were destroyed together by ADON C and licensed pharmacist M every one to two weeks. She said the controlled medications awaiting destruction were not counted each shift. 4. Review of the provider's resident medication refrigerator temperature log revealed that The temperature of patient medication refrigerators is to be (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	monitored and documented daily. Store the medications under proper conditions as soon as possible and contact the pharmacy to determine if the potency of any of the medications has been affected, and recommendations for use or disposal. If pharmacy recommends, dispose of open multiple-use vials of medication. Defrost immediately if needed. Notify maintenance for recommendation regarding repair/maintenance/replacement. Document the actions taken in the space provided on the back of this sheet. The February 2026 temperature log had missing temperature documentation on days 2, 6-7, 11-15, 18, 20-21, and 24-27.The March 2026 temperature log had missing temperature documentation on days 4-7, 14, 18-21, and 26-28. The April 2026 temperature log was missing temperature documentation every day except days 5 and 6. 5. Interview on 5/28/26 at 8:40 a.m. with RN Q revealed she was concerned about the number of controlled medications awaiting destruction. She reported there were numerous controlled medications in the locked cupboard in the medication storage room awaiting destruction with licensed pharmacist M and ADON C. RN Q stated that the controlled medications had been in the cupboard for several weeks, waiting to be destroyed. 6. Observation and interview on 5/28/26 at 11:46 a.m. with ADON C in the medication storage room, and the controlled medications revealed that the controlled medications were locked in a cupboard in the medication storage room. Numerous controlled medications were stored in the cupboard, and the cupboard was disorganized and did not have a clear system of order. The controlled medication disposition forms were not stored with the medications, requiring ADON C to search through the cupboard to match each medication with its corresponding form. She stated that the controlled medications were to be counted and then destroyed at least every one to two weeks. ADON C stated that she and licensed pharmacist M were usually the ones who counted and destroyed the controlled medications together, and that they had not done so in over 2 weeks. She acknowledged that controlled medications awaiting destruction were not counted daily for their accountability, and multiple staff nurses having access to them was a potential risk for diversion. She stated that all medications were destroyed in the RX Destroyer (a liquid, ready-to-use chemical drug destruction product that begins deactivating drugs upon contact with it). Review of destruction logs revealed that she and licensed pharmacist M last counted together on 3/14/26. She acknowledged that the controlled medications had not been destroyed by her and licensed pharmacist M for over two months. The cupboard contained the following unreconciled controlled medications awaiting destruction for residents 7, 8, 11, 13, 32, and 100:Resident 7: Eight tablets of lorazepam 0.5 mg Six tablets of lorazepam 0.5 mg Six tablets of lorazepam 0.5 mg PRN 29 mL of lorazepam Intensol 2 mg/mL Two tablets of diazepam 10 mg 25 mL of morphine sulfate oral solution 20 mg/mLResident 8: 21 mL of lorazepam Intensol oral concentrate 2 mg/mL 75 tablets of hydromorphone 2 mg 26 mL of morphine sulfate 100 mg/5 mL 15 tablets of morphine sulfate ER 60 mg 15 tablets of morphine sulfate ER 60 mg Resident 11: One tablet of buprenorphine 2 mgResident 13: 15 tablets of hydrocodone/APAP 5-325 mg 26 tablets of tramadol 50 mg 22.5 mL of morphine sulfate 20 mg/mL Nine fentanyl 25 mcg/hr patchesResident 32: Three tablets of haloperidol 5 mg One tablet of lorazepam 1 mgResident 100: 28.5 mL of morphine sulfate oral solution 20 mg/mL Five fentanyl 25 mcg/hr patches 29.25 mL of lorazepam Intensol oral concentrate 2 mg/mLUnknown Two unidentified light-orange pills, stored in an unlabeled clear plastic medication cup. 7. Interview on 5/28/26 at 12:28 p.m. with ADON C revealed that DON B reported to her that DON B found medications on the floor in former resident 8's room, but she was unsure of the exact date. She stated that DON B said the medication was brought to resident 8 by a family member or friend. ADON C acknowledged that the medication was not documented on a controlled log sheet, was stored without identification, and that she had no record of it being stored in the medication room cupboard. 