STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455817	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Antonio North Nursing and Rehabilitation	501 Ogden San Antonio, TX 78212

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the resident had the right to be informed of and participate in his or her treatment including the right to be fully informed in language that he or she understood of his or her health status, including his or her medical condition for 1 of 1 resident (Resident #1) reviewed for resident rights. 1. The facility failed to have an effective method of communicating with Resident #1 who was deaf and mute. This failure could place residents at risk of poor communication and a demoralized sense of self-esteem and psychosocial wellbeing.The findings include: A record review of Resident #1's admission record revealed an admission date of 1/27/2025 with diagnoses which included deaf non-speaking, unspecified focal traumatic brain injury, schizoaffective disorder bipolar type (a chronic mental health condition combining psychotic symptoms (hallucinations, delusions) with manic and often depressive mood episodes). A record review of Resident #1's admission MDS dated [DATE] revealed resident #1 was a [AGE] year-old male admitted for long term care with supports for ADL safety with his diagnosed paraplegia (the impairment of motor or sensory function in the lower half of the body, usually caused by spinal cord injury or disease). A record review of Resident #1's physicians orders dated 4/3/2026 revealed the physician ordered the facility for Resident #1, May use hand-talk for communication / interpretation with resident. A record review of Resident #1's care plan dated 4/3/2026 revealed (Resident #1) Has impaired communication due to being deaf and mute. Resident refuses to use a communication board, which is only to have someone who can use sign language. Uses interpreter services with (name of ASL contractor)[JE2] via video. Goals: Will be able to communicate basic needs with a communication / interpreter device through next review date . target date 3/18/2026 . Interventions: answer Questions as needed and repeat as necessary . communicate through communication method - sign language, writing or interpreter / communication device / pad, interpreter services. set up ASL (a complete, visual hand language used by the Deaf community in North America. During a joint interview on 3/31/2026 at 10:00 AM with the Administrator and the DON stated Resident #1 was a resident at the facility and described Resident #1 as a [AGE] year-old male deaf person who could communicate with hand gestures, could read and write, and could read lips. The Administrator and the DON stated the SW could communicate with Resident #1 with ASL and the facility had as needed interpreter services through an ASL interpreter contractor. The Administrator and the DON stated Resident #1 had a tablet computer an iPad which he used to call people and had a visual interpreter service. During an interview on 3/31/2026 at 3:00 PM the Facility's State Agency assigned Ombudsman stated The Ombudsman stated she learned from Resident #1 and the Administrator that the facility believed Resident #1 could read, write, spell, and read lips, which Resident #1 had poor reading, writing, spelling skills, and could not lip read. The Ombudsman stated she learned from Resident #1's (relative) that Resident #1 had lost his hearing early in life before he could learn to speak, read, and write. The Ombudsman stated the facility had failed to assist Resident #1 with his iPad and VRS service. During an interview on 4/1/2026 at 11:00 AM with an independent Pro bono (a Latin phrase meaning for the public good) ASL interpreter and Resident #1, Resident #1 stated The facility has occasionally provided a meeting with an ASL interpreter who can actually sign (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but (Name of the Administrator has not helped me with my computer tablet calling program which has stopped working and when it did work the internet service was too slow and the visual signs could not be seen because of the choppy and blurry video. During a joint interview on 3/31/2026 at 3:35 PM with CNA K and CNA L stated they were CNAs who cared for Resident #1 and demonstrated their CNA Kardex (a centralized, frequently updated, and easy-to-reference nursing electronic documentation system that acts as a summary of patient information and care plans) for Resident #1. CNA K and CNA L stated there was no instructions for communicating with Resident #1 with a phone call and were unaware of a VRS system. CNA K and CNA L stated they and Resident #1 would communicate with hand gestures and head nods for care with ADL. CNA K and CNA L stated they could not use or understand ASL. During an interview on 3/31/2026 at 3:44 PM LVN M stated she was the charge nurse for Resident #1 and reviewed Resident #1's care plan. LVN M stated the care plan had no interventions for a VRS telephone number. LVN M stated she was unaware of a VRS telephone system to communicate with Resident #1. LVN M stated she and Resident #1 would communicate with hand gestures and head nods for assessments and medication administration. LVN M stated she could not use or understand ASL. LVN M stated she was aware Resident #1 could somewhat read and write but the communication was poor. LVN M stated she was unaware how to set up an ASL translator to communicate with Resident #1 and if available she could call upon the SW because the SW could use ASL. During a joint interview on 4/2/2026 at 5:00 PM the Administrator, the DON, and the SW