STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465079	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunshine Terrace Skilled Nursing	248 West 300 North Logan, UT 84321

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 observation, interview, and record review it was determined that the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, the walk-in refrigerator temperature was above 41 degrees Fahrenheit and food was stored in the danger zone. The food temperatures were above 41 degrees. This was cited at an Immediate Jeopardy (IJ). In addition, there were opened and undated food items in the walk-in refrigerator, freezer, and dry storage. Dietary staff were observed during lunch tray line service to touch food and other surfaces. NOTICE: Notice of the Immediate Jeopardy was given verbally to the Administrator (ADM), Dietary Manager (DM), and Director of Nursing (DON) on 4/6/26 at 10:31 AM. At that time, the ADM, DM, and DON were informed of findings of Immediate Jeopardy pertaining to F812 and were asked to develop an immediate plan to ensure that residents of the facility were free from food that had been stored, prepared, distributed, and served in accordance with professional standards for food service safety. On 4/9/26 at 11:03 AM, the ADM provided the following written allegation of removal of the Immediate Jeopardy: IMMEDIATE JEOPARDY ABATEMENT/ALLEGATION OF COMPLIANCE IMMEDIATE JEOPARDY ABATEMENT/ALLEGATION OF COMPLIANCE Facility: Sunshine Terrace Skilled NursingProvider Number: 465079Address: 248 W. 300 N., [NAME] UT 84321Date: April 8, 2026 @ [at] 10:30 PM To: State Survey Agency RE: Immediate Jeopardy Removal- F812 (Food Safety/Temperature Control) Sunshine Terrace Skilled Nursing respectfully submits this Abatement of Immediate Jeopardyand Allegation of Compliance for Tag F812, identified on April 6, 2026 at approximately 8:30AM. Immediate Jeopardy Statement The facility acknowledges that Immediate Jeopardy existed related to failure to maintain properfood storage temperatures, which placed residents at risk for foodborne illness. The facility took immediate action upon identification on April 6, 2026, and implementedadditional system-wide corrective measures. The Immediate Jeopardy was fully abated on April8, 2026 at 10:30 PM. Actions Taken to Remove Immediate Jeopardy Upon identification of the deficient practice, the facility implemented the following immediate corrective actions: All food items in the walk-in refrigerator were immediately evaluated for safe temperature complianceAll potentially hazardous food items exceeding 41 F were discarded immediatelyThe walk-in refrigerator was removed from service immediately, and Dietary Cooler #2 was utilized as the alternative refrigeration unitSafe alternative refrigeration units were utilized to ensure continued safe meal serviceNo food from the affected unit remains in useA review of food served within the prior 24 hours was completedNursing staff were instructed to monitor all residents for signs and symptoms of foodborne illnessNo adverse outcomes identified Systemic Changes Implemented To prevent recurrence, the facility implemented the following: Reinforced policy requiring twice-daily temperature monitoring (AM and PM)Implemented immediate escalation and stop-use procedures for any equipment consistently out of range.Completed staff re-education on food safety, temperature control, and documentation requirementsImplemented process to ensure all prepared food is labeled with date and time when placed in the walk-in coolerImplemented preventative maintenance protocols for refrigeration unitsEstablished daily oversight and audit (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 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	processes by the Dietary Manager and AdministrationInitiated ongoing consultation with the Registered Dietitian to support dietary compliance and food safety practices Monitoring and Ongoing Compliance Temperature logs are completed twice daily (AM and PM) and reviewed daily by the Dietary Manager or designee (Prep Cook/Night Cook)Routine audits are conducted by Administration to ensure:Logs are completeTemperatures are within rangeCorrective actions are taken when indicatedCompliance is monitored through the facility's QAPI [Quality Assurance and Performance Improvement] program, with trends reviewed and addressedAny consistent temperature variance results in immediate corrective action, including:Evaluation of food safetyDiscarding of unsafe itemsRemoval of unit from service if indicatedStaff re-education and follow-up Additional Validation and Process ImprovementThe Administrator and Dietary Manager consulted with the local health department and reviewed guidance consistent with the FDA [Food and Drug Administration] Food code regarding time and temperature control.The Administrator and Dietary Manager also consulted with a licensed refrigeration technician, who confirmed that temporary air temperature fluctuations may occur during periods of frequent door opening or product loading.The facility recognizes that food safety is determined by internal food temperatures, and staff are trained to treat any