| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. Building<br>B. Wing | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Monroe Health and Rehabilitation Center | 465 Isbill Rd<br>Madisonville, TN 37354 |

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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on facility policy review, observations, and interviews, the facility failed to clean and store kitchen equipment in 1 of 1 kitchen and failed to maintain 1 of 1 walk in freezers in a sanitary condition which had the potential to affect 65 of 65 residents residing in the facility. The findings include: Review of the facility's policy titled, Sanitization, dated 12/2008, revealed .All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means . Review of the facility's policy titled, Food Safety Requirements, dated 3/26/2025, revealed .Food safety practices shall be followed throughout the facility's entire food handling process .all equipment used in the handling of food shall be cleaned and sanitized in a manner to prevent contamination . Review of the facility's undated policy titled, Sanitation Inspection, revealed It is the policy of this facility .part of the .sanitation program, to conduct inspections to ensure food service areas are clean, sanitary, and in compliance .Sanitation inspections will be conducted .Daily: Food service staff shall inspect .freezers daily . During an observation and interview with the Certified Dietary Manager (CDM) on 2/23/2026 at 9:45 AM, in the utensil storage area revealed 5 dish scoops with dried and crusted food particles under the mechanical blade and in the metal bowl of the scoop, 1 saute/fry pan with dried beef and dried particles on the pan and 1 full deep pan with dried food particles on the inside of the pan. The CDM and Assistant Dietary Manager both confirmed the scoops, saute/fry pan, and full deep pan had not been clean and sanitized correctly and were ready and available for use. The CDM confirmed it is the expectation for all utensils used for food service to be free of food debris to prevent food born illness and further confirmed there had not been any food borne illnesses in the facility. During an observation and interview on 2/23/2026 at 10:00 AM, with the CDM in the walk-in freezer revealed 4 frozen biscuits, 2 thermometers not in use, and scattered frozen peas in the walk-in freezer on the floor under the bottom shelf of the food storage rack. The CDM confirmed the loose food items had not been removed, the thermometers were not to be placed on the floor out of view, and the freezer had not been cleaned properly. |

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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, observations, and interviews, the facility failed to maintain a clean and sanitary environment for 5 resident rooms (room [ROOM NUMBER], #114, #116, #117 and #118) of 8 rooms observed on 1 of 2 hallways for a clean and sanitary environment.The findings include:Review of the facility policy titled, Routine Bathroom Cleaning, dated 6/2025, revealed .provide a clean and sanitary environment for residents .clean entire toilet including handle and underside of flush rim. Apply disinfectant and allow sufficient contact time .report areas of .damaged items in need of repair .Review of the facility policy titled, Routine Cleaning and Disinfection, dated 6/2025, revealed .it is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible .During observations on 2/23/2026 at 10:56 AM, 2/24/2026 at 11:00 AM, and 2/25/2026 at 2:00 PM, revealed room [ROOM NUMBER]-B contained a motorized wheelchair, with dried debris on the cushion, arms of the chair, and a large amount of multi-colored debris, small pieces to quarter size chunks, on the undercarriage.During observations on 2/23/2026 at 10:58 AM, 2/24/2026 at 11:02 AM, and 2/25/2026 at 2:02 PM, revealed room [ROOM NUMBER]'s bathroom contained a trash can without a bag, with a dried brown substance on the outside, the rim, and the inside of the trash can. Further observation revealed the toilet had 2 areas of dried yellow residue on the seat, and a yellow/orange substance around the base of the toilet.During observations on 2/23/2026 at 11:10 AM, 2/24/2026 at 11:04 AM, and 2/25/2026 at 2:10 PM, revealed room [ROOM NUMBER]'s bathroom had a yellow/orange substance around the base of the toilet.During an observation on 2/23/2026 at 11:18 AM, 2/24/2026 at 11:06 AM, and 2/25/2026 at 2:13 PM, revealed room [ROOM NUMBER]-A contained a wheelchair with a fabric heel protector cushion attached to the right arm as an armrest. The cushion was spattered with small to pea-size unknown multi-colored particles.During observations on 2/23/2026 at 11:21 AM, 2/24/2026 at 11:08 AM, and 2/25/2026 at 2:14 PM, revealed room [ROOM NUMBER]'s bathroom had brown residue at the front base of the toilet. During observations on 2/23/2026 at 11:25 AM, 2/24/2026 at 11:15 AM, and 2/25/2026 at 2:25 PM, revealed room [ROOM NUMBER]'s bathroom had a yellow/orange substance around the base of the toilet.During an observation and interview on 2/26/2026 at 2:30 PM, in room [ROOM NUMBER]'s bathroom, revealed the Administrator stated the substance around the toilets may be related to the wax ring. The Administrator used a wet wipe to determine if the yellow/orange substance could be easily cleaned, and after wiping a small area around the toilet, the substance was easily removed. The Administrator confirmed the area around the toilet was not clean. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interviews, the facility failed to report an allegation of verbal abuse to the State Designated Authority (State Agency) for 1 resident (Resident #37) of 6 residents reviewed for abuse.The findings include:Review of the facility's policy titled, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, dated 7/2025, revealed .it is the guideline of this facility to report all allegations of abuse/neglect/exploitation or mistreatment .immediately to the Administrator of the facility and to other appropriate agencies .when suspicion of abuse .occur .the licensed nurse will notify the Administrator or designee .the Administrator or designee .will notify the appropriate agencies .obtain statements from direct care staff .suspend the accused employee .Review of the medical record revealed Resident #37 was admitted to the facility on [DATE] with diagnoses including Dementia, History of a Stroke with Right Hemiparesis (weakness), and Chronic Obstructive Pulmonary Disease.Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #37 scored an 8 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the resident had severe cognitive impairment.Review of the comprehensive care plan dated 1/13/2026, revealed Resident #37 had .Impaired thought processes r/t [related to] dementia, other cerebrovascular diseases .During an interview on 2/24/2026 at 9:05 PM, CNA D stated on her second night shift of training, about 1-2 weeks ago, she was training with CNA C. Resident #37's call light was on, and CNA D and CNA C went to the room. Resident #37 started yelling at them to put her roommate to bed. CNA C told Resident #37, Shut the f--- up, and Don't tell me what to do. CNA C and Resident #37 were yelling and bickering with each other back and forth while they were putting Resident #37's roommate to bed. As they were leaving the room, CNA C told Resident #37, I said don't tell me what the f--- to do, you can just sit on it and f---ing spin. Then CNA C said to CNA D, Come on, let's go, and left the room. CNA D stated she turned back to Resident #37 to check on (Resident #37) and helped the resident get dressed and ready for bed. When (CNA D) was done, CNA D found CNA C and said to [CNA C], You shouldn't have talked to her (Resident #37) like that, aren't you [CNA C] afraid (Resident #37) will tell on you? and CNA C replied, No, actually, that resident won't tell anything. CNA D stated she told LPN A about the incident including the details of CNA C and Resident #37 bickering back and forth, and CNA C cursing at Resident #37.During an interview on 2/24/2026 at 9:15 PM, LPN A stated CNA D told her the following: CNA C was bickering back and forth with Resident #37 while they were caring for the roommate. CNA D was cursing at Resident #37, using the F word including, Don't tell me what to do, shut the f--- up .You can f---ing sit on it and rotate. LPN A stated it was no more than 10 minutes when (LPN A) checked on Resident #37. Resident #37 wasn't crying at this time. When Resident #37 was asked about the incident, Resident #37 said no. LPN A stated Resident #37 has dementia and has sundowning, when she gets more confused at night. LPN A stated she notified the Administrator, who called the Director of Nursing (DON) with a conference call. LPN A relayed the information CNA D told her, including CNA C allegedly cursing at Resident #37, yelling back and forth with Resident #37. LPN A stated the DON told her to obtain a written statement from CNA C, and escort her off the premises. LPN A stated she obtained a written statement from CNA C and escorted her off the premises as instructed. LPN A wrote a statement herself and obtained a written statement from CNA D. LPN A stated she put all 3 statements under the DON's door as instructed.Review of the nursing schedule assignments for 2/2026 revealed CNA C went home during the night shift on 2/14/2026.During an interview on 2/25/2026 at 11:00 AM, the DON confirmed LPN A had called her when the alleged incident occurred and instructed LPN A to escort CNA C off the premises. The DON stated when she came to work the following day, she asked other residents and staff if there had been any issues with CNA D and there had been no concerns identified. The DON stated CNA D was PRN status (as needed only), and the (continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | facility decided not to schedule her anymore due to poor customer service. The DON stated Resident #37 denied the incident when questioned, therefore the facility did not consider the reported allegation to be abuse. The DON denied possessing any written statements and confirmed there was no documentation of an investigation.Review of the Human Resources (HR) file revealed CNA C was hired on 11/9/2024. New hire orientation for CNA C included the abuse program policies and procedures. The HR file did not contain documentation of the alleged abuse incident on 2/14/2026, documentation of CNA C being sent home during the shift on 2/14/2026, or documentation of the DON's intent to no longer place CNA C on the schedule.During an interview on 2/26/2026 at 2:30 PM, with the Administrator and DON, the Administrator stated he was the facility's Abuse Coordinator, confirmed allegations of abuse should be reported to the State Agency and other entities as required, and confirmed this incident had not been reported to the State Agency or other entities. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interviews, the facility failed to ensure an allegation of verbal abuse was investigated for 1 resident (Resident #37) of 6 residents reviewed for abuse.The findings include:Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated 7/2025, revealed alleged violation is a situation or occurrence that is observed or reported by staff .but has not yet been investigated and, if verified, could be an indication of .abuse .An Immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur . Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses and others who might have knowledge of the allegations . providing complete and thorough documentation of the investigation .taking all necessary actions as a result of the investigation .Review of the medical record revealed Resident #37 was admitted to the facility on [DATE] with diagnoses including Dementia, History of a Stroke with Right Hemiparesis (weakness), and Chronic Obstructive Pulmonary Disease.Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #37 scored an 8 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the resident had severe cognitive impairment.Review of the comprehensive care plan dated 1/13/2026, revealed Resident #37 had .Impaired thought processes r/t [related to] dementia, other cerebrovascular diseases .During an interview on 2/24/2026 at 9:05 PM, CNA D stated on her second night shift of training, about 1-2 weeks ago, she was training with CNA C. Resident #37's call light was on, and CNA D and CNA C went to the room. Resident #37 started yelling at them to put her roommate to bed. CNA C told Resident #37, Shut the f--- up, and Don't tell me what to do. CNA C and Resident #37 were yelling and bickering with each other back and forth while they were putting Resident #37's roommate to bed. As they were leaving the room, CNA C told Resident #37, I said don't tell me what the f--- to do, you can just sit on it and f---ing spin. Then CNA C said to CNA D, Come on, let's go, and left the room. CNA D stated she turned back to Resident #37 to check on (Resident #37) and helped the resident get dressed and ready for bed. When (CNA D) was done, CNA D found CNA C and said to [CNA C], You shouldn't have talked to her (Resident #37) like that, aren't you [CNA C] afraid (Resident #37) will tell on you? and CNA C replied, No, actually, that resident won't tell anything. CNA D stated she told LPN A about the incident including the details of CNA C and Resident #37 bickering back and forth, and CNA C cursing at Resident #37.During an interview on 2/24/2026 at 9:15 PM, LPN A stated CNA D told her the following: CNA C was bickering back and forth with Resident #37 while they were caring for the roommate. CNA D was cursing at Resident #37, using the F word including, Don't tell me what to do, shut the f--- up .You can f---ing sit on it and rotate. LPN A stated it was no more than 10 minutes when (LPN A) checked on Resident #37. Resident #37 wasn't crying at this time. When Resident #37 was asked about the incident, Resident #37 said no. LPN A stated Resident #37 has dementia and has sundowning, when she gets more confused at night. LPN A stated she notified the Administrator, who called the Director of Nursing (DON) with a conference call. LPN A relayed the information CNA D told