stated the SW had basic ASL communication skills and could interpret communication with Resident #1 but the SW had no formal ASL training and held no ASL certificates. The SW stated she worked 40-60 hours a week and served around 100 residents and did not work 7 days a week or 24 hours a day. The Administrator stated that during those times when SW was not available the FSM could also serve as an interpreter, however the FSM also did not have a formal education for ASL and did not hold any ASL certificates as an interpreter. The Administrator stated Resident #1 could read and write and could also read lips. The Administrator stated Resident #1 could also communicate with anyone with his iPad which he used to call out to anyone. The Administrator stated the service was provided by Sorenson's and identified Resident #1's phone number as (phone number) and stated the phone number was documented on Resident #1 admission record, The Administrator stated he had used the number to call Resident #1. The Administrator stated he believed Resident #1's care plan was accurate and adequate to provide instructions for care. A record review of The National Association Of The Deaf website www.nad.org accessed 4/9/2026 revealed, To Whom it May Concern:The National Association of the Deaf (NAD) seeks to ensure that all healthcare providers, including long-term care facilities, rehabilitation facilities, skilled nursing facilities, and similar entities, understand their legal obligations with respect to serving deaf and hard of hearing patients and companions. The Americans with Disabilities Act (ADA) has clear mandates requiring healthcare providers to provide effective communication to individuals who are deaf or hard of hearing. Healthcare providers that violate such provisions are subject to legal action . This letter contains all the information necessary for long-term care facilities and similar entities to understand the requirements for ADA compliance when serving deaf and hard of hearing patients and companions. Title III of the ADA applies to all private health care providers, including long-term care facilities and similar entities. Healthcare providers must furnish (that is, obtain and pay for) any auxiliary aid or service that is necessary to achieve effective communication with the deaf or hard of hearing patient or companion of a patient. To be effective, an auxiliary aid or service must ensure that the deaf or hard of hearing individual can both understand and participate in discussions or other interactions.c. The deaf population varies greatly in its ability to read lips and/or to communicate in written English. Therefore, a short or simple interaction may still require an interpreter if the deaf or hard of hearing individual communicates successfully only through sign language.d. Ultimately, the key inquiry is whether the communication was effective, that is, could the healthcare provider communicate with the patient (or other relevant party) as thoroughly and effectively as he or she could with a hearing (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	person.3) Auxiliary aids and services include but are not limited to qualified sign language interpreters. See 28 C.F.R. S 36.303(b).a. Auxiliary aids and services can also include Video Remote Interpreters (VRIs), oral interpreters, cued speech transliterators, tactile interpreters, Certified Deaf Interpreters (CDIs), captioning of audio-visual materials, and text-based services such as Communication Access Realtime Transcription (CART). See 28 C.F.R. S 36.303(b).b. Any interpreter provided must also be qualified.i. To be qualified, an interpreter must be able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. 28 C.F.R. S 36.104.ii. The following individuals are not qualified interpreters: (1) an employee or staff member who knows basic sign language; (2) family members, adult companions, and minor children of the patient or service recipient, except in certain cases of emergency; (3) any interpreter who does not communicate proficiently with the deaf or hard of hearing individual. It is important to ensure that the interpreter provided is properly licensed as many states require sign language interpreters to obtain state licenses.

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had 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 regarding their LTC facility stay, for 1 of 7 residents (Resident #2) reviewed for resolution of grievances. The facility failed to document, address, and attempted to resolve 11 grievances made by Resident #2 on:1/2/2026 at 11:49 AM.1/2/2026 at 12:06 PM.1/2/2026 at 1:33 PM.3/3/2026 at 11:56 AM.3/4/2026 at 9:39 AM.3/5/2026 at 12:31 PM.3/12/2026 at 2:29 PM.3/17/2026 at 5:08 PM.3/19/2026 at 12:01 PM.3/24/2026 at 5:12 PM.3/26/2026 at 8:33 AM. This failure could place residents at risk for psychosocial and physical decline by not having their grievances heard and resolved.Findings included: Record review of Resident #2's admission record, dated 4/3/2026, revealed an admission date of 11/11/2025 with diagnoses which included hypertensive heart with heart failure (high blood pressure and heart failure) and end stage chronic kidney disease (high blood pressure with heart damage and damaged kidneys.) Record review of Resident #2's quarterly MDS assessment, dated 2/8/2026, revealed a [AGE] year-old female admitted for long term care. Resident #2 was assessed as dependent on staff for support with ADL care and transfer assistance. Record review of the facility's grievance records, dated 01/01/2026 through 3/31/2026, revealed no documented grievances for Resident #2. Record review of the local Ombudsman grievance emails revealed the local Ombudsman sent the facility's Administrator 11 grievance emails as follows: From: (Ombudsman)Sent: Friday, January 2, 2026, 11:49 AMTo: (Administrators email address)Subject: SOS (a universally recognized distress signal for summoning help)(Administrator),(Resident #2) has been calling for help for 45 minutes. Can someone please assist her to get off the bedpan?Thank you,(Ombudsman) From: (Ombudsman)Sent: Friday, January 2, 2026, 12:06 PMTo: (Administrators email address)Subject: FW: SOSImportance: High(Administrator),No one has helped (Resident #2). In addition to that, no one is answering the main number when it is called and the voice mail box is full.