STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455463	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at the Meadow	8383 Meadow Road Dallas, TX 75231

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames that met the residents clinical and psychosocial needs that were identified in the comprehensive assessment for 3 (Resident #5, Resident #21 and Resident #35) out of 6 residents reviewed for comprehensive person-centered care plans. 1. The facility failed to ensure that Resident #5's Comprehensive Care Plan included his physician's order for G-Tube, Advanced Directives, and active diagnoses.2. The facility failed to ensure that Resident #21's Comprehensive Care Plan included her active diagnoses of dementia, diabetes, schizoaffective disorder, bipolar, anxiety and she was a Smoker.3. The facility failed to ensure that Resident #35's Comprehensive Care Plan included her active diagnoses of dementia, diabetes, end-stage renal disease, and dialysis services. These failures could place residents at risk of having received inadequate interventions not individualized to their care needs and diagnoses. Findings Included:Record review of Resident #5's admission face sheet dated 03/05/26 reflected he was a [AGE] year-old male admitted to the facility on [DATE] with active diagnoses that included: hemiplegia and hemiparesis following cerebral infarction (one-sided motor deficits occurring after a cerebral infarction (stroke) affecting left non-dominant side, candidal sepsis (a severe, life-threatening systemic infection where Candida yeast enters the bloodstream and spreads throughout the body, often causing organ failure and septic shock), cirrhosis of the liver (late-stage, chronic scarring (fibrosis) of the liver caused by long-term damage from diseases like hepatitis or alcohol abuse), dysphagia (difficulty, pain, or discomfort when swallowing food, liquids, or saliva), cognitive communication deficit, contracture of the left hip, dementia without behavioral disturbance, acquired absence of the left and right legs above knee, generalized muscle weakness, seizures, cerebral infarction (stroke), and Type 2 diabetes. Resident #5's Advance Directive was Full Code. Record review of Resident #5's Quarterly MDS assessment dated [DATE], reflected a BIMS score of 00 indicating severe cognitive impairment. Resident #5's MDS Assessment reflected he required a Feeding Tube and required total assistance with ADL Care. Resident #5's MDS Assessment reflected diagnoses of Non-Alzheimer's Dementia, aphasia, cerebrovascular accident, transient ischemic attack, or stroke, and hemiplegia or hemiparesis, and seizure disorder or epilepsy. Record review of Resident #5's Care Plan dated 01/26/2025 reflected,Focus: [Resident #5] is dependent on staff etc.for meeting emotional, intellectual, physical, and social needs r/t Cognitivedeficits, Physical LimitationsDate Initiated: 01/26/2026Revision on: 01/26/2026 Goals: [Resident #5] will maintain involvement in cognitive stimulation, social activities as desired/tolerated through reviewdate.Date Initiated: 01/26/2026Revision on: 01/26/2026Target Date: 03/07/2026 Interventions: [Resident #5] needs 1:1 (1 staff member care for only 1 patient at a time) at bedside/in-room visits and activities if unable to attend out of room events. EX: sports talk, musical ent, social visits/ current eventsDate Initiated: 01/26/2026Revision on: 01/26/2026 [Resident #5] prefers activities which do not involve overly demanding cognitive tasks. Engage in simple, structured activities such as musical ent, socials, current events,Date Initiated: 01/26/2026Revision on: 01/26/2026 When [Resident #5] (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	choose not to participate in organized activities, the resident prefers to listen to music for social and sensory stimulation.Date Initiated: 01/26/2026Revision on: 01/26/2026 Record review of Resident #5's Care Plan reflected no information regarding Advanced Directives, G-Tube (a medical device inserted through the abdomen directly into the stomach to provide nutrition, fluids, and medication to individuals who cannot consume enough by mouth), and dementia. Record review of [Resident #5's] Living Will signed by [Resident #5] on 03/30/2021 revealed:I request that I be kept alive in this terminal condition using available life sustaining treatment. I request to be kept alive in this irreversible condition using available life-sustaining treatment. Record review of Resident #5 's active physician orders, dated 08/23/2025, reflected:**Code Status: FULL CODE. Record review of Resident #5 's active physician orders, dated 02/05/2025, reflected: Other one time a day Liquid Protein 30 mL q day via G tube r/t low albumin and creatinine. Record review of Resident #35's admission face sheet dated 03/05/26 reflected she was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with active diagnoses that included: Type 2 diabetes, hyperlipidemia (high cholesterol), dementia without behavioral disturbance, muscle weakness, neuralgia (intense, sharp, burning, or shock-like pain caused by damaged or irritated nerves, often occurring suddenly along specific nerve pathways) and neuritis (the inflammation of a nerve or a group of nerves, often resulting in pain, sensory disturbances (tingling, numbness), weakness, or loss of reflexes in the affected body part) end stage renal disease (he final, irreversible stage of kidney failure where kidney function drops below 15% of normal), presence of cardiac pacemaker, cardiac arrythmia (abnormal heart rhythm where the heart beats too fast), and dependence on renal dialysis (a life-saving, artificial process that filters waste, toxins, and excess fluid from the blood when kidneys have failed). Resident #35's Advance Directive was Full Code. Record review of Resident #35's Quarterly MDS assessment dated [DATE], reflected a BIMS score of 12 indicating moderate cognitive impairment. Resident #35's MDS Assessment reflected she required dialysis due to renal insufficiency, renal failure, or end-stage renal disease. Resident #35's MDS Assessment reflected a diagnosis of Non-Alzheimer's Dementia, diabetes mellitus, and hyperlipidemia. Record review of Resident #35's Care Plan reflected no information regarding Advanced Directives, and active diagnoses of dementia, end-stage renal disease, and dialysis treatments. Record review of Resident #21's admission face sheet dated 03/05/26 reflected she was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with active diagnoses that included:, dementia without behavioral disturbance, COPD (a group of lung diseases that cause ongoing airflow obstruction and breathing difficulties), schizoaffective disorder a chronic mental health condition combining symptoms of schizophrenia (hallucinations, delusions, disorganized thinking) with a major mood disorder, such as bipolar disorder (mania) , bipolar (a chronic mental health condition causing extreme, often disabling, shifts in mood, energy, and activity levels), anxiety, hypertension (high blood pressure), shortness of breath, and diabetes mellitus with diabetic neuropathy (a type of nerve damage that can happen with diabetes). Resident #21's Advance Directive was Full Code. Record review of Resident 21's Quarterly MDS assessment dated [DATE], reflected a BIMS score of 12 indicating moderate cognitive impairment. Resident #21's MDS Assessment reflected that she required dialysis due to renal insufficiency, renal failure, or end-stage renal disease. Resident #21's MDS Assessment reflected a diagnosis of Non-Alzheimer's Dementia, diabetes mellitus, and hyperlipidemia. Record review of Resident #21's Care Plan dated 12/09/2025 reflected, no information regarding Advanced Directives, and active diagnoses of dementia, COPD, diabetes mellitus, schizoaffective disorder, bipolar, anxiety, hypertension, and Resident #21 being a smoker. In an observation and interview with Resident #21 on 03/03/26 at 1:45 PM, she stated that she had been at the facility for about 5 years. Resident #21 stated that she had COPD and had smoked cigarettes almost her entire life and had medical issues such as shortness of breath because of her smoking cigarettes. Resident #21 stated that several times a day, she will use her walker to go across the street to smoke her cigarettes and buy items such as snacks and drinks from the gas station located (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	across the street from the facility. Resident #21 appeared to be well groomed during her interview and observation. In an interview with the MDS Nurse on 03/05/26 at 12:45 PM revealed, she had been employed at the facility for 10 months. The MDS Nurse stated that at the beginning of her employment at the facility, she was given directives by Corporate Office to begin working on updating the Comprehensive Care Plans for all residents in the facility. She stated that when she began employment at the facility, the software program being utilized was Matrix (a cloud-based EHR and practice management software designed for out-of-hospital care, including skilled nursing, home health, hospice, and senior living). She stated that last year, the facility switched software programs from Matrix to PCC (Point Click Care is cloud-based healthcare technology platform for the senior care market in North America). She stated that Corporate Office's expectation of her was to take a residents Comprehensive Care Plan and place everything from their Comprehensive Care Plans from Matrix and transfer everything into PCC. The MDS Nurse confirmed that many of the Comprehensive Care Plans for residents have not been updated and transferred from Matrix into PCC. She stated that she had started transferring the data from Matrix into PCC, but the task is a huge task for 1 person to complete by herself and the expectation was unrealistic. The MDS Nurse stated that she informed Corporate Office that the Comprehensive Care Plans were not completed and was given a directive from Corporate Office to have a RN open the Comprehensive Care Plans for each resident in PCC. The MDS Nurse stated that transferring and entering data from Matrix to PCC should be a collective collaboration with all departments, but the tasks have not been completed by everyone. The MDS Nurse stated that a resident's Care Plan should be updated and completed because they are the voice for the residents because sometimes, they do not have a voice. The MDS Nurse confirmed that the Care Plans for the 3 residents (Resident #5, Resident #21, and Resident #35) were not updated and completed and the Comprehensive Care Plan situation at the facility is terrible. The MDS Nurse stated that Corporate Office is aware of the Care Plan issue, which was a mess. The MDS Nurse stated that there are several risks associated with a resident's Comprehensive Care Plan not being updated such as their Advanced Directives not being on their Comprehensive Care Plan. She stated that if a resident's choice was DNR and there were not any information on the Comprehensive Care Plan, someone may perform a Full Code and provide CPR to the resident, which is against the resident's choice and that could lead to legal issues and psychological harm to the resident. In an interview with the DON on 03/05/26 at 5:20 PM, she stated that she had been employed at the facility for 2 years. The DON stated that she was unaware that the Care Plans for 3 residents (Resident #5, Resident #21, and Resident #35) were not updated and completed with their medical diagnoses, advanced directives and Resident #21 was a Smoker. The DON stated that the MDS Nurse/Coordinator was responsible for having the resident's data for their Comprehensive Care Plans transferred from