8. Interview on 5/28/26 at 1:45 p.m. with DON B in the medication storage room revealed that she acknowledged that resident 5's cardboard medication container was wet and that two boxes of unlabeled, opened wine above were likely what had leaked onto the medication. She removed both open boxes of wine, placed them in the sink, and stated she would discard them. She removed a 12-pack of beer from the door of the medication refrigerator that was (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not labeled with a resident's name. She acknowledged that residents' personal food and beverages should not be stored in the medication refrigerator but should be placed in the hospitality refrigerator behind the nurses' station. She expected nursing staff to complete a thorough check of the medication storage room for expired medications and supplies monthly and dispose of them. She acknowledged that controlled medications awaiting destruction were not counted each shift for accountability, that every nurse who worked a shift had access to the keys for both the medication storage room and the cupboard. She agreed that the controlled medications had not been destroyed by ADON C and licensed pharmacist M for over two months. Additionally, she said that maintenance had access to the medication storage room and acknowledged there was potential for drug diversion. , 9. Interview on 6/1/26 at 2:32 p.m. with licensed pharmacist M revealed she had been with the facility for one year and completed resident chart reviews, managed daily medication refills, and destroyed controlled medications with ADON C. She said that three months ago, she and ADON C changed to routinely destroying medications every other Tuesday to limit the number of controlled medications stored for destruction. Prior to that change, it was the facility contacting the pharmacy to come and destroy the controlled medications when needed. She said that RX Destroyer was used for the destruction of the controlled medications. Licensed pharmacist M was unsure whether another RN could destroy medications with her if ADON C was not available, and said she would have to ask DON B. She stated that she was at the facility frequently but did not have keys or access to the medication room or the locked cupboard that stored the controlled medications awaiting destruction. She was unsure if the controlled medications awaiting destruction were reconciled every shift until destroyed. She stated that there was concern for potential diversion when numerous people had access to keys. Licensed pharmacist M said that it was the nurses' responsibility to go through the medication room and carts for expired meds and supplies, and acknowledged that resident food and beverages should not be stored in the medication refrigerator. She acknowledged that waiting over 2 months to destroy controlled medications was not good practice and was a concern for potential drug diversion as well. She stated that she had not been involved in the facility's pharmacy policymaking. 10. Interview on 6/2/26 at 11:48 a.m. with DON B revealed that the unidentified medication that was stored in the locked cupboard in the medication room belonged to former resident 8 and was Dilaudid 2mg (an opioid medication used to treat moderate to severe pain) tablets that were brought in from home by his family or a friend. She acknowledged that the medication was not documented on a controlled log sheet, was stored in the cupboard unidentified, and she had no record of it being in the medication room cupboard. DON B didn't think about the medication being counted and destroyed because it was not a medication from the facility. She did not remember whether she documented the medication information in resident 8's EMR. 11. Interview on 6/2/26 at 12:31 p.m. with chief executive officer (CEO) A revealed that he expected nursing to go through the medication room monthly to check for expired medications and supplies and dispose of them. He stated that the controlled medications should be counted and then destroyed by licensed pharmacist M and ADON C when necessary. He was not aware that the controlled medications were not destroyed on a routine basis. He was not aware that the controlled medications had not been destroyed for over two months. He acknowledged that nursing staff have access to the keys to the medication storage room and the locked cupboard containing controlled medications awaiting destruction. He also confirmed that maintenance has a key and access to the medication storage room. 12. Medication storage, resident medication refrigerator, drug diversion, consultant pharmacist, and pharmacy services policies were requested between 5/27/26 and 6/2/26 during the survey; the facility did not have those policies for review. 13. Review of the provider's revised August 2018 Outdated Drug Control policy revealed that Outdated medications will not be dispensed for patient use or allowed to remain in the dispensing area of the pharmacy or in patient areas. Pharmacy personnel will check medications for dated items and remove all outdated packages from the shelves monthly. Nursing stations and medication stock areas will be checked monthly for outdated items and replaced. All outdated inventory will be removed and replaced (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	by the pharmacy.14. Review of the provider's reviewed September 2018 Drug Disposition and Destruction policy defined the Procedure for proper disposition of medicines, which are discontinued because of the discharge or death of a resident; the drug is outdated; a drug is found that is not identifiable to a resident; the prescription is discontinued or changed; or destruction of a partial dose is required. Schedule II, III and IV drugs [controlled medications] (medications with risk for abuse and addiction) will be destroyed by a pharmacist and a registered nurse (RN). Discontinued medications (excluding Schedule II, III, and IV drugs) may be kept up to one month after the discontinued date. Destroy medications immediately if: resident was discharged or has expired. Discontinued Schedule