(Ombudsman) From: (Ombudsman)Sent: Friday, January 2, 2026, 1:33 PMTo: (Administrators email address)Subject: (Resident #2) needs help again(Administrator),(Resident #2) has had her call light for 25-30 min this time. Light is being ignored. She needs help to get off the bedpan again. Please.Also, she needs (Nurse) to come and tend to the wraps for legs which are coming off her feet.Thank you,(Ombudsman) From: (Ombudsman)Sent: Tuesday, March 3, 2026, 11:56 AMTo: (Administrators email address)Subject: (Resident #2)(Resident #2) states they have left her on the bed pan for 50 minutes. Please send someone to help her.Thank you.(Ombudsman) From: (Ombudsman)Sent: Wednesday, March 4, 2026, 9:39 AMTo: (Administrators email address)Subject: Grievance(Administrator),It is my understanding that (Resident #2) has already issued a grievance previously that (CNA A) is not to go into her room. Yesterday, (CNA A) was on the 2-10 shift. She serviced (Resident #2). (CNA A) cleaned (Resident #2) by wiping her from her rectum to her vagina. Respectfully - I request that (CNA A) be in-serviced as that is improper hygiene.(Resident #2) AND her roommate have both requested that (CNA A) not attend to them going forward.Thank you,(Ombudsman) From: (Ombudsman)Sent: Thursday, March 5, 2026, 12:31 PMTo: (Administrators email address)Subject: (Resident #2)Hi (Administrator),Can someone please go give (Resident #2) the grilled cheese they have left on her dresser.Thank you,(Ombudsman) From: (Ombudsman)Sent: Thursday, March 12, 2026, 2:29 PMTo: (Administrators email address)Subject: Grievance reported(Administrator),(Resident #2) requested a grievance form yesterday, but no one provided it.(Resident #2) would like to report that she was on the bed pan Mon, Tues and Wed and (CNA B) never answered her call light or came in to help her get off. Others had to help her. (Resident (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#2) reports (CNA B) will not help her get off of the bed pan at all and leaves it for others. Often (CNA C) has to come from the other hall to help. (Resident #2) has even offered to work around (CNA B) on her break but she states she doesn't know when she is going on break and is just not very nice when responding to (Resident #2). (Resident #2) would appreciate a response to this grievance.(Ombudsman) From: (Ombudsman)Sent: Tuesday, March 17, 2026, 5:08 PMTo: (Administrators email address)Subject: Resident #2)Importance: High(Administrator),(Resident #2) has been left on the bed-pan again (45 min now). (CNA B) (is in her hall) and she is not coming in (there is a grievance) or getting her help. Please send (CNA C), ASAP!!!! .Thank you,(Ombudsman) From: (Ombudsman)Sent: Thursday, March 19, 2026, 12:01 PMTo: (Administrators email address)Subject: (Resident #2)(Administrator),So sorry to have missed you yesterday when I was at the facility! . Yesterday during my visit, (LVN D) promised to re-wrap (Resident #2's) leg after she reported that the wrap is too tight and is hurting. That was never done. Please address this oversight and get her leg tended to ASAP.Thank you,(Ombudsman) From: (Ombudsman)Sent: Tuesday, March 24, 2026, 5:12 PMTo: (Administrators email address)Subject: (Resident #2)(Administrator),. Also, please advise the CNA (CNA B) that she should not scold (Resident #2) regarding turning on the light.(Ombudsman) From: (Ombudsman)Sent: Thursday, March 26, 2026, 8:33 AMTo: (Administrators email address)Subject: Grievance from (Resident #2)(Administrator),(Resident #2) states that yesterday (LVN D) yelled at her. She states that her wraps were coming off and (LVN D) yelled at her accusing her of tearing off her leg wraps. She wishes to enter this grievance for the Resident Right of Dignity and Respect being violated.Also, (CNA B) continues to go into the room although a written grievance has been made that (CNA B) should not be providing care in that room.(Ombudsman). During an interview on 3/31/2026 at 9:40 a.m., the Administrator and the DON stated Resident #2 had a documented history of making unrealistic demands and uncooperating with staff in efforts to resolve her complaints and unreasonable demands. The Administrator and the DON stated Resident #2's behaviors were documented and the facility continued to support Resident #2 in all her needs. The Administrator and the DON stated Resident #2 requested the Administrator and the DON not enter her room and thus placed the local Ombudsman as her default Representative. The Administrator and the DON stated the Ombudsman would visit and communicate in person and via telephone calls and emails. During an interview on 3/31/2026 at 11:00 a.m., the Ombudsman stated the relationship between Resident #2 , the Administrator, and the DON, had deteriorated and Resident #2 had refused to allow the Administrator and the DON into her room and thus Resident #2 utilized the Ombudsman as a Representative to