out-of-range condition as a potential risk and respond immediately, Date Immediate Jeopardy Was Removed The facility asserts that the Immediate Jeopardy was removed on: April 8, 2026 at 10:30 PM, as all unsafe food was removed, the unit was taken out of service, and systems were implemented to ensure sustained compliance. Allegation of Compliance The facility alleges compliance with 42 CFR S483.60 (F812) as of April 8, 2026, and affirms that all corrective actions have been implemented to ensure the health and safety of residents. Conclusion Sunshine Terrace Skilled Nursing is committed to maintaining a safe and sanitary food service environment. Immediate and sustained corrective actions have been implemented to ensure this deficient practice does not recur. On 4/9/26 at 12:37 PM, the State Survey Agency reviewed the immediate plan of correction for removal of the Immediate Jeopardy involving food storage and confirmed the abatement of the Immediate Jeopardy as of the alleged abatement on 4/8/26 at 10:30 PM. Findings included: 1. On 4/6/26 at 8:27 AM, an initial tour of the kitchen was conducted.On 4/6/26 at 8:30 AM, an observation of the walk-in refrigerator was conducted. The refrigerator temperature was 50 degrees Fahrenheit. The following items were observed in the refrigerator:Two tubes of ground beefPackaged Deli meatVegetables/fruit-celery, onions, tomatoes, grapesSalad dressing containersA large bowl of puddingPrepared Tuna-in a bowlTartar sauce in a containerOn 4/6/26 at 8:49 AM, a repeat temperature of the refrigerator was conducted with the Dietary Manager. The temperature of the refrigerator was 50 degrees Fahrenheit.On 4/6/26 at 8:50 AM, an interview was conducted with the DM. The DM stated that the temperature for the refrigerator should be at 42 degrees Fahrenheit or below. The DM stated that she would have to contact maintenance about the refrigerator being out of range. The DM stated that with a temperature greater than 42 degrees Fahrenheit, foodborne illness could be an issue and everything in the refrigerator would be pulled and put into a different refrigerator. On 4/6/26 at 9:03 AM, the temperature was obtained for the following items with the DM:A tube of hamburger had a temperature of 43.8 degrees FahrenheitA tube of hamburger had a temperature of 44 degrees FahrenheitA package of cooked deli ham had a temperature of 46.7 degrees FahrenheitA package of cooked deli ham had a temperature of 47 degrees Fahrenheit.A container of tartar sauce had a temperature of 48.3 degrees Fahrenheit.On 4/6/26 at 9:09 AM, a follow-up interview was conducted with the DM. The DM stated that she was going to have to take the temperature of all the items in the refrigerator and discard everything that was over 42 degrees Fahrenheit.On 4/6/26 at 9:43 AM, a follow-up interview was conducted with the DM. The DM stated that the bacon that was served for breakfast today had been stored in the walk-in refrigerator. The DM stated that afternoon snacks for residents included deli meat sandwiches and tuna sandwiches. The DM stated that she did not have a list of the residents who had requested sandwiches for snacks yesterday. The DM stated that staff were expected to check the temperatures of the refrigerator twice a day. The DM stated that the cook had not checked (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	the temperature of the refrigerator last night and the only temperature that was taken was before 11:00 AM. The DM stated there was no way to determine when the temperature had changed yesterday without the evening temperature, but it had to occur after 11:00 AM on 4/5/26.On 4/9/26 at 8:20 AM, an interview was conducted with the Administrator (ADM). The ADM stated that a refrigeration technician had come into the facility and educated her and the DM about how refrigerator walk-ins worked and that they had a much better understanding about how to regulate the temperature in the refrigerator. The ADM stated that going forward the DM would ensure that dietary staff were logging the refrigerator temperatures twice daily. The ADM stated that the facility had two dietitians and they had been notified of the situation with the refrigerator being out of range. On 4/9/26 at 10:31 AM, an interview was conducted with Registered Dietitian (RD) 1. RD 1 stated that she went into the facility monthly to perform audits. RD 1 stated that audits consisted of identifying maintenance issues, watching tray line service, and assisting the DM with any issues that she may have. RD 1 stated that it was a really old kitchen and things broke down quickly. RD 1 stated that she had last been in the facility for an audit at the end of March 2026. RD 1 stated that the walk-in refrigerator was really old and there had been issues with the door sealing completely. RD 1 stated that she audited temperature logs of the kitchen equipment to ensure that all items were within range. RD 1 stated that food items in the walk-in refrigerator should be stored at or below 41 degrees Fahrenheit. RD 1 stated that any refrigerated foods over 41 degrees Fahrenheit would have to be discarded because residents could become ill if the food was consumed.On 4/9/26 