II, III, and IV drugs will be secured, and then destroyed as soon as the pharmacist is available. Drugs with the exception of morphine oral solution and fentanyl patches, will be crushed and mixed in kitty litter in med room by the pharmacist and an RN and discarded. Morphine oral solution and fentanyl will be flushed down the toilet. Unless otherwise instructed, flush tablets, capsules, liquids, and contents of vials and ampules down the toilet. If a drug is found that cannot be readily identified to a resident, the drug will be taken to a pharmacist for identification. If the drug cannot be traced to a resident, it will be destroyed. An attempt will be made to identify the resident and why the drug was not properly administered. A documentation note will be written in the resident's medical record (Medication Reconciliation Form) by the person responsible for destroying the medications. The note will be signed by those persons destroying the medications. The drug disposition record must contain, as a minimum, the following information: date destroyed, name of the drug, dosage of drug, prescription number (if any), the quantity destroyed, method of destruction, and signatures of witnesses. Completed drug disposition records must be forwarded to medical records for the resident's medical record.15. Review of the provider's undated admission Packet revealed that with food and beverages, Family and friends may bring in food and non-alcoholic beverages as approved by the physician's ordered diet. Please report any food and beverages brought in. Alcoholic beverages are permitted only with a doctor's order and are kept in the medication room. Refrigerator space is available for small food and drink items in the facility nourishment room.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on record review, interview, and policy review, the provider failed to ensure the staff received the required training regarding the elements and goals of the facility's Quality Assurance and Performance Improvement (QAPI) program for five of five employees reviewed (G, O, R, Y, and Z).Findings include:1. Review of employee personnel records revealed dietary manager G was hired on 7/28/25. Certified nursing assistant (CNA) O was hired on 2/15/26. Contracted travel CNA Z was hired on 4/6/26. Housekeeping aide Y was hired on 4/7/26. Contracted travel licensed practical nurse (LPN) was hired on 4/27/26. There was no documentation to support employees G, O, R, Y, and Z received training regarding the elements and goals of the facility's QAPI program. 2. Interview on 6/2/26 at 11:48 a.m. with director of nursing (DON) B revealed she managed the QAPI meetings. The staff were informed about any performance improvement plans (PIPS) developed in QAPI by their department manager. The staff did not receive any training regarding the elements and goals of the facility's QAPI program.3. Interview on 6/2/26 at 9:15 a.m. with human resources director J revealed she was responsible for assigning required training for the staff and the staff were not assigned training related to the QAPI program. She was not aware that the elements and goals of the facility's QAPI program was a required training topic.4. Interview on 6/2/26 at 12:31 p.m. with chief executive officer (CEO) A revealed he acknowledged there was required training that was not completed by the staff.5. Review of the provider's August 2018 Required Annual Training of Long-Term Care Healthcare Workers policy revealed that training was to be completed in accordance with state and federal regulations. The provider shall maintain a formal orientation program and an ongoing education program for all personnel.The elements and goals of the facility's QAPI program was not included as required staff training in the policy.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 personnel record review, interview, and review of the director of nursing (DON)'s job description the provider failed to ensure yearly performance evaluations were completed on three of three sampled certified nursing assistants (CNAs) (S, U, and AA) and their in-service training was tailored to address areas of weakness as determined in the nurse aide's performance reviews and facility assessment. Findings include:1.Review of contracted travel CNA S's personnel record revealed she was hired on 3/19/24. There was no yearly performance review in her personnel record. 2. Review of contracted travel CNA U's personnel record revealed she was hired on 3/7/23. There was no yearly performance review in her personnel record. 3. Review of CNA AA's personnel record revealed she was hired on 1/15/08. Her last performance evaluation was on 4/2/25. 4. Interview on 6/2/26 at 10:31 a.m. with director of nursing (DON) B revealed she completed yearly performance evaluations on the provider's nursing staff. She stated that for the contracted travel CNAs, she provided feedback to their travel agency, and she expected the travel agency to complete their yearly performance evaluations. If a CNA was identified to need additional training in an identified area, that training could be added to the basic required training as needed. 5. Review of the provider's undated DON job description revealed, The DON has a primary roll in the evaluation and improvement of nursing and other services provided. Provides effective onboarding, education, and training to assure [ensure] staff competencies. Provides ongoing coaching, mentoring, and performance feedback for staff to succeed. 