communicate her wants and needs to the Administrator. The Ombudsman stated she often verbally advocated for Resident #2 to the Administrator and the DON without resolutions and thus begun to document all communications and grievances to the Administrator via emails. The Ombudsman stated Resident #2's grievances still were not addressed. During an observation and interview on 4/3/2026 at 3:01 PM revealed Resident #2 in her room in bed. Resident #2 stated she was not being helped by the staff who ignored her call lights and was left alone on her bedpan for hours. Resident #2 stated she would use her cell phone to call the facility, but they would never answer and thus she would call the Ombudsman to complain. Resident #2 stated she had many complaints but recalled a few, for example, CNA B was rude and did not provide incontinent care properly and with kindness. Resident #2 stated she had requested that CNA no longer provide care for her and preferred CNA C. During an interview on 4/3/2026 at 4:00 p.m., the Administrator stated he had not documented a grievance for Resident #2 from the Ombudsman's emails and believed he and his staff had addressed Resident #2's concerns and needs by reviewing the emails and providing re-enforced training for the entire staff which included ANE prevention and reporting trainings, however Resident #2 continued to be unsatisfied and continued with her occasional care refusals. A record review of the facility's Resident and Family Grievances policy, dated 6/15/2025, revealed, Policy: It is the policy of this facility to support each resident and family members rights to voice grievances without discrimination reprisal or fear of discrimination or reprisal. Definitions: prompt (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	effort to resolve, include facility acknowledgement of a complaint/grievance and actively working towards resolution of that complaint/grievance. Policy explanation and compliance guidelines: The administrator has been designated as the grievance official . The grievance official is responsible for overseeing the grievance process, receiving and tracking grievances through their conclusion, leading any necessary investigations by the facility, maintaining the confidentiality of all information associated with grievances, issuing written grievance decisions to the resident, and coordinating with state and federal agencies as necessary in light of specific allegations . a resident or family member may voice grievances with respect to care and treatment which has been furnished, as well as that which has not been furnished, the behavior of staff and other residents and other concerns regarding their long term care facility stay . The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form or assist the resident or family member to complete the form, take any immediate actions needed to prevent further potential violations of any resident right, report any allegations involving neglect, abuse, injuries of unknown source and or misappropriation of resident property, immediately to the administrator and follow procedures for those allegations . the grievance official will take steps to resolve the grievance and record information about the grievance and those actions on the grievance form.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 6 residents (Resident #3) reviewed for reporting alleged violations. On 2/22/2026 the facility failed to report to the State Agency an allegation of sexual abuse when a hospice RN alleged Resident #3 was sexually abused. This failure could place residents at risk of ANE and a diminished sense of self-worth.Findings included: A record review of Resident #3's admission record, dated 4/3/2026, revealed an admission date of 2/24/2026 with diagnoses which included senile degeneration of brain (age-related, progressive decline in cognitive function caused by structural brain damage, commonly due to protein buildup), aphasia (impaired ability to understand or produce speech, as a result of brain disease or damage), second degree hemorrhoids (second-degree internal hemorrhoid bulges from the anus during bowel movements, then goes back inside by itself). A record review of Resident #3's change in status MDS assessment, dated 3/23/2026, revealed Resident #3 was an [AGE] year-old male admitted with hospice care. Resident #3 was assessed with a non-traumatic brain disorder and a serious mental illness, highly impaired sense of hearing, severely impaired sight, and could sometimes understand others and sometimes could make himself understood. Resident #3 was assessed as having memory problems and had severely impaired cognitive skills for daily decision making. Resident #3 was assessed as needing substantial maximal assistance with toileting hygiene. Resident #3 was assessed as always incontinent of bowel and bladder. A record review of Resident #3's care plan, dated 4/3/2026, revealed, .Potential for alteration in comfort related to hemorrhoids initiated 03/02/2026 . Assess for s/sa) small amount of blood in the stool or on toilet paper after wipingb) incomplete bowel movementsc) soft lump felt at the anal openingd) rectal itching/burning. A record review of Resident #3's physicians' orders, dated 4/3/2026, revealed Resident #3 was admitted to hospice services on 6/22/2023, call (hospice services) 24/7 for anything (phone number provided). A record review of Resident #3's nursing progress notes revealed LVN E documented on 2/22/2026 at 2:57 p.m. that a CNA checked on Resident #3 for incontinent care when she saw blood on Resident #3's bedding and adult brief; . nurse called (name of