Matrix to PCC. The DON stated that each department is responsible for inputting data on a resident's Comprehensive Care Plan, such as Physical Therapy, Dietary, Nursing and Activities. The DON stated that there are risks to a resident if their Comprehensive Care Plan is not updated. The DON stated that if the Comprehensive Care Plan is not up to date, the resident's care needs may not be met because all staff that review resident's Care Plan need to have the most updated information available to care for the residents. The DON stated that there is potential for harm if a resident's Comprehensive Care Plan is not updated. The DON stated that there had not been any harm caused to any resident's due to their Comprehensive Care Plan not being updated. Record review of the facility's policy, Care Plans, Comprehensive Person-Centered, dated 2001 revealed, Policy Statement:A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legalrepresentative, develops and implements a comprehensive, person-centered care plan for each resident.2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion ofthe required MDS assessment (Admission, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Annual or Significant Change in Status), and no more than 21days after admission.3. The care plan interventions are derived from a thorough analysis of the information gathered as part ofthe comprehensive assessment.4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights toparticipate in the development and implementation of his or her plan of care, including the right to:a. participate in the planning process;b. identify individuals or roles to be included;c. request meetings;d. request revisions to the plan of care;e. participate in establishing the expected goals and outcomes of care;f. participate in determining the type, amount, frequency and duration of care;g. receive the services and/or items included in the plan of care; andh. see the care plan and sign it after significant changes are made.5. The resident is informed of his or her right to participate in his or her treatment, and provided advancenotice of care planning conferences.6. If the participation of the resident and his/her resident representative in developing the resident's careplan is determined to not be practicable, an explanation is documented in the resident's medical record.The explanation should include what steps were taken to include the resident or representative in theprocess.7. The comprehensive, person-centered care plan:a. includes measurable objectives and timeframes;b. describes the services that are to be furnished to attain or maintain the resident's highest practicablephysical, mental, and psychosocial well-being, including:(1) services that would otherwise be provided for the above, but are not provided due to theresident exercising his or her rights, including the right to refuse treatment;(2) any specialized services to be provided as a result of PASARR recommendations; and(3) which professional services are responsible for each element of care;c. includes the resident's stated goals upon admission and desired outcomes;d. builds on the resident's strengths; ande. reflects currently recognized standards of practice for problem areas and conditions.8. Services provided for or arranged by the facility and outlined in the comprehensive care plan are:a. provided by qualified persons;b. culturally competent; andc. trauma-informed.9. Care plan interventions are chosen only after data gathering, proper sequencing of events, carefulconsideration of the relationship between the resident's problem areas and their causes, and relevantclinical decision making.10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptomsor triggers.11. Assessments of residents are ongoing and care plans are revised as information about the residents andthe residents' conditions change.12. The interdisciplinary team reviews and updates the care plan:a. when there has been a significant change in the resident's condition;b. when the desired outcome is not met;c. when the resident has been readmitted to the facility from a hospital stay; andd. at least quarterly, in conjunction with the required quarterly MDS assessment.13. The resident has the right to refuse to participate in the development of his/her care plan and medicaland nursing treatments. Such refusals are documented in the resident's clinical record in accordance withestablished policies.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 2 of 2 residents (Resident #85 and Resident#9) reviewed for catheter care. The facility failed to ensure Resident #85 and Resident #9's catheters were not secured with a Stat Lock (used to secure catheters to patients inner thigh) or leg strap. This failure could place residents at risk of urethral tears or dislodging the catheter.Record review of Resident #85's quarterly MDS assessment, dated 01/30/26, reflected a [AGE] year-old female who was originally admitted to the facility on [DATE] and re-entry of 01/24/2026. Her BIMs score was 12, which indicated moderate cognitive impairment. Her diagnosis included neurogenic bladder (a condition that affects the bladder's ability to function properly due to damage or dysfunction in the nerves that control it). Section H-Bowel and Bladder reflected the resident was coded to have indwelling catheter. Record review of Resident #85 's care plans, dated 06/30/25, reflected: The resident requires a suprapubic catheter (a thin, indwelling tube inserted through the lower abdomen into the bladder to drain urine), R/T neuromuscular dysfunction (disorders affecting the nerves controlling voluntary muscles and the muscles themselves, causing breakdown in communication) of bladder associated with Multiple Sclerosis (.a chronic autoimmune disease of the central nervous system where the immune system attacks the protective myelin sheath surrounding nerves, causing communication issues between the brain and body). She is at risk for complications such as catheter related trauma and infections. Facility interventions included: Do not allow tubing or any part of the drainage system to touch the floor. Record review of Resident #85 's active orders, dated 03/04/26, reflected: Suprapubic catheter care Q shift and PRN every 8 hours as needed Every shift as needed. Order start dated 02/23/2026. Suprapubic catheter care Q shift and PRN every shift order start date 02/23/2026. Suprapubic catheter Dx: Neuromuscular Dysfunction of Bladder, Unspecified order started date 02/23/2026. During an observation on 03/04/26 at 1:30 PM revealed Resident #85's indwelling catheter was not secured with a stat lock or leg strap. 2. Record review of Resident #9's quarterly MDS assessment, dated 02/09/26, reflected a [AGE] year-old female originally admitted to the facility on [DATE]. Her BIMs score was 08, which indicated his cognitive status was moderately impaired. Her diagnoses included hypertension (high blood pressure). Section H-Bowel and Bladder H0100 resident was not coded to have indwelling catheter. Section M -M0300 skin Conditions reflected Resident #9 was not coded to have current pressure ulcer. Record review of Resident #9's active care plan reflected no care plan problem goals, or intervention related to the resident's Indwelling catheter. Record review of Resident #9's active physician orders, dated 03/04/26, reflected: Flush foley with 60cc NS as needed obstruction/occluded: start date 01/09/2026. Record review of Resident #9 's active orders, dated 03/04/26, reflected Foley catheter 18french/10ml balloon dx: wound healing as needed for leakage, blockage, and sedimentation may change foley catheter start date 01/09/2026. Record review of Resident #9 's active orders, dated 03/04/26, reflected Foley catheter 18french/10ml balloon dx: wound healing every shift for wound healing monitor leg strap placement start date 01/09/2026. During an observation on 03/04/26 at 1:40 PM revealed Resident #9's indwelling catheter was not secured with a stat lock or leg strap. During an interview on 03/04/26 at 1:43 PM with LVN A revealed she was Resident #85's and Resident #9's nurse. She stated she always checked to make sure the indwelling catheter was secured to the resident's inner thigh when doing her daily assessments. She stated the indwelling catheters should always be secured with a stat lock or leg strap to the resident's inner thigh. She stated the risk to the resident was pulling or dislodgement of the indwelling catheter. She stated she was in serviced on foley catheter care. During an interview on 03/04/25 at 1:57 PM with CNA J revealed if the resident's (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stat lock came off, she would notify the nurse. She stated the risk to the resident was the catheter would cause injury to the resident if it pulled and dislodged. She stated she was in serviced on catheter care. During an interview on 03/04/25 at 1:57 PM with CNA G revealed she was assigned to Resident#85. She stated she did not know the foley catheter was supposed to be secured with a device to prevent it from moving. She stated she made sure the catheter was positioned so it did not pull and dislodge. She stated she was in serviced on foley catheter care. During an interview on 03/04/25 at 2:47 PM with the ADON revealed the nurses were responsible for ensuring residents indwelling catheters were always secured with a stat lock or leg strap to the resident's inner thigh. She stated the risk to the resident was injury-like urethral tears and dislodgement of the indwelling catheter. She stated the nurses and CNAs were in-serviced on indwelling catheter. During an interview on 03/04/26 at 4:26 PM with the DON revealed her expectation was that nurses checked to ensure indwelling catheters were secure when providing catheter care every shift. She stated indwelling catheters should be secured with a stat lock or leg strap to the resident inner thigh. She stated the risk to the residents was dislodgment of the catheter. She stated the staff were in serviced on foley catheter care. Record review of the facility's policy, Catheter Care, Urinary, dated July 2024, reflected: Changing Catheters1. Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as obstruction, or when the closed system is compromised.2. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh.)