6. Review of the provider's 12/30/25 Facility Assessment revealed, Annual Evaluations- We have implemented an evaluation form that is easier for employees and directors to utilize. We have found it enables more substantial dialogue between the director and staff members.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview, observation, and policy review, the provider failed to make information available on how to file a grievance, ensure the grievance forms were readily available to residents and their representatives, designate who the grievance official was, and follow their grievance process when one of one sampled residents' (5) representative expressed a concern about an injury. Findings Include:1. Observation on 5/27/26 at 8:10 a.m. revealed there were no grievance forms or information on how to file a grievance located in the resident care areas, at the nurses' station, near the dining room, or in the activities room. 2. Interview on 5/27/26 at 8:16 a.m. with social services designee (SSD) F revealed she thought that the grievance official was either licensed social worker (LSW) E or chief executive officer (CEO) A. SSD F was responsible for filing the grievances in a binder. She had not assisted any resident or family member in completing a grievance form.There was no grievance, concern, or complaint filed by resident 5's family member regarding the 11/19/25 incident when resident 5 received a hot liquid burn injury 3. Observation and interview on 5/27/26 at 2:12 p.m. with LSW E revealed she was the grievance official until she began working remotely about two years ago. She supervised SSD F and worked at the facility two days per month. SSD F was the grievance official and was responsible for ensuring that the grievances were investigated by the appropriate department, that follow-up occurred with the individual filing the grievance, and that the grievance form was filed and retained for several years.LSW E expected the grievance forms to be located in each hallway where there were resident rooms, outside of the director of nursing (DON) B's office, and outside of the social services office.She confirmed there were no grievance forms located outside DON B's office or in the 300 hallway. The grievance binder in the 200 hallways was located inside a clear file holder that also held trash bags. It was approximately five feet from the floor and did not contain grievance forms. She agreed that residents who required the use of a wheelchair would not have access to those grievance forms. There were grievance forms in a binder near the front door of the facility outside of the social services office. She confirmed that it was not a resident care area and most residents would not have known they were there. She thought that residents could file a grievance anonymously by sliding a form under SSD F's door or by placing it in the box near the front door.LSW E expected that SSD F would have been responsible for handling a family member's concern if it was not a concern that was required to be reported to the South Dakota (SD) Department of Health (DOH). 4. Interview on 5/27/25 at 2:20 p.m. and again at 3:37 p.m. with LSW E and SSD F revealed SSD F read about resident 5's 11/19/25 hot liquid burn injury the following day (11/20/25) in the nurse's progress note. At that time, it was documented that resident 5 spilled her coffee in her lap. She could not recall when she learned that resident 5's daughter stated that she thought the hot liquid burn injury was caused by a staff member. She was unsure if a grievance form should have been completed or if that hot liquid burn injury should have been reported to the SD DOH.LSW E became aware of resident 5's family members' concern that resident 5 received a hot liquid burn injury and that resident 5's family member thought that a staff member caused that hot liquid burn injury on 12/23/25 when DON B called her several weeks after resident 5 received a hot liquid burn injury from her tea, because a family member complained to the dietitian that staff spilled coffee on resident 5.LSW E was unaware when resident 5's family member first shared the concern that the hot liquid injury was caused by a facility staff member.LSW E expected that if resident 5's family member shared a concern with any staff member that she thought that a staff member caused resident 5's hot liquid burn injury, that a grievance form would have been completed, and that concern would have been reported to CEO A and DON B immediately. 5. Resident Council group interview on 5/27/26 at 2:45 p.m. revealed that three residents attended. The three residents who attended did not know how to file a grievance or where the grievance forms were located. Resident 20 stated that if she had a concern or a grievance, she would tell a nurse and hoped that the nurse would fix the problem. 6. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Phone interview on 5/27/26 at 4:34 p.m. with resident 5's family member regarding resident 5's 11/19/25 hot liquid burn injury revealed she visited resident 5 on 11/24/24 and was told by resident 5, they burned me, and resident 5 showed her the inner thigh area. She was resident 5's emergency contact, and no notification was provided to her or the other listed emergency contact. It had been about a week since that incident occurred. While at the facility on 11/24/25, she spoke with a nurse (she was unable to recall who she spoke with) about the incident and was told that the documentation in resident 5's EMR said that resident 5 spilled her own coffee in her lap and that the emergency contact was notified.She stated that resident 5 was coherent, repeated several times, they burned me, and that she believed resident 5. She told the nurse that she thought a staff member caused resident 5's hot liquid burn injury and that she was upset that she and the emergency contact were not notified. She expected someone to follow up with her about her concerns.Resident 5's family member attended the 12/9/24 care conference meeting and told the staff members, again, that she was concerned that a staff member caused resident 5's hot liquid burn injury, and that she and the other emergency contact were not notified. She recalled that registered dietitian (RD) H was present at that care conference and said she would check into it.On 11/23/25, she stopped to visit with RD H because she was not provided any additional information about what happened when resident 5 was burned or what the facility was doing about it.She was frustrated that the facility did not follow up with her about her concerns and stated that she hoped that an incident like this would not happen again or happen to anyone else. 7. Interview on 6/1/26 at 12:17 p.m. and again on 6/2/25 at 11:31 a.m. with DON B regarding resident 5's 11/19/25 hot liquid burn injury revealed that she was notified on 12/22/25 that resident 5's family member was stating that resident 5 was burned by hot liquid and that she thought that a staff member caused the hot liquid burn injury. She was not notified on 11/19/25 that resident 5 received a hot liquid burn injury, and did not expect to be notified because it was not serious enough to require a visit to the emergency room, and staff thought that she spilled her hot tea on herself.She expected the staff in attendance at resident 5's care conference on 12/9/25 to have completed a grievance form when they were notified by resident 5's family member that she was concerned that resident 5 was burned by a staff member with a hot liquid. If a grievance form was filled out, DON B would have been notified, she would have begun an investigation, and would have had the information to follow up with resident 5's family member after the investigation was completed. 8. Interview on 6/2/26 at 8:25 a.m. with RD H regarding resident 5's 11/19/25 hot liquid burn injury revealed she learned of the injury during resident 5's 12/9/25 care conference. She was unsure if a grievance form was completed when resident 5's family member voiced that she was concerned that resident 5 was burned by a staff member with a hot liquid. RD H expected that SSD F would have completed a grievance form if it was appropriate and followed up with resident 5's family after the 12/9/25 care conference. She was surprised when resident 5's daughter visited her again on 12/23/25 and was still concerned about resident 5's 11/19/25 hot liquid burn injury. 9. Interview on 6/2/26 at 9:48 a.m. with SSD F revealed that she attended resident 5's 12/9/25 care conference and was aware that resident 5's family member was concerned about how resident 5 was burned by her hot tea, but it was documented that resident 5 spilled her tea on herself. She was unsure if a grievance should have been completed. She felt that if resident 5's daughter voiced a concern to a nurse on 11/24/25 or to RD H, they would have completed a grievance form if it was appropriate. Nursing or dietary would have been responsible for completing an investigation into those concerns. She was unaware that resident 5's family member had more concerns about resident 5's hot liquid burn injury or how the burn injury happened. After resident 5's 12/9/25 care conference, SSD F expected RD H to have followed up with resident 5's family member about what interventions the facility implemented.Resident 5 spilled her own tea, so she did not think that there was anything else to follow up with the family about. 10. Review of the provider's reviewed December 2021 Filing Grievances/Complaint policy revealed Our facility will assist residents, their representatives (sponsors), other interested family members, or advocates in filing grievances or complaints when (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	such requests are made. It did not identify who the grievance official was. 11. Review of the Provider's undated Grievance/Concern Follow-up form revealed This form should be completed on any resident comment or criticism not resolved immediately, regarding their care or treatment in any of our facilities. This may come in the form of a resident satisfaction survey, a letter, a phone call, or a conversation with a resident/family member/visitor, etc. 12. Review of the provider's undated Long-Term Care Center Resident Grievance/Concern Procedure revealed .all residents and/or his/her representative have the right to voice grievances/concerns to the facility. Grievance/Concerns can be filed orally or written on the facilities grievance/concern form. (Located in the Grievance/Concern folder outside the social services office or at the end of each wing [hallway]). We want to ensure prompt resolution of all grievances regarding the resident's rights.The grievance official was listed as LSW E. SSD F's contact information was not included in that procedure.