hospice service) hospice and they will send a nurse . A record review of Resident #3's nursing progress notes revealed LVN E documented on 2/22/2026 at 3:49 PM that a hospice nurse approved Resident #3's transfer to a hospital for a SANE evaluation (sexual assault nurse examiner); upon assessment and evaluation,(name of hospice contractor) hospice nurse approved of sending him to ER (emergency room) if there is suspicion of assault. A record review of Resident #3's nursing progress notes revealed LVN E documented on 2/22/2026 at 4:00 PM ADON and Administrator notified of Hospice order to send to ER for eval (evaluation) and treatment. A record review of Resident #3's nursing progress notes revealed LVN D documented on 2/24/2026 at 6:50 PM Resident #3 had returned from the hospital, Date and Time of Patient Arrival: 2/24/26 arrived at 6:20pm; Where admitted from: (name of hospital). A record review of Resident #3's nursing progress notes revealed NP G documented on 2/25/2026 that Resident #3 was assessed at the hospital by a sexual assault examiner with no evidence for sexual assault, . In the ER, thorough exam by SANE nurse showed no obvious external trauma, no abdominal or chest wall tenderness. likely source of bleeding from grade 2 hemorrhoids. During an interview on 4/3/2026 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 1:20 PM ADON H stated Resident #3's hospice nurse had alleged Resident #3 had been sexually assaulted and the facility sent Resident #3 to the hospital for rectal bleeding where he was assessed with hemorrhoids as the source of the bleeding. ADON H stated she was not aware if the facility had reported to the State Agency the alleged sexual assault for Resident #3. During an interview on 4/3/2026 at 5:00 PM the Administrator stated he was aware of the hospice nurses' allegation of sexual assault for Resident #3 and had not reported the allegation of sexual abuse. A record review of the facility's undated Abuse, Neglect, and Exploitation policy revealed, Identification of abuse, neglect, and exploitation: the facility will have written procedures to assist staff in identifying the different types of abuse mental or verbal, sexual, physical, and the deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident to resident altercations. Possible indicators of abuse include, but are not limited to: resident, staff or family report of abuse. Investigation of alleged abuse, neglect, and exploitation: an immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect, or exploitation occur. Reporting of all alleged violations to the Administrator, state agency, adult Protective Services, and to all other required agencies, (e.g., law enforcement when applicable) within specified time frames: immediately, But not later than two hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to evidence that all alleged violations were thoroughly investigated and prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation was in progress, and reported the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation was verified appropriate corrective actions were taken for 1 of 6 residents (Resident #3) reviewed for abuse. On 2/22/2026 the facility failed to investigate and report the results of the investigation to the State Agency an allegation of sexual abuse when a hospice RN alleged Resident #3 was sexually abused. This failure could place residents at risk of harm by ANE and a diminished sense of self-worth.Findings included:A record review of Resident #3's admission record dated 4/3/2026 revealed an admission date of 2/24/2026 with diagnoses which included senile degeneration of brain (age-related, progressive decline in cognitive function caused by structural brain damage, commonly due to protein buildup), aphasia (impaired ability to understand or produce speech, as a result of brain disease or damage), second degree hemorrhoids (second-degree internal hemorrhoid bulges from the anus during bowel movements, then goes back inside by itself). A record review of Resident #3's change in status MDS assessment dated [DATE] revealed Resident #3 was an [AGE] year-old male admitted for hospice care. Resident #3 was assessed with a non-traumatic brain disorder and a serious mental illness, highly impaired sense of hearing, severely impaired sight, and could sometimes understand others and sometimes could make himself understood. Resident #3 was assessed as having memory problems and had severely impaired cognitive skills for daily decision making. Resident #3 was assessed as needing substantial maximal assistance with toileting hygiene. Resident #3 was assessed as always incontinent of bowel and bladder. A record review of Resident #3's care plan, dated 4/3/2026, revealed, .Potential for alteration in comfort related to hemorrhoids Date Initiated: 03/02/2026 . Assess for s/sa) small amount of blood in the stool or on toilet paper after wipingb) incomplete bowel movementsc) soft lump felt at the anal opening.d) rectal itching/burningDate Initiated: 03/02/2026 . A record review of Resident #3's physicians' orders revealed Resident #3 was admitted to hospice services on 6/22/2023, call (hospice services) 24/7 for anything (phone number provided). A record review of Resident #3's nursing progress notes revealed LVN E documented on 2/22/2026 at 2:57 PM that a CNA checked upon Resident #3 for incontinent care when she saw blood on Resident #3's bedding and adult brief; . nurse called (name of hospice service) hospice and they will send a nurse . A record review of Resident #3's nursing progress notes revealed LVN E documented on 2/22/2026 at 3:49 PM that a hospice