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable, for 5 residents (Resident# 71, Resident# 13, Resident#34's, Resident# 75, Resident# 42) on 2 of 3 medication carts reviewed for medication storage (200 hall and 100 (secure unit) hall Medication cart) The facility failed to ensure Resident# 71's expired Nitroglycerin (a fast-acting medication used to treat or prevent angina (chest pain) by relaxing blood vessels, which increases oxygen-rich blood flow to the heart) was removed from the 100 Hall nurses' medication cart and disposed of. The facility failed to ensure Resident#34's expired morphine (a potent, fast-acting opioid used for severe acute or chronic pain management and sometimes for severe shortness of breath) was removed from the 200 hall nurses' medication cart and disposed of. The facility failed to ensure Resident# 13's Nystatin (a prescription antifungal agent used to treat skin infections) was stored in the medication cart and not in the resident's room. The facility failed to ensure Resident# 75's Nystatin (a prescription antifungal agent used to treat skin infections) was stored in the medication cart and not in the resident's room. The facility failed to ensure Resident#42's discontinued triamcinolone 0.1% cream (a prescription-strength corticosteroid used to treat skin conditions reducing itching, redness, and inflammation) was removed from the 100 hall nurses' medication cart and disposed of. The facility failed to ensure an opened bottle of Keppra 100 mg/ml was labeled with the resident's name before storing it in the 200 hall nurses' medication cart. The facility failed to ensure an expired bottle of Colace 100 mg was removed from the 100 hall nurses' medication cart and disposed of. The facility failed to ensure an expired opened bottle of oyster shell calcium 500mg was removed from the 100 hall nurses' medication cart and disposed. These failures could place residents at risk for compromised medication efficacy, unsafe administration, and increased harm to residents. Record review of Resident #71's Quarterly MDS assessment, dated 02/23, 2026, reflected he was a [AGE] year-old male re-admitted to the facility on [DATE]. His BIMs score was 04, indicating his cognitive status was severely impaired. His diagnoses included hypertension. Record review of Resident #71's active care plan, as of 01/23/2026, revealed no care plan problem goals, or intervention related to the resident's prescribed medication. Record review of Resident #71's active Physician Order, dated 3/3/26, reflected: NITROGLYCERIN 0.4 MG TABLET SL Give 1 tablet sublingually every 5 minutes as needed for Chest pain Q5mins PRN for chest pain x3 days. If there is no relief call MD. Order start date 09/09/2025. Record review of Resident #34's Quarterly MDS assessment, dated 02/23/2026, reflected she was [AGE] year-old female originally admitted [DATE], re admitted to the facility on [DATE]. Her BIMs score was 08, indicating her cognitive status was moderately impaired. Her diagnoses included Medically Complex Conditions (with severe, chronic, and multi-system conditions requiring intensive, ongoing, and specialized care). Record review of Resident #34's active care plan revealed Date Initiated: 01/15/2026 Acute Pain / Chronic Pain. Facility interventions: Administer prescribed medication before activity and therapy. Record review of Resident #34's active care plan Date Initiated: 01/15/2026, revealed: Risk for Impaired Circulatory. Facility interventions: Administer pain medications per order if non-medication interventions are Ineffective. Record review of Resident #34's active Physician Order, dated 3/3/26, reflected: Morphine Sulfate (Concentrate) Oral Solution 20MG/ML (Morphine Sulfate) Give 0.25 ml by mouth every 1 hour as needed for Pain - Mild; Shortness of Breath. Order start dated 09/23/2025.Record review of Resident #34's active Physician Order, dated 3/3/26, reflected: Morphine Sulfate (Concentrate) Oral Solution 20MG/ML (Morphine Sulfate) Give 0.5 ml by mouth every 1 hours as needed for Pain - Moderate; Shortness of Breath. Order start (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 09/23/2025.Record review of Resident #34's active Physician Order, dated 3/3/26, reflected: Morphine Sulfate (Concentrate) Oral Solution 20MG/ML (Morphine Sulfate) Give 0.75 ml by mouth every 1 hours as needed for Pain - Moderate ;Shortness of Breath Order start dated 09/23/2025 Record review of Resident #34's active Physician Order, dated 3/3/26, reflected: Morphine Sulfate (Concentrate) Oral Solution 20MG/ML (Morphine Sulfate) Give 1 ml by mouth every 1 hours as needed for Pain - Severe; Shortness of Breath. Order start dated 09/23/2025. Record review of Resident #13's Quarterly MDS assessment, dated 01/28, 2026, reflected he was a [AGE] year-old male re-admitted to the facility on [DATE]. His BIMs score was 04, indicating his cognitive status was severely impaired. His diagnoses included hypertension. Record review of Resident #13's active care plan, as of 10/13/25, revealed: Resident is at risk for pressure ulcers R/T limited mobility and incontinent: Interventions include: Keep clean and dry as possible. Minimize skin exposure to moisture. Record review of Resident #13's active Physician Order, dated 3/3/26, reflected: Nystatin External Powder 100000 UNIT/GM (Nystatin Topical) Apply to Groin topically two times a day Order start date:02/05/2026. Record review of Resident #75's Quarterly MDS assessment, dated 02/25, 2026, reflected she was a [AGE] year-old female admitted [DATE] re-admitted to the facility on [DATE]. Her BIMs score was 10, indicating her cognitive status was moderately impaired. Her diagnoses included hypertension and cancer. Record review of Resident #75's active care plan, as of 01/23/2026, revealed no care plan problem goals, or intervention related to the resident's prescribed medication. Record review of Resident #75's active Physician Order, dated 3/3/26, reflected: Nystatin External Powder 100000 UNIT/GM Nystatin (Topical) Apply to Skin folds topically every day and evening shift for Redness. Order start date 01/02/2026. Record review of Resident #42's Quarterly MDS assessment, dated 02/11/ 2026, reflected he was a [AGE] year-old female admitted [DATE] re-admitted to the facility on [DATE]. No BIMs score was recorded. Her diagnoses included hypertension and pneumonia. Record review of Resident #42's active care plan. Dated 06/27/2025 reflected Resident is at risk for pressure ulcers due to impaired sensory perception. Interventions included skin assessment and inspection weekly. Record review of Resident #42's active Physician Order, dated 3/3/26, reflected: No active orders for triamcinolone 0.1% cream apply 1 application to affected area externally for 30 days. During an observation on 3/3/26 at 9:41 am with LVN C on the 100 East nurses' med cart revealed Resident# 71's expired Nitroglycerin, Resident#42's discontinued triamcinolone 0.1% cream, expired bottle of Colace 100 mg and an expired opened bottle of oyster shell calcium 500mg. During an interview on 3/3/26 at 9:47 AM with the LVN C she said it was the nurse's responsibility to ensure all medication in the cart was properly labeled and within date. She stated Resident#42's triamcinolone 0.1% cream was discontinued. She stated all expired and discontinued medication should be removed immediately from the medication cart and disposed of or given to the DON for destruction. She stated the risk to the resident was administering expired medication that would be ineffective and could have adverse reaction to the resident and leading to hospitalization. She stated the risk of discontinued medication was medication error due to administering medication with no active physician orders. She stated she had been in-serviced on medication storage and labeling. During an observation on 3/4/26 at 9:55am in Resident# 13's room revealed white powder in a medication cup with the resident's name and room number on Residents #13's nightstand. Resident#13 was not interview able and could not explain what was in the medication cup. During an interview on 3/4/26 at 9:57am with the ADON revealed she was the nurse assigned to Resident #13. She stated that the white powder was nystatin powder. She stated she was not sure who put the medication in the resident's room. She stated that medication should not be left in the resident's room. She stated the risk of leaving medication in a resident's room was that another resident would have access to the medication or a resident could overdose without the staff knowing. During an observation on 3/4/26 at 10:55am in Resident# 75's room revealed a bottle of Nystatin External Powder 100000 UNIT/GM on the resident's TV stand. Resident #75 requested that surveyor get her another bottle of nystatin powder so she can have two bottles because the one in the room was (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	halfway through and she did not want to run out. She stated she applied the powder to areas with skin folds and kept the medication in her room all the time. During an interview on 3/4/26 at 10:57am with the LVN B revealed Resident#75 should not have medication in her room and that all her medication was to be administered by the nurses only. She stated the risk to the resident was another resident having access to the medication or the resident could overdose on medication. She stated that she had been in-serviced on medication storage and labeling. During an observation on 3/4/26 at 2:21 PM with RN F on the 200 nurses' medication cart revealed Resident #34's expired morphine, Keppra 100 mg/ml with no patient label. During an interview on 3/4/26 at 2:32 PM with RN F revealed it was the nurses' responsibility to ensure all medication had the patients label, and all medications were within date. She stated if the label came off the nurse was to contact pharmacy or send the medication back for proper labeling or follow any instructions given by pharmacy to include discarding the medication. She stated the risk to the residents was medication error and medication not being effective due to expiration. She stated that she had been in-serviced on medication storage and labeling. During an interview on 3/04/2026 at 3:32PM with LVN E revealed nurses were responsible for ensuring the medication carts were clean, all medications were within date, and all medications had proper patient labels. She stated if medication did not have the proper label, it would not be possible to complete medication rights before administering medication to a resident. She stated risk to the resident when there was expired medication in the cart was medication would lose its potency and not be effective to treat the resident leading to health complications including hospitalization. During an interview on 3/04/2026 at 3:45 PM with ADON revealed the nurses were responsible for ensuring the medication cart was clean, and all medications were within date, and properly labeled. She stated the pharmacy consultant audits the medication rooms and the medication carts monthly. She stated the risk to the resident when expired medication is in the medication cart was accidentally administering expired medication which could be ineffective or could cause adverse reaction to the residents stated if medication does not have the proper label to include a resident's name it could lead to medication error. She stated the nurses had been in-serviced on medication storage. During an interview on 03/4/26 at 4:04 PM, the DON stated her expectation was the nurses would ensure there was no expired medication in the medication cart and all medications had the proper label with the right resident's name. She stated the nurses were responsible for ensuring the medication cart was clean, and all medications were within date, and properly labeled. She stated the pharmacy consultant audits the medication rooms and the medication carts monthly. She stated the risk to the resident when expired medication is in the medication cart was accidentally administering expired medication which could be ineffective or could cause adverse reaction to the residents stated if medication does not have the proper label to include a resident's name it could lead to medication error. She stated the nurses had been in-serviced on medication storage. Review of the facility's policy Medication Storage and Labeling in the Facility Revised February 2023 reflected the following:1. Medications and biologicals are stored in the packaging containers or other dispensing systems they are received in. Only the issuing pharmacy is authorized to transfer medications between containers.3. If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.6. Medication requiring refrigeration is stored in a refrigerator located in the medication room at the nurse's station or other secured location. Medications are stored separately from food and are labeled accordingly.Medication labeling1. Labeling of medication and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceuticals practices.2. The medication label includes, at a minimum:a. Medication name (generic and /or brand).b. Prescribed dose.c. Strength d. Expiration date, when applicable.e. Residents' name.f. Route of administration; andg. Appropriate instructions and precautions.8. If medication containers are missing, incomplete, improper, or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, and interview, the facility failed to provide foods which were palatable, attractive, and at a safe and appetizing temperature for 1 of 1 meal observed for food preparation. (lunch 03/04/26). 