her, including CNA C allegedly cursing at Resident #37, yelling back and forth with Resident #37. LPN A stated the DON told her to obtain a written statement from CNA C, and escort her off the premises. LPN A stated she obtained a written statement from CNA C and escorted her off the premises as instructed. LPN A wrote a statement herself and obtained a written statement from CNA D. LPN A put all 3 statements under the DON's door as instructed.Review of the nursing schedule assignments for 2/2026 revealed CNA C went home during the night shift on 2/14/2026.During an interview on 2/25/2026 at 11:00 AM, the DON confirmed LPN A had called her when the alleged incident occurred and instructed LPN A to escort CNA C off the premises. The DON stated when she came to work the following day, she asked other residents and staff if there had been any issues with CNA D and there had been no concerns identified. The DON stated CNA D was PRN status (as needed only), and the<br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | facility decided not to schedule her anymore due to poor customer service. The DON stated Resident #37 denied the incident when questioned, therefore the facility did not consider the reported allegation to be abuse. The DON denied possessing any written statements and confirmed there was no documentation of an investigation.Review of the Human Resources (HR) file revealed CNA C was hired on 11/9/2024. New hire orientation for CNA C included the abuse program policies and procedures. The HR file did not contain documentation of the alleged abuse incident on 2/14/2026, documentation of CNA C being sent home during the shift on 2/14/2026, or documentation of the DON's intent to no longer place CNA C on the schedule.During an interview on 2/26/2026 at 2:30 PM, with the Administrator and DON, the Administrator stated he was the facility's Abuse Coordinator, confirmed allegations of abuse should be reported to the State Agency and other entities as required, and confirmed this incident had not been reported to the State Agency or other entities and had not been thoroughly investigated. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, Lippincott Nursing Center website review, medical record review, observation, pharmacy documentation review, and interviews, the facility failed to ensure basic standards for the rights of medication administration were followed for 1 resident (Resident #25) of 3 residents reviewed for medication administration.The findings include:Review of the facility's undated policy titled, Medication Administration, revealed .ensure that the six rights of medication administration are followed .Right resident .Right drug .Right dosage .Right route .Right time .Right documentation .Review MAR [Medication Administration Record] to identify medication to be administered .Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, time .Review of the Lippincott Nursing Center Website resource of the Nursing Drug Handbook dated 2025- 2026, revealed .Medication Errors in Nursing .As a final step in the administration process .and the .defense against medication errors .nurses must follow the rights of medication administration .Right Patient .Right medication .Right dose .Right route .Right time .Right Documentation .Right reason .Right response .Review of the medical record revealed Resident #25 was admitted to the facility on [DATE] with diagnoses including Hypertension (high blood pressure), Polyneuropathy (nerve damage), and Alcohol Use, Unspecified, With Withdrawal.Review of a comprehensive care plan for Resident #25 dated 1/19/2026, revealed .The resident has altered cardiovascular status r/t [related to] Hypertension .Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #25 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Further review revealed Resident #25 had an active diagnosis of Hypertension. Review of the Physician's Orders for Resident #25 revealed the following orders prescribed by the Nurse Practitioner (NP):1. An order dated 1/16/2026, .Lisinopril 40 mg one time a day . to start 1/17/2026. This was discontinued on 1/19/2026.2. An order 1/19/2026, . Lisinopril 40 mg one time a day .hold for sbp [systolic blood pressure] < [less than] 115 .for 7 days . scheduled to start 1/20/2026 and end 1/26/2026.3. An order dated 1/19/206, . Lisinopril 40 mg one time a day . with no blood pressure parameters, scheduled to start on 1/27/2026. This was discontinued on 1/22/2026.4. An order dated 1/22/2026, .Lisinopril 10 mg one time a day .hold for sbp <115 . scheduled to start 1/23/2026 and end 1/26/2026.5. An order dated 1/22/2026, .Lisinopril 10 mg one time a day . with no blood pressure parameter, to start on 1/27/2026 to present (2/24/2026). Review of the pharmacy's delivery manifests for Resident #25 from admission on [DATE] through 2/24/2026, revealed the pharmacy sent the following medications to the facility for Resident #25:1. 1/16/2026 Lisinopril 40 mg - quantity of 30 tablets2. 1/19/2026 Lisinopril 40 mg - quantity 37 tablets2. 1/23/2026 Lisinopril 10 mg - quantity of 4 tablets3. 1/26/2026 Lisinopril 40 mg - quantity of 37 tabletsReview of the Automated Medication Dispensing System (AMDS) transaction report for Resident #25 from admission on [DATE] through 2/24/2026, revealed there were no doses of Lisinopril retrieved from the AMDS for Resident #25, until 2/24/2026 by Registered Nurse (RN) D.Review of the MAR dated 2/1/2026 to 2/28/2026 revealed, .Lisinopril 10 mg .one time a day . was signed daily as administered. Further review revealed the MAR was signed off primarily by Medication Aide (MA) A 7 times, and by MA B 10 times.During an observation of medication administration on 2/24/2026 at 8:20 AM, RN D was observed preparing morning medications for Resident #25. RN D viewed the order on the MAR, which read .Lisinopril [medication used to lower blood pressure] 10 mg [milligrams] .daily . RN D retrieved the card of Lisinopril from the medication cart drawer, and checked the pharmacy label which read, .Lisinopril 40 mg . RN D did not give the medication off this card and retrieved the correct dose of Lisinopril 10 mg for Resident #25 from the Automated Medication Dispensing System (AMDS).During an interview on 2/25/2026 at 2:15 PM, MA B stated she gave Resident #25 medication from the card that was on the medication cart. When she was told the pharmacy only sent 4 tablets of Lisinopril 10 mg, and the only other<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Lisinopril that had been sent from the pharmacy was Lisinopril 40 mg, MA B stated, .if that's the case, I may have given that . MA B confirmed the rights of medication administration, including right dose, were supposed to be followed by checking the MAR and the medication card label before preparing the medication for administration, and confirmed she may not have done that.During an interview on 2/26/2026 at 12:30 PM, MA A stated she only gave Resident #25 medication from the card on the medication cart. When she was told the pharmacy only sent 4 tablets of Lisinopril 10 mg, and the only other Lisinopril that had been available from the pharmacy was Lisinopril 40 mg, MA A stated, .if that's all that was in the cart, I guess that's what I gave . MA A confirmed the rights of medication administration, including right dose, were supposed to be followed by checking the MAR and the medication card label before preparing the medication for administration, and stated, I may have missed it.During an interview on 2/26/2026 at 1:30 PM, the Director of Nursing (DON) stated the expectation is to check the order on the MAR against the medication card to ensure it is the correct medication and dosage. After reviewing the pharmacy manifests and the AMDS transaction report for Resident #37, the DON confirmed Lisinopril 10 mg was only available for 4 doses from the order date of 1/22/2026 through 2/24/2026, and the incorrect dosage of Lisinopril 40 mg was the only one available on the medication cart for resident use. The DON confirmed the standard of practice for the rights of medication administration were not followed. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observations, and interviews the facility failed to ensure an order was obtained for oxygen (O2) administration, failed to ensure O2 warning signs were placed on the resident's door, and failed to ensure tubing was changed timely for 1 resident (Resident #61), failed to ensure oxygen tubing (nasal cannula) was stored appropriately for 2 residents (Residents #61 and #41), and failed to administer O2 at the prescribed physician rate for 1 resident (Resident #5) of 6 residents reviewed for O2 administration. The findings include:<br><br>Review of the facility's policy titled, Oxygen Administration, dated 1/8/2024, revealed .Oxygen is administered under orders of a physician .Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy .Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated .Keep delivery devices covered in plastic bag when not in use .Oxygen warning signs must be placed on the door of the resident's room where oxygen is in use .Types of delivery systems include .Nasal Cannula .<br><br>Review of the medical record revealed Resident #61 was admitted to the facility on [DATE] with diagnoses including Acute Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease, and Heart Failure.<br><br>Review of the comprehensive care plan for Resident #61 dated 1/21/2026, revealed .resident has altered respiratory status/difficulty breathing .<br><br>Review of the O2 Sats (oxygen saturation- measures oxygen levels in the blood) Summary dated 1/22/2026 at 9:07 AM, revealed Resident #61's oxygen saturation was .98.0% [percent] .Method .Oxygen via Nasal Cannula .<br><br>Review of the Occupational Therapy Evaluation & Plan of Treatment dated 1/22/2026, revealed .Diagnoses .Acute respiratory failure with hypoxia .Patient Referral and History .66 yo [[AGE] year old] male admitted to hospital for shortness of breath .now presents to this facility to continue therapy program to improve strength, adl [activities of daily living] and mobility .Oxygen .Is Oxygen needed? .Yes .Continuous .Nasal cannula .Liters of Oxygen needed .2 .<br><br>Review of the Physical Therapy Evaluation & Plan of Treatment, dated 1/23/2026, revealed .Diagnoses .Acute respiratory failure with hypoxia .Heart failure .Chronic obstructive pulmonary disease with (acute) exacerbation .Patient Referral and History .66 y.o [year old] .admitted to the hospital for SOB [shortness of breath] .Now in this facility to continue rehb [rehab] program to improve strength and mobility .Oxygen .Is Oxygen needed? .Yes .Continuous .Nasal cannula .Liters of oxygen needed .2 .<br><br>Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #61 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact.<br><br>Review of the Nurses Note for Resident #61 dated 2/11/2026 at 10:15 AM, revealed . Resident wearing O2 this morning, stated he has 'some trouble' in the night with being short of breath. Lungs are clear, denies any respiratory distress at this time, no increase in respiratory effort assessed .O2 sat varies on oximeter reading .Out to smoke per his normal routine, has been up walking per usual, (continued on next page) |

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| | 445457 | A. Building<br>B. Wing | 02/26/2026 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | denies any distress .<br><br>Review of the O2 Sats Summary dated 2/16/2026 at 2:01 AM, revealed Resident #61's oxygen saturation was .93.0% .Method .Oxygen via Nasal Cannula .<br><br>Review of Resident #61's medical record revealed no order for oxygen administration.<br><br>During an observation on 2/23/2026 at 11:42 AM, Resident #61 was not in the room. There was an oxygen concentrator beside Resident #61's bed with oxygen tubing attached. The oxygen tubing was lying on the bedside table uncovered, undated, and open to air. There was no storage bag at Resident #61's bedside to store the oxygen tubing in when not in use. There was no warning signage posted outside the resident's room that indicated Resident #61 was on oxygen.<br><br>During an observation on 2/23/2026 at 1:09 PM, Resident #61 was observed smoking during the facility smoking time with no concerns noted. Resident #61 was not wearing oxygen.<br><br>During an observation and interview on 2/24/2026 at 9:17 AM, Resident #61 returned to his room from smoking outside. Resident #61 was seated on the side of bed and stated he had been wearing oxygen for the last 5 years and since he was admitted to the facility .mostly at night . Resident #61 stated he removed the oxygen to go outside to smoke and when ambulating throughout the facility. There was an oxygen concentrator at the bedside set at 2 liters by nasal cannula. The oxygen tubing was lying across Resident #61's bed uncovered, undated, and open to air. There was no storage bag at the bedside for the oxygen tubing to be stored in when not in use. This surveyor asked Resident #61 how he stored the oxygen tubing when he took it off and he stated .I just lay it on the bed or the table . Resident #61 confirmed facility staff had not educated him on storing oxygen tubing when he was not using it.<br><br>During an interview and medical record review on 2/24/2026 at 9:21 AM, outside Resident #61's room, revealed Registered Nurse (RN) A confirmed she was assigned to Resident #61 today and provided care for him often. This surveyor asked RN A if Resident #61 received oxygen therapy and RN A stated she was unaware. RN A and this surveyor reviewed Resident #61's physician's orders and RN A confirmed there was no order for oxygen administration for Resident #61. RN A stated oxygen tubing was to be stored in a bag when not in use. Oxygen tubing was to be changed .every 2 weeks . and documented on the Treatment Administration Record (TAR). RN A confirmed there was no documentation on Resident #61's TAR regarding when oxygen tubing had been changed. RN A confirmed there was no warning signage outside Resident #61's room. RN A was unaware if warning signage was to be posted outside the room of resident's receiving oxygen therapy.