at 12:38 PM, an interview was conducted with [NAME] 1. [NAME] 1 stated that she needed to make sure that temperatures were taken in the morning and evening. [NAME] 1 stated that the refrigerator temperature should not be over 41 degrees Fahrenheit. [NAME] 1 stated that if the temperature was over 41 degrees Fahrenheit she was to notify the DM. On 4/9/26 at 12:40 PM, an interview was conducted with Prep [NAME] 1. Prep [NAME] 1 stated that she just started last week at the facility. Prep [NAME] 1 stated that she received training regarding the walk-in refrigerator temperature and if the temperature was over 41 degrees Fahrenheit then she would contact the DM. Prep [NAME] 1 stated she was trained verbally and also was given a handout. On 4/9/26 at 12:42 PM, an interview was conducted with Prep [NAME] 2. Prep [NAME] 2 stated that she had received training for food safety and refrigeration monitoring. Prep [NAME] 2 stated that all items in the refrigerator and freezers should be properly labeled and closed. Prep [NAME] 2 stated that the walk-in refrigerator should be at 41 degrees Fahrenheit or below. Prep [NAME] 2 stated that every time she walked by the walk-in refrigerator she would keep an eye on the temperature to monitor it. Prep [NAME] 2 stated that she would notify the DM if the refrigerator was out of range. On 4/9/26 at 12:47 PM, an interview was conducted with the DM. The DM stated that she changed the temperature logs for the refrigerator that now included the time the temperature was taken. The DM stated that she had informed all of her kitchen staff that refrigerator temperatures needed to be checked first thing in the morning and right before the cooks left in the evening. The DM stated that staff had been instructed to notify her if the refrigerator temperature was over 41 degrees Fahrenheit. 2. On 4/6/26 at 8:27 AM, an initial tour of the kitchen was conducted. The following observations were made:An opened jar of pickles with a date of 9/5 on the lid in dry storage.An opened and undated bag of hamburger buns in the reach-in refrigerator.An opened and undated bag of wheat bread in the reach-in refrigerator.An opened and undated bag of fries in the freezer.An opened and undated bag of crinkle fries in the freezer.An opened and undated bag of frozen mixed vegetables in the freezer.An opened and undated bag of raising bran in dry storage.On 4/6/26 at 8:43 AM, an interview was conducted with the DM. The DM stated that all opened food should be dated with the opened date. The DM stated that she would remind staff to do this.On 4/8/26 at 10:27 AM, a follow-up tour of the kitchen was conducted. The following observations were made: An opened and undated bag of corn dogs open to air in the freezer.An opened and undated bag of peas and carrots in the freezer.An opened and undated bag of salmon in the freezer.An opened and undated bag of tater tots in the freezer.3. On 4/8/26 at 10:55 (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	AM, lunch tray line service was conducted. The following observations were made:At 11:00 AM, [NAME] 1 was observed to wash hands and place gloves on. At 11:03 AM, [NAME] 1 was observed to touch mixed vegetables with a gloved hand.At 11:04 AM, [NAME] 1 was observed to touch chicken and mixed vegetables with a gloved hand.At 11:07 AM, [NAME] 1 was observed to wipe her cheek with a gloved hand.At 11:09 AM, [NAME] 1 was observed to touch mixed vegetables on the plate with a gloved hand.At 11:11 AM, [NAME] 1 was observed to cut up chicken with scissors and touch the chicken and mixed vegetables with her gloved hands.At 11:16 AM, [NAME] 1 was observed to touch mixed vegetables on the plate with a gloved hand.At 11:27 AM, [NAME] 1 was observed to leave her station to get lids for bowls and then return to her station. [NAME] 1 was observed to be wearing the same gloves from the beginning of service. It should be noted that [NAME] 1 did not change her gloved hands throughout lunch service.On 4/8/26 at 11:33 AM, an interview was conducted with [NAME] 1. [NAME] 1 stated that gloves should be changed anytime she walked away from the tray line or if there was an allergy that a resident might have and she wanted to avoid cross-contamination. [NAME] 1 stated that she should not touch her face with gloved hands and if she did touch her face she should change gloves. [NAME] 1 stated she was not sure if she should touch food with gloved hands. On 4/8/26 at 11:40 AM, an interview was conducted with the DM. The DM stated that she did not like staff wearing gloves because they did not know if their hands were dirty or not. The DM stated that food should not be touched with bare hands or gloved hands. The DM stated that all foods in the freezer should have opened dates and should never be opened to air.