1.The facility failed to serve food at an appetizing temperature for the lunch meal on 03/04/26 for the regular, mechanical soft and pureed meals. This failure could place residents who consumed food prepared in the kitchen at risk for reduced meal satisfaction, diminished nutritional intake, weight loss and a decreased quality of life.Findings included: In confidential resident interviews on at an undisclosed date and time, the residents stated that their food for all 3 of their daily meals was often cold. In an observation on 03/04/26 at 12:30 PM, the State Survey Team participated in the sampling of the Lunch Meal which included 3 Test Trays (regular, mechanical, and puree). The 3 lunch trays were served with covered tops. The 3 Test Trays consisted of roasted pork loin, baked sweet potato, seasoned cauliflower, and dinner roll. The food on all 3 Test Trays were cold. In an Interview with [NAME] L on 03/04/2026 at 2:54 PM, she stated he had been employed at the facility for 1 1/2 years. She stated that she was unaware that all the meals on the State Surveyors Test Tray were cold. She stated that temperatures of each meal are taken daily. [NAME] L stated that she did not receive any returned food trays to the kitchen after the Lunch Meal on 03/04/26. She stated that if a resident received cold food, she advised the staff to return the food to the kitchen and the resident will be served another food tray, which food temperatures would be taken to ensure that the replacement food tray is warm and not cold. [NAME] L stated that the food trays [NAME] L stated that if anyone ingested cold food from the facility's kitchen, there was a risk of sickness such as diarrhea and vomiting, which can cause some harm to the body. In an interview with Dietary Manager on 03/04/26 at 3:13 PM she stated he had been employed at the facility for 1 1/2 years. The Dietary Manager stated that her expectation is that all meals to be served from the facility's kitchen are warm and flavorful. The Dietary Manager tasted the pureed mashed potatoes and confirmed the mashed potatoes lacked flavor. The Dietary Manager revealed it was the responsibility of the kitchen staff to taste the food for palatability, flavor and temperatures before the food was served to the residents. The Dietary Manager stated that she did not try the food served from the facility's kitchen for the lunch meal served on 03/04/26. The Dietary Manager stated that the food temperatures are taken every day and the problem is that the food trays are taken from the kitchen to the floor and the staff are not giving the food to the residents in a timely manner, therefore the food trays may be cold when they are given to the residents. The Dietary Manager stated that there was a risk of anyone to become sick and ill if they eat food from the facility's kitchen that is cool. She stated that different foods are supposed to be eaten at a certain temperatures and harm can be caused to a person's stomach if they ingest cold food. In a confidential group interview on an undisclosed date and time, residents said their food was seldom hot when it arrived to their rooms. In an interview with the Administrator on 03/05/26 at 4:00 pm, he stated that his expectation that the food was served to the residents warm and not cold. The Administrator stated that if residents were to receive cold food, they can notify the staff and a new tray would be provided to them. He stated that he had eaten the food from the facility's kitchen before and he did not have any concerns. The Administrator revealed that he did not try the food served from the facility's kitchen for lunch served on 03/04/26. Record review of the facility's policy, Food and Nutrition Services, dated 2001 and revised October 2017 revealed, Policy Statement:Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional andspecial dietary needs, taking into consideration the preferences of each resident.Policy Interpretation and Implementation:1. The multidisciplinary staff, including nursing staff, the attending physician and the dietitian will assess eachresident's nutritional needs, food likes, dislikes and eating habits, as well as physical, functional, andpsychosocial factors that affect eating and nutritional intake and utilization.7. Food and nutrition services staff will inspect food trays to ensure that.the food appears palatable and attractive, and it (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	is served at a safe and appetizing temperature.a. a meal does not appear palatable, nursing staff will report it to the food service manager so that a new food tray can be issued. Record review of the facility's policy, Food Preparation and Service, dated 2001 and revised November 2022 revealed, Policy Statement:Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe foodhandling practices.Policy Interpretation and Implementation1. Danger Zone means temperatures above 41 degrees Fahrenheit (F) and below 135 degrees F that allowthe rapid growth of pathogenic microorganisms that can cause foodborne illness. Potentially HazardousFoods (PHF) or Time/Temperature Control for Safety (TCS) Foods held in the danger zone for more than4 hours (if being prepared from ingredients at ambient temperature) or 6 hours (if cooked and cooled) maycause a foodborne illness outbreak if consumed. 2. Potentially Hazardous Food (PHF) or Time/Temperature Control for Safety (TCS) Food meansfood that requires time/temperature control for safety to limit the growth of pathogens (i.e., bacterial orviral organisms capable of causing a disease or toxin formation). Examples of PHF/TCS foods includeground beef, poultry, chicken, seafood (fish or shellfish), cut melon, unpasteurized eggs, milk, yogurt andcottage cheese. General Guidelines:1. Identification of potential hazards in the food preparation process and adhering to critical control points canreduce the risk of food contamination and thereby minimize the risk of foodborne illness. Food Preparation, Cooking and Holding Time/Temperatures1. The danger zone for food temperatures is above 41 F and below 135 F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness.2. Potentially hazardous foods include meats, poultry, seafood, cut melon, eggs, milk, yogurt and cottage cheese.3. The longer foods remain in the danger zone the greater the risk for growth of harmful pathogens. Therefore, PHF must be maintained at or below 41 F or at or above 135 F.7. Fresh, frozen or canned fruits and vegetables are cooked to a holding temperature of 135 F.Food Distribution and Service:1. Proper hot and cold temperatures are maintained during food distribution and service.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen safety. 1. The facility failed to ensure food in the facility's dry storage, refrigerator, and freezer areas were labeled and dated according to guidelines. 2. The facility failed to seal open items in plastic bags in the dry storage pantry, refrigerator, and freezer areas. 3. The facility failed to ensure that expired items in the dry storage pantry and freezer areas were removed. 4. The facility failed to ensure that dented cans were removed in the dry pantry area were separated from the other canned food. These deficient practices could affect residents who received meals and/or snacks from the main kitchen and place them at risk for cross contamination and other food-borne illnesses.Findings Included: Observation of the kitchen during the brief initial tour of the kitchen on 03/03/26 at 9:45 AM, revealed the following: Dry Pantry area:* 1 package of 6.6 oz. presweetened lemonade flavored soft drink mix with an expiration date of 07/10/25.* 5 packages of 6.6 oz. presweetened orange flavored soft drink mix with an expiration date of 09/05/25.* 9 boxes of 16 oz. baking soda with an expiration date of 02/22/26.* 1 package of 106 oz. pasta noodles were unsealed and exposed to air.* 2 boxes of 36 oz. grain and wild rice were unsealed and exposed to air.* 1 opened bag of 25 lb. bag of seasoned fish fry was unsealed in an unsealed brown box and exposed to air.* 1 white plastic container of 5 lb. creamy peanut butter was unsealed and exposed to air.* 1 blue plastic bag of infused dried cranberries was unsealed in an unsealed box and exposed to air.* 1 box of lasagna was unsealed and exposed to air.* 2-gallon bag of graham cracker crumbs was unsealed and exposed to air.* 1 plastic container of labeled sugar was unsealed and exposed to air.* 1 dented can of 106 oz. spaghetti sauce.* 1 dented can of 105 oz. sliced pears.* 1 dented can of 106 oz. Manwich sloppy joe.* 1 dented can of 106 oz. black beans. Refrigerator area:* 1 plastic Ziploc bag labeled, bread was unsealed and exposed to air. Freezer area:* 1 blue plastic bag of pureed bread and dessert mix was unsealed in an unsealed box and exposed to air.* 1 blue plastic bag of chocolate chip cookies was unsealed in an unsealed box and exposed to air.* 1 container of vanilla ice cream was unsealed and exposed to air.* 1 box of shredded hash browns with an expiration date of 09/03/25. In an interview with the Interim Dietary Manager on 03/03/26 at 10:15 AM, she stated that she had been employed at the facility for 1 1/2 years. The Dietary Manager was informed about the state surveyors findings during the initial brief tour of the kitchen, which included dented cans, labeling, expired and unsealed items in the dry storage, refrigerator, and freezer areas. She stated that she performed daily checks in the dry storage, refrigerator and freezer areas in the facility's kitchen. She stated that the items that were found by the state surveyor were overlooked by mistake. She stated that the staff in the kitchen are all responsible for ensuring that the items in the dry storage, refrigerator, and freezer areas in the kitchen are labeled, including the name of the item, the date the item was stored and the use by date. She stated that all items in the dry storage, refrigerator, and freezer areas in the kitchen should be sealed and closed and expired items, if found should be immediately thrown away. She stated that all items that were unsealed in the kitchens dry pantry, refrigerator and freezer areas during the brief tour of the kitchen would immediately be discarded and thrown in the trash. She stated that if staff found dented cans, the dented cans were to be immediately removed from the shelf and placed in the designated area that is marked as Dented Cans. The Dietary Manager stated all kitchen staff have been reeducated and retrained on Food Storage, Food Safety and Food Preparation via in-service training. She stated that the staff also have been reeducated on using the First In, First Out (an asset management and valuation method where the oldest inventory, stock, or data items are processed, sold, or used first) procedures to ensure there were not any expired food items throughout the dry pantry, refrigerator, and freezer areas facility's kitchen. The Dietary (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Manager stated that she would inform all kitchen staff of the findings of the state surveyor's initial brief tour of the kitchen and provide an In-Service Trainings. She stated if staff were to find any food items such as expired items, her expectation