<br><br>During an observation and interview on 2/24/2026 at 9:26 AM, with RN A in Resident #61's room, revealed the resident seated on the side of the bed. Resident #61's oxygen concentrator at bedside was set on 2 liters per minute and the oxygen tubing was lying across the bed uncovered, undated, and open to air. RN A asked Resident #61 if he used oxygen and the resident stated .yes .RN A asked Resident #61 if the oxygen helped him and he stated .yes . RN A confirmed the nasal cannula was open to air, undated, and not stored appropriately. RN A confirmed oxygen tubing was to be stored in a bag when not in use. RN A confirmed the oxygen tubing was undated and was unaware when it was changed last. RN A stated she was going to take care of obtaining a physician's order for the oxygen .right now .<br><br>During an observation on 2/24/2026 at 9:31 AM, with RN A, in Resident #61's room, revealed Resident<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | #61 was lying in bed with oxygen infusing at 2 liters via nasal cannula. Resident #61's respirations were slightly labored at 24 per minute and oxygen saturation was 66% and came up to 96% while deep breathing with the oxygen on. Resident #61 denied shortness of breath and stated he had just placed the oxygen back on after returning from his smoke break.<br><br>During an observation on 2/24/2026 at 9:47 AM, with RN A, in Resident #61's room, revealed RN A changed Resident #61's oxygen tubing and placed a plastic bag at the bedside to store the oxygen tubing in when not in use. RN A educated Resident #61 to keep the oxygen tubing in the bag when not in use.<br><br>During an interview on 2/24/2026 at 8:59 PM, Certified Nursing Assistant (CNA) A stated they were a regular caregiver for Resident #61. Resident #61 had worn oxygen periodically since he arrived at the facility.<br><br>During an interview on 2/25/2026 at 8:32 AM, the Director of Nursing (DON) confirmed Resident #61 did not have an order for oxygen until 2/24/2026. The DON stated .My guess is he [Resident #61] was satting low .nurse put him on oxygen .and did not obtain the order . The DON confirmed there should be an order for oxygen prior to oxygen administration. The DON confirmed oxygen tubing was to be stored in a plastic bag when not in use to maintain infection control practices. The DON confirmed residents that remove their oxygen on their own would be provided with a bag and educated to store the tubing in the bag when not in use. The DON confirmed warning signage was to be placed outside the resident's door for residents on oxygen therapy.<br><br>During an observation on 2/25/2026 at 8:43 AM, Resident #61's room had no warning signage indicating that oxygen was in use in the room.<br><br>During an interview on 2/25/2026 at 8:46 AM, RN B stated she was a regular caregiver for Resident #61. RN B stated Resident #61 started using oxygen .at least a couple weeks ago .he had low sats on night shift . RN B stated Resident #61 mostly wore oxygen when sleeping.<br><br>During an observation on 2/25/2026 at 9:00 AM, the DON confirmed no warning signage was posted outside Resident #61's room to indicate the resident was on oxygen.<br><br>During an interview on 2/25/2026 at 11:26 AM, the DON confirmed oxygen tubing was to be changed every 7 days and as needed and was to be documented on the TAR. The DON stated night shift nurses were responsible for checking and changing oxygen tubing on Saturday or Sunday night. The DON confirmed she was unaware when Resident #61's tubing was changed because it wasn't dated and there was no order for the initiation of the oxygen so it wouldn't show up on the TAR.<br><br>Review of the medical record revealed Resident #41 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Acute Kidney Failure, Atherosclerotic Heart Disease, Anxiety, and Chrondrocostal Junction Syndrome (benign inflammatory condition characterized by chest pain and swelling where ribs meet sternum).<br><br>Review of the admission MDS assessment dated [DATE], revealed Resident #41 scored a 14 on the BIMS assessment which indicated the resident was cognitively intact. Resident #41 did not receive oxygen therapy.<br><br>Review of a physician's order for Resident #41 dated 2/23/2026 revealed . O2 @[at] 2 liters per (continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | minute via nasal cannula continuously. May titrate to keep O2 sats above 94% .every shift related to Chondrocostal Junction Syndrome .<br><br>Review of the comprehensive care plan for Resident #41 revised on 2/23/2026, revealed .OXYGEN SETTINGS: O2 at 2 lpm [liters per minute] via nasal cannula continuously. Resident prefers to use O2 at night only .<br><br>Review of Resident #41's Treatment Administration Record (TAR) for February 2026, revealed Resident #41 was started on oxygen on 2/23/2026.<br><br>During an observation and interview on 2/23/2026 at 11:50 AM, in Resident #41's room, Resident #41 was seated in the wheelchair beside the bed. Resident #41 had an oxygen concentrator at the bedside with a nasal cannula attached that was lying on the bed, uncovered, and open to air. This surveyor was unable to visualize the flow rate due to resident positioning. Resident #41 reported she wore oxygen at night. There was no bag available in the room to store the oxygen tubing in when not in use.<br><br>During an observation and interview on 2/24/2026 at 11:20 AM, in Resident #41's room, Resident #41 was seated in the wheelchair beside the bed. Resident #41's oxygen concentrator was beside the bed with a nasal cannula attached that was lying on the bed uncovered and open to air. There was no bag at the bedside to store the oxygen tubing in when not in use. This surveyor asked Resident #41 where she stored the nasal cannula when she wasn't using it and she stated .I just lay it on the bed . Resident #41 stated staff had not provided her education or a plastic bag to store the nasal cannula in when not in use.<br><br>During an observation and interview on 2/25/2026 at 8:55 AM, with RN B, in Resident #41's room, revealed Resident #41 seated outside the door of her room awaiting smoking time with no oxygen on. RN B and this surveyor entered Resident #41's room with the resident's permission. There was an oxygen concentrator in the room with a nasal cannula attached to it. The nasal cannula was lying in between the mattress and the bedrail of Resident #41's bed uncovered and open to air. There was no bag in the resident's room to store the oxygen tubing when not in use. RN B stated oxygen tubing was to be stored in a plastic bag when not in use and confirmed there was no bag available for Resident #41 to store the tubing in when not in use.<br><br>Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Diabetes, and End Stage Renal Disease.<br><br>Review of the comprehensive care plan dated 8/1/2025, revealed Resident #5's care plan included .the resident has dx [diagnoses] acute/chronic respiratory failure, COPD .O2 [oxygen] via [by] nasal cannula as ordered .<br><br>Review of a Physician's Order for Resident #5 dated 10/10/2025, revealed .oxygen at 2 liters per minute via nasal canula .every shift .