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined that the facility did not ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choice. Specifically, for 3 out of 32 residents, the facility did not provide a resident additional treatment for constipation which resulted in hospitalization for a bowel obstruction; a resident with Moisture Associated Skin Damage (MASD) did not have their wound evaluated by a wound care provider and received wound care without a physician order; and a resident with open wounds on their buttocks did not have wound prevention or skin assessments completed weekly as ordered. Resident identifiers: 3, 28, and 63. Findings included: 1. Resident 3 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included cerebral infarction, pseudobulbar affect, epilepsy, chronic pain, Parkinsonism, type II diabetes mellitus, hypertension, and hemiplegia of the left nondominant side. On 4/07/26 at 9:36 AM, an interview was conducted with resident 3. Resident 3 stated that she went to the hospital for a bowel obstruction. Resident 3 stated that they administered a narcotic for abdominal pain to her and that the narcotic made her constipated. Resident 3 stated that Sometimes one thing leads to another. Resident 3 stated that she began receiving Miralax for the bowel obstruction. On 2/12/26 at 12:11 PM, a progress note documented that resident 3 noticed blood in her brief, experienced nausea, and was transferred to the emergency room (ER). On 2/12/26, resident 3's hospital History & Physical assessment and plan documented Constipation Likely related to chronic opiate use, and laxatives or stool softeners at [name of facility]. The patient has chosen not to be on these agents due to her dense left hemiparesis from her ischemic stroke, making bowel movements difficult, and she is concerned regarding loose stools when they occur. Nevertheless, she has significant fecal impaction, and this is likely the cause of her nausea/vomiting in this case. Significant polypharmacy in this individual that will need to be reconciled on discharge. - Given a normal saline enema in the ED [emergency department] - Given additional Dulcolax suppository, and then mineral oil this evening. Resident 3's Bowel Movement (BM) monitoring documented a medium BM on 2/2/26, with no further BMs documented until a small BM occurred on 2/11/26. No documentation was located to confirm that resident 3 was offered or refused additional medication for constipation, or that the physician had been notified of the issue. Resident 3's February 2026 Medication Administration Record (MAR) revealed the following: Bisacodyl [OTC] (over-the-counter) suppository; 10 milligram (mg) rectally as needed (PRN). The order was initiated on 5/15/24 and discontinued on 2/12/26. Resident 3 did not have any doses administered from 2/1/26 up until her hospitalization on 2/12/26. Hydrocodone-acetaminophen tablet; 5-325 mg, every 4 hours PRN. The order was initiated on 1/27/26 and discontinued on 2/12/26. Resident 3 received two doses on 2/3/26 at 12:10 AM and on 2/10/26 at 12:20 AM. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Metamucil Fiber Thin wafer; 2 gram three times a day PRN. The MAR documented that no doses were administered prior to resident 3's hospitalization on 2/12/26. Miralax powder; 17 gram/dose two times daily PRN. The order was initiated on 6/18/25 and discontinued on 2/12/26. The MAR documented that no doses were administered prior to resident 3's hospitalization on 2/12/24. Oxycodone tablet; 10 mg every 4 hours PRN. The MAR documented that resident 3 received 20 doses prior to her hospitalization from 2/1/26 through 2/12/26. Resident 3 had a care plan initiated for Gastrointestinal Distress that was initiated on 2/23/26. The goal was that resident 3 would not experience any complications or require outside medical intervention. Interventions included administering medication as ordered, monitor response and side effects and notify the physician of concerns, observe for nausea and vomiting, epigastric pain, blood in stool, diarrhea, firm abdomen, indigestion and constipation and report to the physician. It should be noted that resident 3 did not have a care plan for constipation prior to her hospitalization on 2/12/26. On 4/8/26 at 8:45 AM, an interview was conducted with Certified Nurse Assistant (CNA) 1. CNA 1 stated that they documented resident bowel movements in the computer and on a sheet of paper. CNA 1 stated at the end of the shift they filed the paperwork and charted on the computer the resident bowel movement for that shift. CNA 1 stated that the nurse would be notified if the resident had not had a BM by the computer charting. CNA 1 stated that resident 3 used a sit to stand to transfer to the toilet and sometimes she was incontinent of bladder and bowel. On 4/08/26 at 8:49 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that the night shift printed out a report of residents who had not had a BM in 3 days and they followed the orders for constipation. RN 1 stated that the facility did not have a standing bowel protocol. RN 1 stated that if a resident had not had a BM for 3 days she would notify the physician and document that in a progress note. RN 1 stated that resident 3 was resistant to care and often refused treatment. RN 1 stated that if the resident refused treatment or a medication it should be documented in a progress note. On 4/08/26 at 9:46 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that day staff charted and monitored the resident's bowel movements. The DON stated that the licensed nurse would administer