was they immediately throw away the item (s) and inform her about the item (s) that were thrown away. She stated if any item (s) were not labeled and/or dated, her expectation was for her staff to inform him of their findings, therefore she would reeducate and retrain all kitchen staff through in-service training. She stated all kitchen staff were to ensure items in the kitchen's dry pantry, refrigerator, and freezer areas were not expired, unsealed, labeled and dated. She stated the kitchen staff were reeducated and retrained through in-service training regularly, at least monthly. She stated that she could not recall when the kitchen staff received their previous in-service training on Food Storage was taken. She stated if anyone ate food from the kitchen that was expired, dented cans and unsealed containers or bags, there was risk of becoming very ill, which could cause them to have stomach aches, vomiting and diarrhea. In an interview with [NAME] L on 03/04/26 at 11:35 AM, she stated he had been employed at the facility for 1 1/2 years. She stated that she was unaware there were expired and unsealed items in the dry storage, and refrigerator areas. [NAME] L stated that the Dietary Manager informed the kitchen staff about the state surveyors findings during the initial brief tour of the kitchen on 03/03/26. She stated all the staff were responsible for labeling and storing the items on the shelf and checking the expiration dates on everything in the dry storage, refrigerator, and freezer areas in the facility's kitchen. [NAME] L stated dented cans were to be immediately removed from the shelf with the other dented cans and placed in the designated area marked Dented Cans. [NAME] L stated that all kitchen staff received previous education and training on food storage utilizing the FIFO method. [NAME] L stated if she observed food that was expired and/or unsealed, and not labeled in the dry pantry, refrigerator, and/or freezer areas, she would immediately trash the item(s), then immediately notify the Dietary Manager of her findings. [NAME] L stated that prior to 03/03/26, the Dietary Manager provided several In-Service training courses for all kitchen staff on food storage, handling and preparation. [NAME] L stated if someone ingested food from the facility's kitchen dry pantry, refrigerator and freezer areas that were unsealed or expired, they were at risk for food-borne illness from cross-contamination and could become sick. She stated that any ingestion of food that had been unsealed or expired, can cause a person to have stomach issues including stomach aches, diarrhea and vomiting. Record review of the facility's policy, Food Receiving and Storage, dated 2001 and November 2022 revealed, Policy Statement:Foods shall be received and stored in a manner that complies with safe food handling practices.Dry Food Storage:. 3. Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging untilthey are ready to use.4. Dry foods that are stored in bins are removed from original packaging, labeled and dated (use by date).Such foods are rotated using a first in - first out system.Refrigerated/Frozen Storage:1. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date).3. Refrigerated foods are stored in such a way that promotes adequate air circulation around food storagecontainers.7. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded.8.Wrappers of frozen foods must stay intact until thawing. Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306. Tag: F689/N4027S/S= DSurveyor Name: [NAME] BrimidgeImmediate Supervisor: [NAME] DoyleBased on observation, interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 1 (200 Hallway) out of 2 hallways reviewed for accidents and hazards. 1.The facility failed to ensure that the mechanical lift on the 200 Hallway was locked and secured when not in use. 2.The facility failed to ensure that the mechanical lift on the 200 Hallway in the entry of the Dining/Activity Room (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	area was locked and secured when not in use. These failures could place residents at risk of falls and/or injury. Findings Include:Observation of the facility's 200 Hallway on 03/04/26 at 10:15 AM revealed an unlocked and unsecured mechanical lift parked in front of a resident's room. Observation of the facility's 200 Hallway on 03/04/26 at 12:01 PM revealed an unlocked and unsecured mechanical lift parked in front of a resident's room. Observation on 3/04/2025 at 12:11 PM revealed an unlocked Mechanical Lift on the 200 Hallway near the 2nd floor elevator in front of the entry to the dining room. Residents and staff were observed going around the Mechanical Lift as they entered and exited the Dining/Activity Room. In an interview on 3/04/2025 at 12:21 PM with CNA I, she stated that she should not have left the Mechanical Lift by the elevator on the 200 Hallway in front of the entry to the Dining/Activity Room. She stated she used the Mechanical Lift for a resident and had to take a resident downstairs due to being in a rush and did not store the Mechanical Lift in the Supply Room where the Mechanical Lifts are stored. CNA I stated that when she placed the Mechanical lift where it was observed by the Surveyor, she did not lock the Mechanical Lift. CNA I stated that she had taken previous In-Service Trainings on accidents, hazards and Mechanical Lift Storage. CNA I stated that leaving an unattended and unlocked Mechanical Lift in the Hallways, there was a risk for residents to be injured, which there is a potential for harm. CNA I stated that all Mechanical Lifts were to be stored in the designated area on the 200 hallway. CNA I stated that there was a risk that a resident could fall and trip on an unlocked and unsecured Mechanical Lift in the Hallways. CNA I stated that a resident can fall and hit their head or have bruises if they were trying to lift themselves using an unlocked and unsecured Mechanical Lift for assistance with standing. In an interview on 3/04/2026 at 12:30 PM with CNA A revealed that she observed residents going around the unlocked and unsecured Mechanical Lift that was near the elevator in the walkway of the dining/activity room. CNA A confirmed that she observed the residents as they exited the dining/activity room and observed the residents that were from the elevator. CNA A stated the reason she did not move the unlocked and unsecured Mechanical Lift from the area was because she had a food tray in her hands. CNA A stated that all Mechanical Lifts are to be stored at all times in the facility's Utility Room on the 200 Hallway. CNA A stated that she had previously taken In-Service training on accidents, hazards and Mechanical Lifts and Mechanical Lift Storage. CNA A stated that residents could be at risk for injuries when an unlocked Mechanical Lift is left on the hallway and not stored in the designated area. CNA A stated that improper storing equipment, such as Mechanical Lift could result in a resident(s) injuring or cutting themselves. In an interview with LVN E on 03/05/26 at 3:46 PM, she stated that she had been employed at the facility for 5 months. She stated that she was unaware that there were 2 Mechanical Lifts unlocked and unsecured in different areas on the 200 Hallway on 03/04/26. LVN E stated that Mechanical Lifts should not be stored on the hallways and should be stored in the Utility Closet on each floor. LVN E stated that all staff have been trained via In-Service training on accidents, hazards and Mechanical Lifts and Mechanical Lift Storage. LVN E stated that all staff would be reeducated and retrained on Mechanical Lifts and Mechanical Lift Storage including safety, accidents, and hazards. LVN E stated that the Mechanical Lift being stored in the hallway was a fire hazard. LVN E revealed that every staff member was responsible for ensuring equipment was locked and safely stored. LVN E stated that there is a risk of someone hitting their head or tripping on an unlocked and unsecured Mechanical Lifts that are stored in the hallway. LVN E stated that if someone tripped on a Mechanical Lift that was stored in the hallway, they could have a fall and break their hips, break their legs, have superficial injuries, which may require sutures. In an interview with the DON on 03/05/26 at 5:20 PM, she stated that she had been employed at the facility for 2 years. The DON stated that she was unaware that there were 2 Mechanical Lifts unlocked and unsecured in different areas on the 200 Hallway on 03/04/26. The DON stated that all mechanical lifts were to be stored safely in the Utility Room near the Nurses Station on the 200 Hallway when they were not in use. The DON stated that Mechanical Lifts should never be stored on the hallways and should not block the entry or exit areas. The DON stated that she had provided ongoing In-Service training with (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	all staff regarding safety, accidents, hazards and Mechanical Lifts including Mechanical Lift Storage. She stated that she will reeducate staff with In-Service training on Mechanical Lifts and Mechanical Lift Storage. She stated that there was a risk to anyone to incur injuries when there was an unlocked and unsecured Mechanical Lift stored on the Hallways. The DON stated that there was a potential of harm to anyone if an unlocked and unsecured Mechanical Lift stored on the hallways. The DON stated that residents can slip and/or fall if there was an unlocked and unsecured Mechanical Lift stored on the hallways. Record review of the facility's policy, Safety and Supervision of Residents, dated 2001 and November July 2017 revealed, Policy Statement:Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.Policy Interpretation and ImplementationFacility-Oriented Approach to Safety1. Our facility-oriented approach to safety addresses risks for groups of residents.2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization.3. When accident hazards are identified, the QAPI/safety committee shall evaluate and analyze the cause(s) of the hazards and develop strategies to mitigate or remove the hazards to the extent possible.4. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents.5. The QAPI committee and staff shall monitor interventions to mitigate accident hazards in the facility and modify as necessary.Individualized, Resident-Centered Approach to Safety1. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents.2. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents.3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.4. Implementing interventions to reduce accident risks and hazards shall include the following:a. Communicating specific interventions to all relevant staff;b. Assigning responsibility for carrying out interventions;c. Providing training, as necessary;d. Ensuring that interventions are implemented; ande. Documenting interventions.5. Monitoring the effectiveness of interventions shall include the following:a. Ensuring that interventions are implemented correctly and consistently;b. Evaluating the effectiveness of interventions;c. Modifying or replacing interventions as needed; andd. Evaluating the effectiveness of new or revised interventions.Systems Approach to Safety:1. The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly.2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment.3. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition.Resident Risks and Environmental Hazards1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following:.b. Safe lifting and movement of residents;c. Falls;.e. Unsafe wandering;g. Electrical safety.2. Other topics related to resident risk and environmental hazards may be addressed within related policies and procedures (for example, adequate lighting is addressed under the topic of falls). Record review of the facility's policy, Lifting Machine, Using a Mechanical, dated 2001 revealed, Purpose:The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. It is not a substitute for manufacturer's training or instructions.General Guidelines:.2. Mechanical lifts may be used for tasks that require:a. Lifting a resident from the floor;b. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Transferring a resident from bed to chair;c. Lateral transfers;d. Lifting limbs;e. Toileting or bathing; [NAME]. Repositioning.3. Types of lifts that may be available in the facility are:a. Floor-based full body sling lifts;b. Overhead full body sling lifts; andc. Sit-to-stand lifts.3. Types of lifts that may be available in the facility are:a. Floor-based full body sling lifts;b. Overhead full body sling lifts; andc. Sit-to-stand lifts.Steps in the Procedure:. 7. Make sure the lift is stable and locked.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure assessments accurately reflected the resident's status for 1 of 5 residents (Resident#9) reviewed for accuracy of assessments. The facility failed to ensure Resident #9's MDS accurately reflected the resident's clinical status for indwelling catheter and pressure ulcers. This failure could place residents at risk inaccurate resident assessments, inappropriate care planning, and misrepresentation of the residents' condition. Record review of Resident #9's Quarterly MDS assessment, dated 02/09/26, reflected a [AGE] year-old female who was originally admitted to the facility on [DATE]. Her BIMs score was 08, which indicated his cognitive status was moderately impaired. Her diagnoses included hypertension (high blood pressure). Section H-Bowel and Bladder H0100 reflected the resident was not coded to have an indwelling catheter. Section M -M0300 skin Conditions Resident #9 was not coded to have current pressure ulcer. Record review of Resident #9 's care plans, dated 12/12/2025 and Revision on: 02/02/2026, reflected: I have actual impairment to skin integrity of the coccyx r/t rash (irritant contact dermatitis) stage 3 pressure ulcer. Facility interventions: Observe my skin. Keep my skin clean and dry. Hydrate my skin with lotion, as needed. I will specify any areas that should not have lotion applied coccyx. Report any skin alterations to nurses. Observe/document/report location, size, and treatment of skin injury and/or any new or worsened alterations in skin integrity. Weekly treatment documentation to include measurement of each area(s) of skin breakdown: width, length, depth; type of tissue and exudate; and any other notable changes or observations. Report improvements and declines to the MD. Record review of Resident #9 's active physician orders, dated 03/05/26, reflected: Flush foley with 60cc NS as needed obstruction/occluded: start date 01/09/2026. Record review of Resident #9 's active orders, dated 03/05/26, reflected foley catheter 18french/10ml balloon dx: wound healing as needed for leakage, blockage, and sedimentation may change foley catheter start date 01/09/2026. Record review of Resident #9 's active orders, dated 03/05/26, reflected foley catheter 18french/10ml balloon dx: wound healing as needed for soiled replace leg strap start date 01/09/2026. Record review of Resident #9 's active orders, dated 03/05/26, reflected foley catheter 18french/10ml balloon dx: wound healing every shift foley catheter care with soap and water start date 01/09/2026. Record review of Resident #9 's active orders, dated 03/05/26, reflected foley catheter 18french/10ml balloon dx: wound healing every shift for wound healing monitor leg strap placement start date 01/09/2026. Record review of Resident #9 's active orders, dated 03/05/26, reflected Foley catheter care Q shift and PRN every shift Phone. Record review of Resident #9 's active orders, dated 03/05/26, reflected wound care: cleanse coccyx with wound cleanser apply Manuka High Density superlite with superabsorbent. Daily and PRN one time a day for irritant contact dermatitis (common skin inflammation causing red, itchy, dry rashes, often triggered by immune system responses, genetics, or environmental irritants/allergens) one time a day for wound Record review of Resident #9 's active orders, dated 03/05/26, wound care: cleanse coccyx with wound cleanser apply medical honey fiber with superabsorbent. Daily and PRN May use Medi Honey paste and calcium alginate until Medi honey fiber come in. one time a day for irritant contact dermatitis order start date 02/18/2026. Record review of Resident #9's physician orders reflected the resident had an indwelling urinary catheter in place during the assessment period. During wound care observation on 3/5/2026 at 12:45 PM revealed Resident #9 had wound to the coccyx, and she had an indwelling urinary catheter draining yellow urine to gravity. During an interview on 3/5/2026 at 1:30 PM, the MDS Coordinator reviewed the record and acknowledged Resident #9 had an indwelling urinary catheter during the assessment reference period and should have been coded accordingly on the MDS assessment. She stated she was responsible for coding the residents urinary catheter in the MDS. She stated the risk to the resident was inaccurate care planning as the care plan relied on the MDS data to identify clinical conditions and develop appropriate interventions. During an (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 3/5/2026 at 2:23 PM, the ADON stated the MDS Coordinator was responsible for MDS coding. She stated the care plans were pulled from the MDS. She stated the risk to the residents when the MDS was not coded correctly was there would be an inaccurate care plan which could put the residents at risk of not receiving the care they needed. She stated the nurses did assessments on admission and every shift and they were aware Resident #9 had a Foley catheter and received the care she needed. During an interview on 3/5/2026 at 3:23 PM with the DON revealed Resident #9 had an indwelling catheter during the assessment period. She stated each department inputted in different parts of the care plan, but the MDS coordinator was responsible for the overall MDS. She stated the risk to the resident, when the MDS was not coded correctly, was an inaccurate care plan which could put the resident at risk of not receiving the care they need.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 1 (200 Hallway) out of 2 hallways reviewed for accidents and hazards. 1.The facility failed to ensure that the mechanical lift on the 200 Hallway was locked and secured when not in use. 2.The facility failed to ensure that the mechanical lift on the 200 Hallway in the entry of the Dining/Activity Room area was locked and secured when not in use. These failures could place residents at risk of falls and/or injury.Findings Include:Observation of the facility's 200 Hallway on 03/04/26 at 10:15 AM revealed an unlocked and unsecured mechanical lift parked in front of a resident's room.Observation of the facility's 200 Hallway on 03/04/26 at 12:11 AM revealed an unlocked and unsecured mechanical lift parked in front of a resident's room.Observation on 3/04/2025 at 12:11 PM revealed an unlocked Mechanical Lift on the 200 Hallway near the 2nd floor elevator in front of the entry to the dining room. Residents and staff were observed going around the Mechanical Lift as they entered and exited the Dining/Activity Room.In an interview on 3/04/2025 at 12:21 PM with CNA I, she stated that she should not have left the Mechanical Lift by the elevator on the 200 Hallway in front of the entry to the Dining/Activity Room. She stated she used the Mechanical Lift for a resident and had to take a resident downstairs due to being in a rush and did not store the Mechanical Lift in the Supply Room where the Mechanical Lifts are stored. CNA I stated that when she placed the Mechanical lift where it was observed by the Surveyor, she did not lock the Mechanical Lift. CNA I stated that she had taken previous In-Service Trainings on accidents, hazards and Mechanical lift and Mechanical Lift Storage. CNA I stated that leaving an unattended and unlocked Mechanical Lift in the Hallways, there was a risk for residents to be injured, which there is a potential for harm. CNA I stated that all Mechanical Lifts were to be stored in the designated area on the 200 hallway. CNA I stated that there was a risk that a resident could fall and trip on an unlocked and unsecured Mechanical Lift in the Hallways. CNA I stated that a resident can fall and hit their head or have bruises if they were trying to lift themselves using an unlocked and unsecured Mechanical Lift for assistance with standing.In an interview on 3/04/2026 at 12:30 PM with CNA A revealed that she observed residents going around the unlocked and unsecured Mechanical Lift that was near the elevator in the walkway of the dining/activity room. CNA A confirmed that she observed the residents as they exited the dining/activity room and observed the residents that were from the elevator. CNA A stated the reason she did not move the unlocked and unsecured Mechanical Lift from the area was because she had a food tray in her hands. CNA A stated that all Mechanical Lifts are to be stored at all times in the facility's Utility Room on the 200 Hallway. CNA A stated that she had previously taken In-Service training on accidents, hazards and Mechanical Lifts and Mechanical Lift Storage. CNA A stated that residents could be at risk for injuries when an unlocked Mechanical Lift is left on the hallway and not stored in the designated area. CNA A stated that improper storing equipment, such as Mechanical Lift could result in a resident(s) injuring or cutting themselves.In an interview with LVN E on 03/05/26 at 3:46 PM, she stated that she had been employed at the facility for 5 months. stated that she was unaware that there were 2 Mechanical Lifts unlocked and unsecured in different areas on the 200 Hallway on 03/04/26. LVN E stated that Mechanical Lifts should not be stored on the hallways and should be stored in the Utility Closet on each floor. LVN E stated that all staff have been trained via In-Service training on accidents, hazards and Mechanical Lifts and Mechanical Lift Storage. LVN E stated that all staff would be reeducated and retrained on Mechanical Lifts and Mechanical Lift Storage including safety, accidents, and hazards. LVN E stated that a Mechanical Lift being stored in the hallway was a fire hazard. LVN E revealed that every staff member was responsible for ensuring equipment was locked and safely stored. LVN E stated that there is a risk of someone hitting their head or tripping on an unlocked and unsecured Mechanical Lifts that are stored (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the hallway. LVN E stated that if someone tripped on a Mechanical Lift that was stored in the hallway, they could have a fall and break their hips, break their legs, have superficial injuries, which may require sutures.In an interview with the DON on 03/05/26 at 5:20 PM, she stated that she had been employed at the facility for 2 years. The DON stated that she was unaware that there were 2 Mechanical Lifts unlocked and unsecured in different areas on the 200 Hallway on 03/04/26. The DON stated that all mechanical lifts including Mechanical Lifts were stored safely in the Utility Room near the Nurses Station on the 200 Hallway when they were not in use. The DON stated that Mechanical Lifts should never be stored on the hallways and should not block the entry or exit areas. The DON stated that she had provided ongoing In-Service training with all staff regarding safety, accidents, hazards and Mechanical Lifts including Mechanical Lift Storage. She stated that she will reeducate staff with In-Service training on Mechanical Lifts and Mechanical Lift Storage. She stated that there was a risk to anyone to incur injuries when there was an unlocked and unsecured Mechanical Lift stored on the Hallways. The DON stated that there was a potential of harm to anyone if an unlocked and unsecured Mechanical Lift stored on the hallways. The DON stated that residents can slip and/or fall if there was an unlocked and unsecured Mechanical Lift stored on the hallways.Record review of the facility's policy, Safety and Supervision of Residents, dated 2001 and November July 2017 revealed, Policy Statement:Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.Policy Interpretation and ImplementationFacility-Oriented Approach to Safety1. Our facility-oriented approach to safety addresses risks for groups of residents.2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization.3. When accident hazards are identified, the QAPI/safety committee shall evaluate and analyze the cause(s) of the hazards and develop strategies to mitigate or remove the hazards to the extent possible.4. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents.5. The QAPI committee and staff shall monitor interventions to mitigate accident hazards in the facility and modify as necessary.Individualized, Resident-Centered Approach to Safety1. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents.2. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents.3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.4. Implementing interventions to reduce accident risks and hazards shall include the following:a. Communicating specific interventions to all relevant staff;b. Assigning responsibility for carrying out interventions;c. Providing training, as necessary;d. Ensuring that interventions are implemented; ande. Documenting interventions.5. Monitoring the effectiveness of interventions shall include the following:a. Ensuring that interventions are implemented correctly and consistently;b. Evaluating the effectiveness of interventions;c. Modifying or replacing interventions as needed; andd. Evaluating the effectiveness of new or revised interventions.Systems Approach to Safety:1. The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly.2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment.3. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition.Resident Risks and Environmental Hazards1. Due to their (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following:.b. Safe lifting and movement of residents;c. Falls;.e. Unsafe wandering;g. Electrical safety.2. Other topics related to resident risk and environmental hazards may be addressed within related policies and procedures (for example, adequate lighting is addressed under the topic of falls). Record review of the facility's policy, Lifting Machine, Using a Mechanical, dated 2001 revealed, Purpose:The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. It is not a substitute for manufacturer's training or instructions.General Guidelines:.2. Mechanical lifts may be used for tasks that require:a. Lifting a resident from the floor;b. Transferring a resident from bed to chair;c. Lateral transfers;d. Lifting limbs;e. Toileting or bathing; [NAME]. Repositioning.3. Types of lifts that may be available in the facility are:a. Floor-based full body sling lifts;b. Overhead full body sling lifts; andc. Sit-to-stand lifts.3. Types of lifts that may be available in the facility are:a. Floor-based full body sling lifts;b. Overhead full body sling lifts; andc. Sit-to-stand lifts.Steps in the Procedure:. 7. Make sure the lift is stable and locked.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 5 residents (Resident#13) reviewed for respiratory care. The facility failed to ensure Resident #13's nebulizer mask was changed weekly, which was consistent with facility's policy. This failure could place residents at increased risk of infections. Record review of Resident #13's Quarterly MDS Assessment, dated 01/28/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. She had a BIMs score of 04, which indicated severe cognitive impairment. The resident had diagnoses which included respiratory failure (when the respiratory system cannot adequately provide oxygen to the body), heart failure (a chronic, progressive condition where the heart muscle is too weak or stiff to pump enough blood to meet the body's needs for oxygen) and hypertension (a chronic condition defined as consistently high blood pressure). Record review of Resident #13's Comprehensive Care Plan revealed a care plan, Date Initiated: 10/10/2026, Resident is at risk for impaired gas exchange R/T COPD and he is a smoker. Facility intervention includes Monitor oxygen saturation via pulse oximetry Q shift and PRN. Assess and record signs of impaired gas exchange (confusion, restlessness, irritability, inability to move secretions.) Record review of Resident #13's active physician orders, dated 02/01/2026, reflected Iprat-Albut 0.5-3(2.5) MG/3 ML 1 vial inhale orally every 6 hours as needed for SOB related to Start date 09/08/2025. During an observation on 3/3/2026 at 1:05 p.m. revealed Resident #13's nebulizer mask was in a plastic bag. The nebulizer mask was dated 2/16/2026.The resident was not showing any signs of respiratory distress or infection. Resident# 13 was uninterviewable. During an interview on 3/3/2026 at 1:34 p.m. with LVN D, she stated the Nebulizer mask should be changed every Sunday night and as needed. She stated the risk to the resident was respiratory infections due to bacteria growing in the mask. She stated she had been in serviced on infection control and respiratory treatments. During an interview on 3/3/2026 at 1:44 p.m. with LVN B revealed she was Resident #13's nurse. She stated she was not aware Resident #13 nebulizer mask and tubing had not been changed and was dated 2/16/2026. She stated he had not had breathing treatment on her shift. She stated the nebulizer mask and tubing was supposed to be changed weekly and as needed. She stated she usually checked the nebulizer mask and tubing to make sure they were dated. She stated the importance of changing the nebulizer mask and tubing was to track its age so it could be replaced according to the recommended schedule. She stated she had been in-serviced on infection control and respiratory equipment care. During an interview on 3/4/2026 at 1:52 p.m. with the ADON revealed her expectation was the assigned nurse should check and make sure, the nebulizer mask and tubing's were within date and stored in plastic bags. She stated the facility policy was to change the nebulizer mask and tubing every week on Sunday night shift and PRN. She stated the risk to the resident if tubing was not changed as scheduled was growth of bacteria leading to infection to the resident. She stated the nurses were in serviced on infection control and respiratory. During an interview on 3/4/2026 at 2:02 p.m. with the DON revealed her expectation was the assigned nurse should check the nebulizer mask and tubing as part of the overall assessment to make sure, the tubing's were within date and stored in plastic bags. She stated the facility policy was to change the nebulizer mask and tubing every week on Sunday night shift and PRN. She stated the risk to the resident if tubing was not changed as scheduled was growth of bacteria leading to infection to the resident. She stated the nurses were in serviced on infection control and respiratory equipment's care. She stated when the nebulizer mask and tubing was changed the nurse should document the treatment administration record. Record review of the facility's policy titled Oxygen Administration, Revised 10/2020, reflected:Weekly Documentation Oxygen/nebulizer tubing/masks to be changed by nursing department, weekly, and documented in the electronic health record.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 2 of 2 medications on 1 of 3 medication carts, reviewed for pharmacy services. The facility failed to ensure proper disposal of Resident#38's Tramadol 50 mg (controlled medication) and Resident#35's Tramadol 50 mg (controlled medication) by taping narcotic medication. This failure could place residents at risk of drug diversion and risk of pills contamination due to broken seals. Record review of Resident #38's admission MDS Assessment, dated 01/22/26, reflected the Resident #38 was a [AGE] year-old male who was admitted to the facility on [DATE]. He had a BIMs score of 08, which indicated moderate cognitive impairment. The resident had a diagnosis which included Pain Disorder with related psychological factors. Record review of Resident #38's Comprehensive Care Plan, dated 01/20/2026, reflected [Name] is on pain medication therapy Tramadol r/t generalized pain. Facility Interventions included: Ask physician to review medication if side effects persist Review quarterly for pain medication efficacy. assess whether pain intensity acceptable to resident, no treatment regimen or change in regimen required; Controlled adequately by therapeutic regimen no treatment regimen or change in regimen required but continue to monitor closely; Controlled when therapeutic regimen followed but not always followed as ordered; Therapeutic regimen followed, but pain control not adequate, changes required. Record review of Resident #38's active physician orders, dated 03/04/2026, reflected the resident had orders for tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 8 hours as needed for Pain order date: 01/14/2026. 2. Record review of Resident #35's Quarterly MDS Assessment, dated 02/10/26, reflected Resident #35 was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. She had a BIMs score of 12, which indicated moderate cognitive impairment. Her diagnoses included Pain, unspecified. Record review of Resident #35's active physician orders, dated 03/04/2026, reflected the resident had orders for Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 6 hours as needed for Pain Prescriber start date 01/28/2026. During an observation on 03/04/26 at 2:21 PM of the 200 [NAME] Hall Nurses Cart station, revealed Resident #38's tramadol 50mg had 2 blister seals broken and taped and Resident# 35's tramadol 50mg had 3 blister seals damaged. The damaged blisters had the pills still inside secured with tape at the time the state surveyor inspected the medication cart. During an interview on 03/04/26 at 2:32 PM, RN F stated she was unaware Resident#38's and Resident#35's Tramadol 50mg blister pack seal was broken and did not know how the blister packs were broken. She stated the risk of a damaged blister would be potential for drug diversion and contamination of the medication. She stated the nurses were responsible for checking the medication blister packs for broken seals during the count of narcotics during the change of shift. She stated she did not see the broken blister during the count. She stated she was in serviced on medication storage. During an interview on 3/04/26 at 3:12 PM with LVN B revealed when a narcotic bubble seal was broken the medication was to be disposed wasted and witnessed by two nurses. She stated the risk to the resident was potential medication error because there was no guarantee the pill in the broken seal was the prescribed medication. Narcotics should not be taped, and he would notify the charge nurse so the medication could be discarded. She stated she was in-serviced on medication storage. During an interview on 3/04/26 at 3:32 PM with LVN E revealed nurses were responsible for ensuring the medication cart was clean and narcotics were not supposed to be secured with tape. She stated that when a narcotic bubble seal was broken