<br><br>Review of a quarterly MDS assessment dated [DATE], revealed Resident #5 scored a 13 on the BIMS assessment which indicated the resident was cognitively intact. Further review revealed Resident #5 had shortness of breath while lying flat, and oxygen was in use continuously while in the facility. During an observation on 2/24/2026 at 11:15 AM, revealed Resident #5 was lying in bed with oxygen in use by nasal cannula which was set at 3 liters per minute.<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation and interview on 2/24/2026 at 3:47 PM, the Director of Nursing (DON) confirmed Resident #5 was lying in bed with oxygen in use by nasal cannula which was set at 3 liters per minute. The DON confirmed Resident #5 had a Physician's Order for oxygen at 2 liters per minute, and the resident's oxygen was not set at the prescribed rate. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observations, and interviews, the facility failed to ensure care needs related to dialysis were consistent with professional standards of practice and the comprehensive person-centered care plan for 1 resident (Resident #5) of 2 residents reviewed for dialysis. The findings include: Review of the facility's policy titled, Hemodialysis, dated 12/2024, revealed .The facility will provide the necessary care and treatment, consistent with professional standards of practice .the facility will coordinate and collaborate .to assure that the resident's needs related to dialysis treatments are met .the facility will ensure that the physician's orders for dialysis include .The type of access for dialysis (e.g. [for example] graft, arteriovenous shunt, external dialysis catheter) and location .the dialysis schedule .nephrologist name and phone number .dialysis facility name and phone number .transportation arrangements to and from the dialysis facility .any medication administration or withholding of specific medications .Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Diabetes Mellitus, End Stage Renal Disease, and Dependence on Hemodialysis (use of machinery to filter wastes from the blood).Review of the comprehensive care plan dated 8/1/2025, revealed Resident #5's care plan included, .The resident receives dialysis r/t [related to] ESRD [End Stage Renal Disease] .check and change dressing daily at access site as ordered .do not draw blood or take B/P [blood pressure] in arm with graft .encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis Tuesday, Thursday, and Saturday .Review of the current Physician's Orders for Resident #5 revealed the following orders related to dialysis:1. Physician's Order dated 10/10/2025, .Dialysis communication form - send form with resident to dialysis . scheduled Monday, Wednesday, and Friday.2. Physician's Order dated 10/10/2025, .Dialysis: check access site for bleeding every shift .3. Physician's Order dated 10/10/2025, .Do not administer any medications through or flush dialysis catheter .4. Physician's Order dated 1/15/2026, .Dialysis - obtain weight before and after dialysis . scheduled Monday, Wednesday, and Friday.5. Physician's Order dated 2/20/2026, .Sack lunch sent with resident for dialysis . scheduled Monday, Wednesday, and Friday.Continued review of the current Physician's Orders for Resident #5 revealed no orders were present for the type and location of the dialysis access site, the dialysis clinic or schedule, the nephrologist's name and phone number, transportation arrangements, and no order to adjust the medication schedule on dialysis days.During an observation and interview on 2/23/2026 at 12:15 PM, revealed Resident #5 was not in the facility. RN D stated the resident went to the dialysis clinic on Monday, Wednesday, and Friday. During an observation on 2/24/2026 at 10:30 AM, revealed Resident #5 lying in bed. Resident #5 stated the dialysis access site was in his chest, and showed this surveyor his dialysis catheter, which was observed in the left chest area and had a dressing in place at the insertion site.Review of the Physician's Orders and the Medication Administration Record (MAR) dated 2/1/2026 - 2/28/2026, revealed the following medications and supplements were held with the documented code of a 5 which meant the resident was out of the facility.1. Physician's Order dated 2/19/2026 for house shake (nutritional supplement) 4 oz [ounces] - scheduled at noon daily - not given on Friday 2/20/2026 and Monday 2/23/20262. Physician's Order dated 2/10/2026 for Metoclopramide (medication given to treat slow stomach emptying) 5 mg before meals - scheduled at 6:30 AM, 11:30 AM, and 4:30 PM - not given at 11:30 AM on Monday 2/11/2026, Tuesday 2/12/2026, Wednesday 2/13/2026, Monday 2/16/2026, Wednesday 2/18/2026, Friday 2/20/2026, and Monday 2/23/2026.3. Physician's Order dated 2/10/2026, Guaifenesin Syrup (medication to thin lung secretions and help relieve chest congestion) 10 mL (milliliters) four times a day for 10 days (ended 2/20/2026) - not administered at 12:00 PM on Monday 2/11/2026, Tuesday 2/12/2026, Wednesday 2/13/2026, Monday 2/16/2026, Wednesday 2/18/2026, and Friday 2/20/2026.4. Physician's Order dated 12/3/2025 for Insulin Lispro [fast-acting injectable<br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | medicine used to lower blood glucose levels] sliding scale, not given at noon on Monday 2/2/2026, Thursday 2/5/2026, Friday 2/6/2026, Monday 2/9/2026, Tuesday 2/11/2026, Wednesday 2/12/2026, Thursday 2/13/2026, Monday 2/16/2026, Wednesday 2/18/2026, Friday 2/20/2026, and Monday 2/23/2026.During an interview on 2/26/2026 at 3:30 PM, the Director of Nursing confirmed Resident #5 did not have Physician's Orders per the facility policy for the type and location of the dialysis access site, the dialysis clinic or schedule, the nephrologist's name and phone number, and transportation arrangements, and Resident #5's care plan for dialysis was incorrect for the dialysis days and the access site, and confirmed Resident #5's medication schedule had not been adjusted for the when the resident is out at the dialysis clinic. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interviews, the facility failed to ensure the pharmacy provided an accurate physician prescribed medication for 1 resident (Resident #25) of 3 residents observed for medication administration. The findings include:Review of the Pharmacy Services Agreement, dated 2/2023 and continued as current agreement, revealed .Responsibilities of the Pharmacy .maintain accurate drug profiles, consistent with the information provided to the Pharmacy, on each facility resident served by pharmacy .Review of the medical record revealed Resident #25 was admitted to the facility on [DATE] with diagnoses including Hypertension (high blood pressure), Polyneuropathy (nerve damage), and Alcohol Use, Unspecified, With Withdrawal.Review of a comprehensive care plan for Resident #25 dated 1/19/2026, revealed .The resident has altered cardiovascular status r/t [related to] Hypertension .Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #25 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Further review revealed Resident #25 had an active diagnosis of Hypertension. Review of the Lisinopril pharmacy card for Resident #25 available in the medication cart revealed the pharmacy label read, .Lisinopril 40 mg .give 1 tablet .daily .for 7 days hold for sbp <115 . Further review revealed an order date of 1/19/2026, and a refill date of 1/26/2026.Review of the Physician's Orders for Resident #25 revealed the following orders prescribed:1. An order dated 1/16/2026, .Lisinopril 40 mg one time a day . to start 1/17/2026. This was discontinued on 1/19/2026.2. An order 1/19/2026, . Lisinopril 40 mg one time a day .hold for sbp [systolic blood pressure] < [less than] 115 .for 7 days . scheduled to start 1/20/2026 and end 1/26/2026.3. An order dated 1/19/206, . Lisinopril 40 mg one time a day . with no blood pressure parameters, scheduled to start on 1/27/2026. This was discontinued on 1/22/2026.4. An order dated 1/22/2026, .Lisinopril 10 mg one time a day .hold for sbp <115 . scheduled to start 1/23/2026 and end 1/26/2026.5. An order dated 1/22/2026, .Lisinopril 10 mg one time a day . with no blood pressure parameter, to start on 1/27/2026 to present (2/24/2026).Review of the pharmacy's delivery manifests for Resident #25 from admission on [DATE] through 2/24/2026, revealed the pharmacy sent the following medications to the facility for Resident #25:1. 1/16/2026 Lisinopril 40 mg - quantity of 30 tablets2. 1/19/2026 Lisinopril 40 mg - quantity 37 tablets2. 1/23/2026 Lisinopril 10 mg - quantity of 4 tablets3. 1/26/2026 Lisinopril 40 mg - quantity of 37 tabletsDuring an observation of medication administration on 2/24/2026 at 8:20 AM, RN D was observed preparing morning medications for Resident #25. RN D viewed the order on the MAR, which read .Lisinopril [medication used to lower blood pressure] 10 mg [milligrams] .daily . RN D retrieved the card of Lisinopril from the medication cart drawer, and checked the pharmacy label which read, .Lisinopril 40 mg . RN D did not give the medication off this card and retrieved the correct dose of Lisinopril 10 mg for Resident #25 from the Automated Medication Dispensing System (AMDS). During an interview on 2/26/2026 at 1:15 PM, the Pharmacy Director confirmed Physician Orders are electronically sent to the pharmacy when entered into the Electronic Health Record and confirmed Lisinopril 40 mg was sent to the facility on 1/26/2026, instead of Lisinopril 10 mg which was ordered on 1/22/2026. |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interviews, the facility failed to accurately assess the dental status and assist in providing alternate funding sources or delivery systems to meet the dental needs of 1 resident (Resident #43) of 3 residents reviewed for dental services. The findings include:Review of the facility's policy titled, Dental Services, dated 11/2024, revealed .It is the policy of this facility to assist residents in obtaining routine .and emergency dental care .'Routine dental services' means .smoothing of broken teeth .'Emergency dental services' includes services needed to treat an episode of acute pain in teeth .broken, or otherwise damaged teeth .the dental needs of each resident are identified through the physical assessment and MDS [Minimum Data Set] assessment processes, and are addressed in each resident's plan of care .oral/dental status shall be documented according to assessment findings .Review of the medical record revealed Resident #43 was admitted to the facility on [DATE] with diagnoses including History of a Stroke with Aphasia (difficulty speaking), Chronic Obstructive Pulmonary Disease, Chronic Pain Syndrome, and Diabetes.Review of a care plan for Resident #43 revealed a problem dated 6/6/2024, .The resident dips snuff on a regular basis . with interventions including, .monitor oral hygiene .Review of a referral for dental appointment transportation for Resident #43 revealed .f/u [follow up] dental r/t [related to] mouth pain . the appointment date was scheduled for 3/6/2025.Review of a dental evaluation for Resident #43 dated 3/6/2025, revealed .Pt [patient] [Resident #43] will need several fillings/exts [extractions] & [and] a debridement. Pt will need more advanced care that we [outside dental office] can provide @ [at] our office . Further review revealed the resident needed 8 teeth extracted.Review of a referral for dental appointment transportation for Resident #43 revealed .f/u oral surgeon . The appointment date was scheduled for 4/15/2025.Review of a Patient Benefit Summary from the dental office for Resident #43 dated 4/16/2025 (for the appointment on 4/15/2025), revealed the resident required simple extractions of 13 teeth, surgical extraction of 3 teeth, and Alveoplasty (reshaping and smoothing of the jawbone after extractions). Further review revealed a total expense estimate of $5,780.00, which included an upfront cost in the amount of $1855.00 due at the time of surgery.Review of the medical record for Resident #43 revealed no further dental visits had been conducted after the 4/15/2025 visit.Review of an annual MDS assessment dated [DATE], revealed Resident #43 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Further review revealed Resident #43 had no behavior such as rejection of care, required set-up or clean-up assistance of staff for oral hygiene, used tobacco, and had no natural teeth or tooth fragment(s) (edentulous).Review of a care plan for Resident #43 revealed a problem dated 11/18/2025, .The resident has potential for oral/dental health problems r/t [related to] poor oral hygiene .coordinate arrangements for dental care .Review of a quarterly MDS assessment dated [DATE], revealed Resident #43 scored a 13 on the BIMS assessment which indicated the resident was cognitively intact. Further review revealed Resident #43 required set-up or clean-up assistance of staff for oral hygiene, During an interview and observation on 2/23/2026 at 10:40 AM, Resident #43 had difficulty speaking due to aphasia and was unable to form words other than yes and no. When asked if the resident had difficulty chewing food, Resident #43 stated, Yes. When asked if he was able to tolerate eating and drinking despite current dental issues, Resident #43 stated, Yes. Resident #43 opened his mouth for this surveyor to view his teeth, and the resident was observed with darkened or decayed teeth, with what appeared to be broken and/or chipped areas throughout. When asked if the resident wanted to have the teeth extracted that were recommended by dental services, Resident #43 stated, Yes.Review of the Electronic Health Record's (EHR's) documentation of Activities of Daily Living (ADL's) dated 2/2/2026 - 2/25/2026, revealed Resident #43 received oral care 1 to 3 times daily and typically consumed 100% of meals.Review of the Physician's Orders from 1/1/2026 - 2/25/2026, revealed Resident #43 received a regular diet, no added salt, and did not<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. Building<br>B. Wing | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Monroe Health and Rehabilitation Center | 465 Isbill Rd<br>Madisonville, TN 37354 |

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