any PRN medication if needed. The DON stated that if a resident had not had a bowel movement in 3 days then the nurse should administer a PRN medication for constipation. The DON stated that they had no standing orders for a bowel protocol. The DON stated that if they had not had any success with a PRN medication then the nurse should notify the physician and ask for something else. The DON stated that if a resident refused medication it was not being documented. The DON stated that resident 3 refused a lot of the treatments or would have the medication discontinued because it made her feel bad. 2. Resident 63 was admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which included stenosis of right carotid artery, chronic embolism and thrombosis, lymphedema, chronic pain, peripheral vascular disease, congestive heart failure, type II diabetes mellitus, and chronic kidney disease. On 4/07/26 at 9:26 AM, an interview was conducted with resident 63. Resident 63 stated that she had wounds on both legs on the inside of her thighs and no one had told her what it was from. Resident 63 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	stated that she wondered if it was shingles and her leg broke out in lots of little blisters. Resident 63 stated that she had not had it before. Resident 63 stated that staff put cream on the areas and had said that it was starting to heal but was not completely gone. Resident 63's physician orders included the following: Calmoseptine ointment; 0.44-20.6% topical application 4 times daily PRN. The order was initiated on 9/17/25. Barrier cream to buttocks and peri-area; apply as needed one time a day PRN. The order was initiated on 9/18/25 Consult wound providers of choice to evaluate and treat wounds as needed. The order was initiated on 9/18/25. Skin Assessments weekly on Monday. The order was initiated on 9/18/25. On 3/7/26, 3/16/26, and 4/6/26 resident 63's skin assessment documented Yes to a preexisting wound. No other documentation was found of the wound characteristics and no interventions were identified. On 9/18/25, resident 63 had a care plan initiated for Moisture Associated Skin Damage (MASD) to right buttocks with a history of actual pressure ulcer to right buttocks. The care plan was last edited on 4/6/26. Interventions identified were to assess for other moisture problem areas; avoid hot water, use mild soap and soft cloths; check incontinence pads frequently (every 2-3 hours) and change as needed; consider low air loss bed; dressing changes per orders, skin assessment and inspection, and use moisture barrier ointments. On 4/08/26 at 9:18 AM, an interview was conducted with CNA 1. CNA 1 stated that resident 63 was totally dependent for toileting and was incontinent of bowel and bladder. CNA 1 stated that resident 63 had skin breakdown on her bottom and she applied barrier cream to her bottom. CNA 1 stated that resident 63 had bandages on her wounds and the nurse changed the bandage after her bed bath and incontinence care. On 4/08/26 at 9:31 AM, an interview was conducted with RN 1. RN 1 stated that they put a Mepilex bandage on resident 63's coccyx for protective measures to cushion the coccyx, but there was not an open wound. On 4/08/26 at 10:36 AM, an observation was made of resident 63's coccyx with RN 1. An observation was made of the right buttock and left gluteal fold.The skin appeared red and was not intact. RN 1 stated that the wounds were caused by shearing. The DON entered the room and observed the wound. RN 1 stated that they would apply barrier cream and a Mepilex dressing to both areas. RN 1 stated that the wounds were not open but were sloughing. RN 1 applied barrier cream with gloved hands and then a foam dressing was applied over the top of the right buttocks and left gluteal fold. Resident 63 asked RN 1 why she put a dressing on the thigh and the nurse responded that the skin was sloughing and they put the dressing there as a protective measure. Resident 63 stated that would explain why the area was hurting. RN 1 was asked what would classify an open wound and was unable to answer. RN 1 was asked if the skin was sloughing off was that considered open, and RN 1 replied I guess so. The resident was not observed on an air mattress. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 4/08/26 at 10:44 AM, an interview was conducted with the DON. The DON stated that resident 63 had not been assessed by a wound care provider, and that would be initiated when the wound opened up. The DON stated that resident 63's wound was not open but was flaky skin. The DON stated that the floor nurses assessed the resident wounds. The DON stated that if the wound was over a boney prominence they would assess to see if it was a pressure ulcer. On 4/08/26 at 11:15 AM, a follow-up interview was conducted with the DON. The DON stated that resident 63's skin on the coccyx was not macerated, the skin was flaky and would be considered intact. The DON stated that they were currently trying to find a new wound care provider as the last one went out of business. The DON stated that they had been without a wound care provider for a few months. The DON stated that the floor nurse should