nurse approved Resident #3's transfer to a hospital for a SANE evaluation (sexual assault nurse examiner); upon assessment and evaluation, (name of hospice contractor) hospice nurse approved of sending him to ER if there is suspicion of assault. A record review of Resident #3's nursing progress notes revealed LVN E documented on 2/22/2026 at 4:00 PM ADON and Administrator notified of Hospice order to send to ER (emergency room) for eval and treatment. A record review of Resident #3's nursing progress notes revealed LVN D documented on 2/24/2026 at 6:50 PM Resident #3 had returned from the hospital, Date and Time of Patient Arrival: 2/24/26 arrived at 6:20pm; Where admitted from: (name of hospital). A record review of Resident #3's nursing progress notes revealed NP G documented on 2/25/2026 that Resident #3 was assessed at the hospital by a sexual assault examiner with no evidence for sexual assault, . In the ER, thorough exam by SANE nurse showed no obvious external trauma, no abdominal or chest wall tenderness. likely source of bleeding from grade 2 hemorrhoids. During an interview on 4/3/2026 at 1:20 PM ADON H stated Resident #3's hospice nurse had alleged Resident #3 had been sexually assaulted and the facility sent Resident #3 to the hospital for rectal bleeding where he was assessed with hemorrhoids as the source of the bleeding. ADON H stated she (continued on next page)

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	455817	A. Building B. Wing	04/03/2026

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not aware if the facility had reported to the State Agency the alleged sexual assault for Resident #3. During an interview on 4/3/2026 at 5:00 PM the Administrator stated he was aware of the hospice nurses' allegation of sexual assault for Resident #3 and had not reported nor submitted an investigation report for the allegation of sexual abuse. A record review of the facility's undated Abuse, Neglect, and Exploitation policy revealed, Identification of abuse, neglect, and exploitation: the facility will have written procedures to assist staff in identifying the different types of abuse mental or verbal, sexual, physical, and the deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident to resident altercations. Possible indicators of abuse include, but are not limited to: resident, staff or family report of abuse. Investigation of alleged abuse, neglect, and exploitation: an immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect, or exploitation occur. Reporting of all alleged violations to the Administrator, state agency, adult Protective Services, and to all other required agencies, (e.g., law enforcement when applicable) within specified time frames: immediately, But not later than two hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and described the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, for 1 of 6 resident (Resident #1) reviewed for care plans. The facility failed to ensure the care plan included instructions necessary for implementing communication interventions with Resident #1 who was deaf and mute. This failure could place residents at risk of harm due to poor communication.The findings include: A record review of Resident #1's admission record revealed an admission date of 1/27/2025 with diagnoses which included deaf non-speaking, unspecified focal traumatic brain injury, schizoaffective disorder bipolar type (a chronic mental health condition combining psychotic symptoms (hallucinations, delusions) with manic and often depressive mood episodes). A record review of Resident #1's admission MDS dated [DATE] revealed Resident #1 was a [AGE] year-old male admitted for long term care with supports for ADL safety with his diagnosed paraplegia (the impairment of motor or sensory function in the lower half of the body, usually caused by spinal cord injury or disease). A record review of Resident #1's physicians orders dated 4/3/2026 revealed May use hand-talk for communication / interpretation with resident. A record review of Resident #1's care plan dated 4/3/2026 revealed there were no interventions instructions for how staff could call Resident #! On his ASL telephone, (Resident #1) Has impaired communication due to being deaf and mute. Resident refuses to use a communication board, which is only to have someone who can use sign language. Uses interpreter services with [language service] via video. Goals: Will be able to communicate basic needs with a communication / interpreter device through next review date . target date 3/18/2026 . Interventions: answer Questions as needed and repeat as necessary . communicate through communication method - sign language, writing or interpreter / communication device / pad, interpreter services. set up ASL (a complete, visual hand language used by the Deaf community in North America. During a joint interview on 3/31/2026 at 10:00 AM the Administrator and the DON stated Resident #1 was a deaf person who could communicate with hand gestures, could read and write, and could read lips. The Administrator and the DON stated the SW could communicate with Resident #1 with ASL and the facility had as needed interpreter services through an ASL interpreter contractor. The Administrator and the DON stated Resident #1 had a tablet computer an iPad which he used to call people and had a visual interpreter service. During an interview on 3/31/2026 at 3:00 PM the Facility's State Agency assigned Ombudsman stated she learned from Resident #1 and the Administrator that the facility believed Resident #1 could read, write, spell, and read lips, which Resident #1 had poor reading, writing, spelling