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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 policy review, the provider failed to ensure the resident's baseline care plan (personalized plan that addresses a resident's care needs, goals, and interventions) was completed, was reviewed with, and a copy was offered to the resident or the resident's representative within 48 hours of the resident's admission to the facility for three of four sampled newly admitted residents (3, 6, and 14). Findings include: 1. Review of resident 14's electronic medical record (EMR) revealed he was admitted to the facility on [DATE]. His 5/14/26 Brief Interview of Mental Status (BIMS) assessment score was 13, which indicated his cognition was intact. His diagnoses included hemiparesis (paralysis on one side of the body following cerebral infarction (stroke) affecting his right dominant side, adult failure to thrive, repeated falls, hypertension (high blood pressure), chronic ischemic heart disease (a long-term condition where the heart muscle receives insufficient blood and oxygen), and vitamin D and B deficiencies. His baseline care plan assessment was initiated on 2/19/26, but was not completed. There was no documentation that indicated his diagnoses, his diet, or that the social services section had been completed. There was no documentation that a copy of the baseline care plan was offered to or reviewed with the resident or his representative within 48 hours of his admission to the facility. 2. Review of resident 6's EMR revealed he was admitted to the facility on [DATE]. His 5/14/26 BIMS assessment score was 5, which indicated his cognition was severely impaired. His diagnoses included type 2 diabetes mellitus (a chronic metabolic condition characterized by high blood sugar levels), peripheral vascular disease (a circulation disorder characterized by the narrowing, blockage, or spasms of blood vessels outside of the heart and brain), chronic kidney disease (loss of the kidneys' ability to filter waste and excess fluid from the blood), cerebral infarction (stroke), repeated falls, weakness, and tremor (involuntary, rhythmic shaking or trembling movement).His baseline care plan assessment was completed on 11/17/26. There was no documentation that indicated his diagnoses, his bed-to-chair transfer status, or that the social services section had been completed. There was no documentation that a copy of the baseline care plan was offered to or reviewed with the resident or his representative within 48 hours of his admission to the facility. 3. Review of resident 5's EMR revealed she was admitted on [DATE]. Her 5/19/26 BIMS assessment score was 13, which indicated her cognition was intact. Her diagnosis included diverticulosis (a painful digestive condition that occurs when small, bulging pouches in the lining of your colon (called diverticula) become inflamed or infected), atrial fibrillation (a type of irregular heart beat), type 2 diabetes mellitus (a chronic metabolic condition characterized by high blood sugar levels), hypertension, low back pain, depressive episodes (a distinct period of at least two weeks characterized by a persistent low mood, sadness, or a complete loss of interest in activities), presence of cardiac pacemaker (a small, battery-operated medical device implanted in the chest or abdomen), Alzheimer's Disease (a progressive, irreversible brain disorder that slowly destroys memory and thinking skills), and dementia (a group of symptoms that negatively impact memory, thinking, and social abilities).Her baseline care plan assessment was completed on 3/11/25. There was no documentation that indicated her diagnoses, her code status, or that the social services section had been completed. There was no documentation that a copy of the baseline care plan was offered to or reviewed with the resident or his representative within 48 hours of his admission to the facility. 4. Interview on 6/1/26 at 12:17 p.m. with director of nursing (DON) B regarding baseline care plans revealed she expected the baseline care plan to be completed as soon as possible, within 48 hours after a resident admitted to the facility. She was unsure if the social services department contributed to the baseline care plan. The resident or the resident's representative was not offered or provided a copy of the baseline care plan. She was unaware that the regulation required the baseline care plan to be (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435056	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winner Regional Healthcare Center	805 E 8th St Winner, SD 57580

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed with the resident or their representative, and a copy was to be provided. 5. Review of the provider's revised February 2020 Care Plans: Preliminary, Comprehensive and Reviews policy revealed the provider assures each resident has a preliminary care plan developed at admission to address immediate care needs. Preliminary care plans are used until the Comprehensive Care plan has been completed and addressed the following areas of care for the resident: Problems , Strengths , Short/Long-ter Goals , Approach , Time Frame.