document the wound characteristics under wound management in the chart. It should be noted that no such documentation was found. The DON stated that the floor nurses were not wound care certified and that was why they would have a wound care provider who was certified. The DON stated that according to the nurse the resident had requested having the dressing on for comfort. The DON was informed of the observation of the resident asking RN 1 why she put a dressing on her leg and the nurse informing the resident that it was because the skin was sloughing and was for protection. The DON stated that if the nurses applied a dressing they would need a doctor's order for that wound care. It should be noted that resident 63 did not have physician orders for wound care. Review of the facility policy for Wound Care documented that in preparation for the wound care the staff should verify the physician's order for the procedure. The policy stated that documentation should include the type of wound care given, date and time of wound care, position in which the resident was placed, the name and title of the individual performing the wound care, any change in the resident's condition, all assessment data (i.e. wound bed color, size, drainage, etc.) obtained when inspecting the wound. The policy was last revised in October 2010. 3. Resident 28 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included mixed incontinence, neuromuscular dysfunction of bladder, and multiple sclerosis. On 4/6/26 at 1:26 PM, an interview was conducted with resident 28. Resident 28 stated that she had some open sores on her buttocks. A review of resident 6's physician orders revealed: On 11/6/25 an order for Skin Assessment Weekly on Thursday. On 2/24/26 an order for Wound Care: Barrier cream and cover w/ [with] brief to L [left buttock daily. A review of resident 28's skin assessments revealed that resident 28's last skin assessment was completed on 3/19/26 at 6:22 PM. The skin assessment showed that resident 28 had a preexisting wound that was a heat and moisture sore. The wound had scant exudate and the tissue surrounding the wound was erythematous. Resident 28 had skin checks completed on 11/6/25, 11/14/25, 11/20/25, 11/27/25, 12/4/25, 12/11/25, 1/1/26, 1/8/26, 2/5/26, 2/12/26, 3/5/26, 3/12/26, and 3/19/26. On 4/8/26 at 12:31 PM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that she had not looked at resident 28's wounds since 3/19/26. RN 2 stated that resident 28 had an open wound near her coccyx that was 0.5 X 0.5 inches. RN 2 stated that per facility policy she was keeping (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	a dressing on the wound and resident 28 was using a pressure reducing air mattress. On 4/8/26 at 2:27 PM, a follow-up interview was conducted with RN 2. RN 2 stated that if a resident required wound care there needed to be a physician's order. RN 2 stated that if a resident had a wound then she would notify the doctor or nurse practitioner for treatment orders.RN 2 stated that resident 28 had a wound from heat and moisture. On 4/9/26 at 9:44 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that he believed that resident 28 had a wound on her buttocks, but had not assessed it. The DON stated that the nurses were monitoring the wound. The DON stated that he was unsure if a nurse practitioner or physician had assessed or examined the wound. On 4/9/26 at 2:12 PM, a follow-up interview was conducted with RN 2. RN 2 stated that she checked resident 28's wound near her coccyx and the wound was healed. RN 2 stated that there was a new wound on the lower left side of resident 28's buttocks. RN 2 stated that she let the nurse practitioner know about the new wound. RN 2 stated that she got an order for a dressing to be placed on the wound. RN 2 stated that the nurse practitioner had not examined or assessed the wound while she was in the facility today. RN 2 stated that the wound was 0.5 X 0.5 inches and was reddish in color. RN 2 stated that she had not measured the wound and had guessed the size. RN 2 stated that she applied a 3X3 foam bandage to the wound. On 4/13/26 at 11:09 AM, an observation of resident 28's wound care with RN 3. Resident 28 had two wounds on her buttocks. There was a wound located at the top of the buttocks near the coccyx and a wound located on the left lower side of the buttocks near the left leg. The wounds were reddish in color. On 4/13/26 at 11:17 AM an interview was conducted with RN 3. RN 3 stated that resident 28 had a new wound that was located near the coccyx. RN 3 stated that the new wound appeared to be two skin tears and there was a small amount of blood draining from the wound. RN 3 stated this wound was charted as new on 4/9/26. RN 3 stated that the lower left sided wound appeared to look the same as it had 2 to 3 weeks ago. RN 3 stated that nurses should be charting in wound management and performing weekly skin assessments. On 4/13/26 at 11:48 AM, a follow-up interview was conducted with the DON. The DON stated that nurses should be doing weekly skin assessments and documenting them. The DON stated that he did not know why weekly skin checks were not documented for resident 28. The DON stated that he did not know why there was conflicting information about resident 28's wounds and was only aware of one wound.