skills, and could not lip read. The Ombudsman stated she learned from Resident #1's relative that Resident #1 had lost his hearing early in life before he could learn to speak, read, and write. The Ombudsman stated the facility had failed to assist Resident #1 with his iPad and VRS service. During an interview on 4/1/2026 at 11:00 AM with an independent Pro bono (a Latin phrase meaning for the public good) ASL interpreter and Resident #1, Resident #1 stated the facility has occasionally provided a meeting with an ASL interpreter who can actually sign but the Administrator had not helped him with his computer tablet calling program which has stopped working and when it did work the internet service was too slow and the visual signs could not be seen because of the choppy and blurry video. During a joint interview on 3/31/2026 at 3:35 PM CNA K and CNA L stated they were CNAs who cared for Resident #1 and demonstrated their CNA Kardex (a centralized, frequently updated, and easy-to-reference nursing electronic documentation system that acts as a summary of patient information and care plans) for Resident #1. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA K and CNA L stated there were no instructions for communicating with Resident #1 with a phone call and were unaware of a VRS system. CNA K and CNA L stated they and Resident #1 would communicate with hand gestures and head nods for care with ADL. CNA K and CNA L stated they could not use or understand ASL. During an interview on 3/31/2026 at 3:44 PM LVN M stated she was the charge nurse for Resident #1 and reviewed Resident #1's care plan. LVN M stated the care plan had no interventions for a VRS telephone number. LVN M stated she was unaware of a VRS telephone system to communicate with Resident #1. LVN M stated she and Resident #1 would communicate with hand gestures and head nods for assessments and medication administration. LVN M stated she could not use or understand ASL. LVN M stated she was aware Resident #1 could somewhat read and write but the communication was poor. LVN M stated she was unaware how to set up an ASL translator to communicate with Resident #1 and if available she could call upon the SW because the SW could use ASL. During a joint interview on 4/2/2026 at 5:00 PM the Administrator, the DON, and the SW stated the SW had basic ASL communication skills and could interpret communication with Resident #1 but the SW had no formal ASL training and held no ASL certificates. The SW stated she worked 40-60 hours a week and served around 100 residents and did not work 7 days a week or 24 hours a day. The Administrator stated that during those times when SW was not available the FSM could also serve as an interpreter, however the FSM also did not have a formal education for ASL and did not hold any ASL certificates as an interpreter. The Administrator stated Resident #1 could read and write and could also read lips. The Administrator stated Resident #1 could also communicate with anyone with his iPad which he used to call out to anyone. The Administrator stated the service was provided by a language services company and identified Resident #1's phone number as (phone number) and stated the phone number was documented on Resident #1's admission record. The Administrator stated he had used the number to call Resident #1. The Administrator stated he believed Resident #1's care plan was accurate and adequate to provide instructions for care. A record review of the facility's Comprehensive Care Plans policy dated 5/5/2025 revealed, It is the policy of this facility to develop and implement A comprehensive person centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a residence medical, nursing, and mental and psychosocial needs and services that are identified in the residence comprehensive assessment and need professional standards of quality. The comprehensive care plan will describe, at a minimum, the following:the services that are to be furnished to attain or maintain the resident's highest practicable physical mental and psychosocial well-being. Resident specific interventions that reflect the residents' needs and preferences and align with the residents' cultural identity, as indicated. If the resident is non-English speaking, the facility will identify how communication will occur with the resident. The care plan will identify the language spoken and tools used to communicate.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record reviews the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration dates for 2 of the facility's 5 medication carts (1 cart for the 200-hall and 1 cart for the 400-hall) reviewed for medication storage. The Medication Aide 200-hall medication cart had 4 pill form medications stored in a small plastic cup and not in pharmacy labeled containers.The Nurse 400-hall medication cart had 3 pill form medications stored in a small plastic cup and not in pharmacy labeled containers. These failures could place residents at risk of not receiving the therapeutic effects of their medication. Findings included: During an observation and interview on 4/3/2026 at 3:40 PM MA I attended her medication cart on the 200-hall. MA I stated she was in the process of administering medications for residents on the 200-hall. MA I stated she had intended to administer medications for a resident but could not because the resident was receiving a shower. MA I stated she did not want to be wasteful, so she stored the pills in a small cup and then proceeded to administer medications to other residents. MA I revealed a small clear medication cup with 4 small pills in the cup