the medication was to be disposed wasted and witnessed by two nurses. She stated the risk to the residents was potential medication error and drug diversion. She stated she was in-serviced on medication storage. During an interview on 3/04/2026 at 3:45 PM (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the ADON revealed the nurses were responsible for ensuring the medication cart was clean, and all medications were within date, and narcotics were secured. She stated the pharmacy consultant audited the medication rooms and the medication carts monthly. She stated the risk to the resident when narcotics were taped could be medication error because the pills could have been switched out and contamination of the pill due to a broken seal. She stated the policy was if the seal of a narcotic was broken the medication should be disposed of and wasted witnessed by two nurses. She stated the nurses were in serviced on medication storage and controlled medication storage. During an interview on 03/4/26 at 4:04 PM, the DON stated her expectation was that the nurses would not tape narcotics. She stated narcotics with broken seals should be wasted witnessed by two nurses. She stated the pharmacy consultant audited the medication rooms and the medication carts monthly. She stated the risk to the residents of taping narcotics was contamination and medication error. She stated the nurses were in serviced on medication storage. She stated the nurses were in serviced on medication storage. Record review of the facility's policy Medication Storage and Labeling in the Facility Revised February 2023, reflected the following:1. Medications and biologicals are stored in the packaging containers or other dispensing systems they are received in. Only the issuing pharmacy is authorized to transfer medications between containers.3. If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.7. Controlled substances (listed as Scheduled II-V of the comprehensive Drug Abuse Prevention Act of 1976) and other drugs subject to abuse are separately locked in permanently affixed except when using single unit package drug distribution sys in which the quantity store is minimal and a missing dose cane be readily detected.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 5 Residents (Resident#85) reviewed for infection control. The facility failed to ensure Resident #85's foley catheter was not on the floor. This failure could place residents at risk of urethral tears or dislodging catheter and urinary tract infections.Record review of Resident #85's quarterly MDS assessment, dated 01/30/26, reflected a [AGE] year-old female who was originally admitted to the facility on [DATE] and re-entry of 01/24/2026. Her BIMs score was 12, which indicated moderate cognitive impairment. Her diagnosis included neurogenic bladder (a condition that affects the bladder's ability to function properly due to damage or dysfunction in the nerves that control it). Section H-Bowel and Bladder reflected the resident was coded to have an indwelling catheter. Record review of Resident #85 's care plans, dated 06/30/25, reflected: The resident requires a suprapubic catheter R/T neuromuscular dysfunction of bladder associated with MS. She is at risk for complications such as catheter related trauma and infections. Facility interventions included: Do not allow tubing or any part of the drainage system to touch the floor. Record review of Resident #85's active orders, dated 03/04/26, reflected: Suprapubic catheter care Q shift and PRN every 8 hours as needed Every shift as needed. Order start dated 02/23/2026. Suprapubic catheter care Q shift and PRN every shift order start date 02/23/2026. Suprapubic catheter Dx: Neuromuscular Dysfunction of Bladder, Unspecified order started date 02/23/2026. During an observation on 03/04/26 at 1:40 PM revealed Resident #85's catheter drainage bag was on the floor. The catheter was not anchored to a non-moveable part of the bed. During an interview on 03/04/26 at 1:40 PM with the Resident#85 revealed the CNA had emptied her drainage bag at the end of her shift. During an interview on 03/04/26 at 1:43 PM with LVN A revealed she was Resident #85's nurse. She stated the Foley drainage bag should always be anchored on a non-moveable part of the resident's bed and not on the floor. She stated the risk to the patient when the Foley drainage bag was placed on the floor was contamination leading to urinary tract infections and the bag could get punctured. She stated she was in serviced on foley catheter care and infection control. During an interview on 03/04/25 at 1:57 PM with CNA G revealed she was assigned to Resident #85. She stated she emptied the foley at the end of her shift but did not recall placing the drainage bag on the floor. She stated the foley catheter drainage bag should always be positioned below the bladder, anchored on the side of the bed and not on the floor. She stated the risk to the resident was risk for infection. She stated she was in serviced on foley catheter care and infection control. During an interview on 03/04/25 at 2:47 PM with the ADON revealed all foley drainage bags should never be placed on the floor. She stated the CNA and the nurse were responsible for ensuring the foley drainage bag was properly anchored on a non-moveable part of the resident's bed. She stated the risk to the resident was the foley could be caught on something and dislodge and/or put the resident at risk for infection. She stated the nurses and CNAs were in-serviced on indwelling catheter care and infection control. During an interview on 03/04/25 at 3:37 PM with LVN B revealed the Foley catheter drainage bag needed to be positioned below the bladder, anchored on the side of the bed and not on the floor. LVN B stated the risk to the residents was risk for infection. She stated she was in service on foley catheter care and infection Control. During an interview on 03/04/26 at 4:26 PM with the DON revealed her expectation was that nurses and the CNA's provided catheter care every shift. She stated Foley catheter drainage bags should never be on the floor and they should be anchored to the bed frame. The DON stated placing the drainage bag on the floor could put the residents at risk of urinary tract infection, and dislodgment of the catheter. She stated the staff were in serviced on foley catheter care and infection Control. Record review of the facility's policy, Catheter Care, Urinary, dated July 2024, reflected: PurposeThe (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	purpose of this procedure is to prevent catheter-associated urinary tract infections.Infection Control1. Use standard precautions when handling or manipulating the drainage system.2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag.a. Do not clean the periurethral area with antiseptics to prevent catheter-associated UTIs while the catheter is in place. Routine hygiene (e.g., cleansing of the meatal surface during daily bathing or showering) is appropriate.b. Be sure the catheter tubing and drainage bag are kept off the floor.c. Empty the drainage bag regularly using a separate, clean collection container for each resident. Avoid splashing and prevent contact of the drainage spigot with the nonsterile container.d. Empty the collection bag at least every eight (8) hours.

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Many	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 observations, interviews, and record review, the facility failed to notify residents or their representatives on how to file a grievance or complaint in an anonymous manner.The facility failed to notify residents or their representatives either individually or through prominent postings throughout the facility on how to file a grievance or complaint in an anonymous manner.These failures could affect resident's ability to file a grievance without the fear of discrimination, reprisal, retribution, and their right to anonymously file their grievance.Findings included:Observation on 03/04/26 at 2:45 PM the State Surveyor observed there were no grievance forms available in any common areas nor indications of places where grievance forms were normally kept. Interview on an undisclosed date and undisclosed date and time with six confidential residents revealed the residents were unaware where grievance forms were located. The residents stated that they did not know how to anonymously file a grievance. Residents expressed wanting to have the option to file an anonymous grievance. Interview on 3/4/26 at 2:45pm with CNA.A stated grievance forms are at the nurse's stations for the CNAs to give to residents if residents ask for them. After the resident fills out the grievance they give it to the nurse. If residents, ask for the nurse or CNA. to fill out the grievance for the residents they will do so. CNA.A stated the grievance forms are only kept at the nurse's station. The CNA. stated if a resident is not able to fill out grievance anonymously it violates their rights and could cause harm by causing trauma and retaliation. Interview on 3/5/26 at 1:50pm. The ADON revealed she was not sure where the blank grievance forms are kept. The ADON stated that when grievance forms are completed, they go to the social worker. The ADON stated she is not sure how a guest or resident would obtain a grievance form to fill out anonymously. The ADON stated if a resident, family member, visitor or anyone else wanted to fill out a grievance form anonymously and grievance form was not available it had the potential to cause harm due to prolonging an investigation. Interview on 3/5/26 at 3:03pm The LVN B stated she would notify The Administrator or The DON if someone wanted to do a grievance. If The Administrator or The DON are not around, she would notify her ADON. LVN B stated if someone wanted to complete an anonymous grievance they could go to Human Resources. LVN B said it is important for a resident to be able to file grievance because it is important for expressing themselves to get help with problems. Interview on 3/5/26 at 5:20pm with The DON. The DON stated residents can get grievance forms from The Social Worker or after hours at the reception desk. The DON stated residents can submit grievances anonymously to The Social Worker office by sliding the grievance under her door. The DON stated it is Important to be able to complete a grievance anonymously so there is no fear of retaliation. The DON stated the worse thing to happen would be not being able to file a grievance and would have unresolve grievances. Review of the facility's policy titled, Grievances/Complaints, Filing dated revised April 2017 revealed that the Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances (e.g., the State Ombudsman).5. Grievances and/or complaints may be submitted orally or in writing and may be filed anonymously.13. If the grievance was filed anonymously, the grievance officer will inform the resident that a grievance has been anonymously filed on his or her behalf and the steps that will be taken to investigate the grievance(s) and report the findings. The grievance officer will reiterate to the residents that it is against facility policy and federal regulations to discriminate or sanction a resident who has filed or verbalized a complaint against the facility, and that his or her rights to be free of discrimination or reprisal will be protected. Review of the Resident's Rights subsection Grievances revealed.The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns (continued on next page)

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Many	regarding their LTC facility stay. The facility must make information on how to file a grievance or complaint available to the residents.