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | require any changes to his diet due to the resident's dental status. During an interview on 2/24/2026 at 2:00 PM, the Social Services Director (SSD) stated Resident #43's mother attended the dental appointment with the resident on 4/15/2025. Resident #43's mother had told the Social Services Director she did not have the money to pay the fee required of $1855.00 before dental services could be completed.During an interview on 2/25/2026 at 3:30 PM, the SSD confirmed the facility had not provided assistance to Resident #43 or his mother to help obtain alternate funding sources or delivery systems for the dental services Resident #43 needed. The SSD stated, I didn't give them [Resident #43 or the resident's mother] any other options. I should have tried to find maybe somewhere that does charity cases, or maybe a grant, but I didn't .During an interview on 2/26/2026 at 4:25 PM, the Director of Nursing (DON) confirmed Resident #43's annual MDS dated [DATE] was inaccurate for dentition and Resident #43's care plan did not include the resident's dental issues including the need for extractions. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, medical record review, and interviews, the facility failed to maintain an accurate and complete medical record for 3 residents (Resident's #77, #5, and #6) of 24 sampled residents.The findings include:<br><br>Review of the facility policy titled Fall Prevention Program, revised 10/01/2025, revealed .When any resident experiences a fall, the facility will .document all evaluations/assessments and actions taken .<br><br>Review of the facility's undated policy titled Medication Administration, revealed .Review MAR [Medication Administration Record] to identify medication to be administered .Remove medication from source .Administer medication as ordered .Sign MAR after administered .<br><br>The findings include:<br><br>Review of the facility policy Fall Prevention Program dated 10/08/2024, revised 10/01/2025, revealed .When any resident experiences a fall, the facility will .document all evaluations/assessments and actions taken .<br><br>Review of the medical record revealed Resident #77 was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction, Difficulty in Walking, Heart Failure and Breast Cancer.<br><br>Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #77 scored an 11 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Further review revealed Resident #77 had a history of falls.<br><br>Review of a comprehensive care plan dated 9/15/2025, revealed Resident #77 had a .ADL [activities of daily living] self-care performance deficit related to CVA [stroke] .at risk for falls .<br><br>Review of a Fall Scene Investigation Report for Resident #77 dated 10/3/2025 5:30 PM, .found on the floor .<br><br>Review of an unwitnessed Fall with head injury record dated 10/3/2025 at 17:30, revealed Resident #77 found in room on the floor at foot of bed.<br><br>During an interview on 2/25/2026 at 9:45 AM, Director of Nursing (DON) stated that on 10/3/2025 Resident #77 had a fall on 10/3/2025 at 5:30 PM and confirmed the documentation in Resident #77's medical record was not accurate and did not reflect the fall.<br><br>Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Diabetes Mellitus, End Stage Renal Disease, and Dependence on Hemodialysis (use of machinery to filter wastes from the blood).<br><br>Review of the comprehensive care plan dated 8/1/2025, revealed Resident #5's care plan included, .The resident has Diabetes Mellitus .Administer Diabetes medication as ordered by doctor .<br>(continued on next page) |

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| | 445457 | A. Building<br>B. Wing | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #5 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact.<br><br>Review of a Physician's Order for Resident #5 dated 10/13/2025, revealed .Lacosamide Oral Solution 100 MG [milligrams]/10 ML [milliliter] .Give 10 mL .in the evening every Mon [Monday], Wed [Wednesday], and Fri [Friday] for seizure disorder, give after HD [Hemodialysis] sessions .<br><br>Review of the MAR for Resident #5 dated 2/1/2028-2/28/2028, revealed Lacosamide was scheduled for the PM med pass (3:00 PM-6:00 PM). Further review revealed no documentation the lacosamide was administration on 2/23/2026.<br><br>Review of a Physician's Order for Resident #5 dated 10/30/2025, revealed .Levothyroxine Sodium .75 mcg [micrograms] . give 1 tablet .one time a day .<br><br>Review of the MAR for Resident #5 dated 2/1/2028-2/28/2028, revealed no documentation the levothyroxine was administered on 2/21/2026 at 6:00 AM.<br><br>Review of a Physician's Order for Resident #5 dated 12/2/2025, revealed .Insulin Lispro Injection Solution .Inject as per sliding scale: if 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 450 = 12 units; 451+ = Notify MD, subcutaneously every 6 hours for Diabetes .glucose <60 or >451 notify MD .<br><br>Review of the MAR for Resident #5 dated 2/1/2028-2/28/2028, revealed no documentation of the blood glucose level (required to determine the amount of insulin units to administer) on 2/2/2026 at 6:00 PM, 2/5/2026 at 6:00 PM, 2/7/2026 at 6:00 PM, and 2/23/2026 at 6:00 PM.<br><br>Review of a Physician's Order for Resident #5 dated 2/10/2026, revealed .[metoclopramide] .5 mg .give 1 tablet .before meals for nausea .<br><br>Review of the MAR for Resident #5 dated 2/1/2028-2/28/2028, revealed no documentation the metoclopramide was administered on 2/21/2030 at 6:30 AM, 2/23/2026 at 4:30 PM, and 2/24/2026 at 6:30 AM.<br><br>Review of the medical record revealed Resident #6 was admitted to the facility on [DATE] with diagnoses including Type 1 Diabetes Mellitus with Chronic Kidney Disease, History of a Stroke, and Congestive Heart Failure.<br><br>Review of the comprehensive care plan dated 8/4/2025, revealed Resident #6's care plan included .The resident has Diabetes Mellitus .Administer Diabetes medication as ordered by doctor . Review of a quarterly MDS assessment dated [DATE], revealed Resident #6 scored a 12 on the BIMS assessment, which indicated the resident had moderate cognitive impairment. Review of a Physician's Order for Resident #6 dated 2/20/2026, revealed .Insulin Lispro Injection Solution 100 units/mL .Inject as per sliding scale: if 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 450 = 12units; >451 notify physician, subcutaneously three times a day every Mon [Monday], Wed [Wednesday], Fri [Friday] for dm [Diabetes Mellitus] .<br><br>Review of the MAR for Resident #6 dated 2/1/2026-2/28/2026, revealed no documentation of the blood glucose level (required to determine the amount of insulin units to administer) on 2/23/2026 at (continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 5:00 PM.<br><br>During an interview on 2/26/2026 at 4:00 PM, the Director of Nursing (DON) confirmed medications should be documented on the MAR when administered or withheld and should contain the reason for holding a medication. The DON confirmed the MAR for Residents #5 and #6 contained blanks which meant those doses of scheduled medications were not documented. |