which she had stored in the first drawer of the medication cart along with other medications. MA I stated she wrote the resident's name upon the cup as a reminder of whose medications they were. MA I identified the medications as risperidone, melatonin, quetiapine, and famotidine. MA I stated she understood the practice of pre-pouring medications was not acceptable as a professional standard but did not want to waste the medication and was aware of who the medication was intended. MA I stated the potential danger for residents was for a potential medication error. During an observation and interview on 4/3/2026 at 4:00 PM LVN J was at her nurse medication cart by the nurse station for the 400-hall. LVN J stated she had just returned from a 2-3-minute lunch break. LVN J opened her medication cart and demonstrated a small clear plastic cup with 3 pills within the cup. The cup had a handwritten resident's name on the side of the cup. LVN J identified the pills as Depakote 250mg and Depakote 500mg, and carbamazepine unknown milligrams. LVN J stated, I don't remember the dosage of the carbamazepine, I would need to look it up. LVN J stated she had pre-poured a resident's medication because when she prepared the medications the resident was not available for medication administration, so she stored the medications and took her lunch break. LVN J stated she understood the practice of pre-pouring was not per professional practice, but she intended to administer the medications as soon as she returned from her break. During an interview on 4/3/2026 at 4:20 PM ADON H stated the training, expectations and professional practice for medication administration was for nursing staff to identify the intended resident and then immediately dispense and administer the medications to the resident and the practice of pre-pouring medications was against policy and could lead to medication errors. During an interview on 4/3/2026 at 5:00 PM the Administrator stated he received a report of nursing staff pre-pouring medications and would have the DON review the incidents. A record review of the facility's policy Medication Administration dated 5/9/2025 revealed, Policy: medications are administered by licensed nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy explanation and compliance guidelines: identify a resident; perform hand hygiene prior to administrating medication per facility protocol and product; knock or announce presence;; explain purpose of visit; provide privacy; . position resident to accommodate administration of medication; ensure that the six rights of medication administration are followed: right resident, right drug, right dosage, right route, right time, and write documentation. review medication administration record to identify medication to be administered. Compare medication source with medication administration record to verify resident (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	name, medication name, form, dose, route, end time. remove medication from source, . administer medication . observe resident consumption of medication . sign medication administration record .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety, for 1 of 5 residents medication carts (200-hall medication cart) reviewed for food safety. The facility stored resident's pudding and jelly in the Resident's medication cart without labels and dates to indicate if the foods were safe to serve. These failures could place residents at risk for food borne illnesses.Findings included: During an observation and interview on 4/3/2026 at 3:08 PM LVN D was at his medication cart preparing to administer medications for his assigned residents. The medication cart presented with a covered 1-gallon water pitcher filled with water. The water pitcher had no label to identify when the water was poured. LVN D demonstrated the first drawer where he stored a clear plastic cup with a lid which held approximately 2 ounces of pudding and another similar clear plastic cup with jelly. The containers had no labels and dates to indicate what the contents were or when they were served. LVN D stated he had filled the pitcher with water at the beginning of his shift today 4/3/2026 around 2:00 PM. LVN D stated he had received from the kitchen the pudding and jelly today 4/3/2026 around 2:00 PM. LVN D stated he had not labeled the water and the pudding and jelly and was aware per professional standards he was to label the water and pudding with a date they were prepared to indicate the water and pudding were safe to serve. During an interview on 4/3/2026 at 4:00 PM ADON H stated nursing staff used fresh water and puddings and jellies to assist residents consuming their medications. The ADON stated the training, professional practice, and policy was for nursing staff to place a label on the water pitcher indicating the date the water was poured and for the same practice for the pudding and jelly. The ADON stated the label indicated the date the water and the puddings were prepared and ensured the foods were safe to serve. The ADON stated the water and pudding without labels indicated an uncertainty when the foods were prepared and therefore uncertain if they were safe to serve. A record review of the facility's Medication administration policy dated 5/9/2025 revealed, Policy: medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by physician and in accordance with professional standards of practice, in any manner to prevent contamination or infection. Policy explanation and compliance guidelines: keep medication card clean, organized, and stocked with adequate supplies. Cover and date fluids and food.