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined that the facility did not ensure that each resident who was given a psychotropic drug had an adequate indication for use of the medication; that psychotropic drugs received a gradual dose reduction and behavioral interventions, unless clinically contraindicated; as needed (PRN) orders for psychotropic drugs were limited to 14 days unless the practitioner documented a clinical rationale to extend beyond 14 days with a duration of use for the order; and PRN orders for anti-psychotics were limited to 14 days and cannot be renewed unless the attending physician evaluated the resident for the appropriateness of the medication. Specifically, for 5 out of 32 sampled residents, the facility did not document an adequate indication of use for Seroquel and Haldol; did not have monitoring for episodes of behavior with non-pharmacological behavioral interventions; did not have monitoring for adverse side effects (ASE) of psychotropic medications; did not have a gradual dose reduction (GDR) attempt or a documented clinical contraindication to the GDR for psychotropic medications; and PRN order for Seroquel and Haldol did not have an evaluation by the physician for the appropriateness of the medication. Resident identifiers: 7, 35, 50, 58, and 63. Findings included: 1. Resident 58 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included dementia, insomnia, fracture of right femur, and pain. Resident 58's physician orders included: Seroquel (Quetiapine) tablet; 50 milligram (mg) at bedtime, 8:00 PM. The order was initiated on 10/29/25. Seroquel (Quetiapine) tablet; 25 mg at bedtime PRN. The order was initiated on 11/4/25. Seroquel (Quetiapine) tablet; 25 mg one time a day at 5:00 PM. The order was initiated on 12/19/25. Seroquel (Quetiapine) tablet; 50 mg one time a day at 12:00 PM. The order was initiated on 1/2/26. Tylenol PM Extra Strength (diphenhydramine-acetaminophen) tablet; 2 tablets oral at bedtime PRN. The order was initiated on 10/29/25. The March 2026 Medication Administration Record revealed the following: The Seroquel PRN order was administered on 3/7/26 at 4:27 PM for anxiety/worried. It should be noted that this PRN dose was not administered at bedtime and was given approximately 30 minutes prior to the scheduled 5:00 PM dose. The Seroquel PRN dose was administered on 3/9/26 at 9:42 PM for increased anxiety, Restless, crying. The Tylenol PM was administered on 3/6/26 at 7:06 PM, on 3/9/26 at 7:02 PM, on 3/10/26 at 7:18 PM, on 3/11/26 at 4:43 PM, on 3/13/26 at 4:22 PM on 3/18/26 at 5:04 PM, on 3/20/26 at 6:45 PM, and on 3/27/26 at 4:51 PM. All administrations were documented for pain. It should be noted that 5 administrations were given well before bedtime and not as ordered. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Tylenol PM was administered on 3/14/26 at 7:25 PM, on 3/15/26 at 8:28 PM, and on 3/16/26 at 7:26 PM. All administrations were documented for sleep. It should be noted that the order did not have a diagnosis or special instructions indicated. No documentation could be found for monitoring for episodes of behavior, non-pharmocological behavioral interventions, or monitoring for ASE for the antipsychotic Seroquel. On 1/29/26, resident 58 had a Psychotropic Medication Review and the form indicated that the Seroquel was for anxiety. The form did not indicate if they were to continue with the current dose or make any changes. The form had a statement at the bottom that read, Scheduling, adding doses to or discontinuing any PRN medications would be detrimental to the outcome of their care. I also understand the black box warnings and prescribing recommendations of antipsychotic medication. I will continue to review medications monthly, and as indicated, I will adjust dosing to ensure best outcome of their care. The review was signed by a Doctor of Osteopathic Medicine (DO). It should be noted that the statement was not individualized to resident 58 and was the same statement found on other residents' psychotropic review. It should be noted that the antipsychotic medication Seroquel did not have a documented appropriate indication for long-term use for a resident with a diagnosis of dementia. On 4/07/26 at 12:09 PM, an interview was conducted with Registered Nurse (RN) 4. RN 4 stated that resident 58's mood was usually pleasant, but she became anxious later in the day and sundowned. RN 4 stated that resident 58 had confusion, anxiety, and would become fearful and worried. RN 4 stated that resident 58 needed a lot of reassurance and involvement in activities to calm the resident down. RN 4 stated that they documented behaviors for the medication Quetiapine and the behavior tracking was usually attached to the medication order. RN 4 looked at resident 58's medical records and confirmed that the resident did not have behavior tracking for Seroquel. RN 4 stated that the medication should have behavior tracking to determine if it was effective and to monitor for adverse reactions such as over sedation. RN 4 stated that the Seroquel was usually prescribed for Schizophrenia, bipolar disorder, and major depressive disorder. RN 4 stated that resident 58 did not have any of those diagnoses and had a diagnosis of dementia with unspecified behavioral disturbances. On 4/07/26 at 12:50 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 58 had behaviors and got really anxious. The DON stated that the Seroquel was prescribed for anxiety. The DON stated that none of the current Seroquel orders had an indication for use. The DON stated that Seroquel was an anti-psychotic medication and resident 58 did not have a diagnosis for schizophrenia, bipolar disorder, or major depressive disorder. The DON stated that they did not have monitoring in place for the Seroquel order and they should be monitoring for episodes of anxiety. The DON stated that they reviewed the psychotropic medications with the doctor to ensure that they had the appropriate diagnosis for each medication. The DON stated that they did not have documentation of the ASE. The DON stated that they had a psychotropic medication review two times a year and they had not attempted a GDR for resident 58's Seroquel. The DON stated that the psychotropic review contained the provider's rationale for the use of the medication and also addressed the use of PRN antipsychotic medications. 2. Resident 63 was admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which included insomnia, major depressive disorder and generalized anxiety disorder. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 63's physician orders included: Clonazepam - Schedule IV tablet; 0.5 mg oral 2 times a day PRN. The order was initiated on 10/2/25. Clonazepam - Schedule IV tablet; 1 mg oral at bedtime 8:00 PM. The order was initiated on 10/27/25. Hydralazine oral tablet; 20 mg Three Times A Day at 08:00 AM, 12:00 PM, 05:00 PM. The order was initiated on 9/17/25. Sertraline capsule; 200 mg oral one time a day at 8:00 AM. The order was initiated on 12/29/25. Trazodone tablet; 200 mg oral at bedtime at 8:00 PM. The order was initiated on 9/18/25. No documentation could be found for monitoring for episodes of behavior, non-pharmocological behavioral interventions, or monitoring for ASE for the psychotropic medications. On 3/11/24, resident 63 had a Psychotropic Medication Review for Seroquel 100 mg at bedtime for Major Depressive Disorder, Trazodone 200 mg at bedtime for insomnia, Sertraline 150 mg daily for Major Depressive Disorder, and Clonazepam 0.5 mg two times a day as needed for anxiety disorder. The recommendation was to continue with the same dose. The form had a statement at the bottom that read, Scheduling, adding doses to or discontinuing any PRN medications would be detrimental to the outcome of their care. I also understand the black box warnings and prescribing recommendations of antipsychotic medication. I will continue to review medications monthly, and as indicated, I will adjust dosing to ensure best outcome of their care. The review was signed by Medical Doctor (MD) 1. It should be noted that the statement was not individualized to resident 63 and was the same statement found on other resident's psychotropic review. It should be noted that no other Psychotropic Medication Review was found for resident 63 since 2024, and no attempted GDR had been done. Additionally, resident 63 had not had another GDR or Psychotropic Review since March 2024. On 4/08/26 at 12:01 PM, an interview was conducted with the DON. The DON stated that the GDR for the psychotropic medication was not found in resident 63's chart. The DON stated that he was not finding the GDR, but he was sure that they did one for resident 63. The DON stated that he was not sure why the GDR was not located in the resident's medical records. 3. Resident 35 was admitted to the facility on [DATE] with diagnosis that included Parkinson's disease, dementia, anxiety, delirium, and hypersomnia. Resident 35's physician orders included: Klonopin; 1 mg at bedtime. This order was initiated on 3/14/2024. Alprazolam; 0.25 mg; every 6 hours as needed for anxiety or agitation. This order was initiated on 3/28/24. Alprazolam; 0.25 mg; twice a day at 12:00 PM and 07:00 PM. This order was initiated on 6/13/2025. Alprazolam; 0.25 mg; at bedtime at 12:00 AM. This order was initiated on 9/5/25. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Seroquel; 75 mg; at bedtime for delirium due to known physiological condition. The order was initiated on 11/11/24. Seroquel; 25 mg; twice a day for delirium due to known physiological condition. The order was initiated on 3/29/24 and discontinued on 4/18/25. It should be noted when the order was discontinued the physician initiated new orders, increasing the afternoon dose while maintaining the morning dose. Seroquel tablet; 50 mg; once a day at 12:00 PM. The order was initiated on 4/18/25. The indication delirium due to known physiological condition was added on 5/16/25. Seroquel tablet; 25 mg; once a day at 8:00 AM for delirium due to known physiological condition. The order was initiated on 4/19/25. On 11/11/24, a Psychotropic Medication Review for Resident 35 reviewed Seroquel 25 mg twice a day, Seroquel 100mg at bedtime, Clonazepam 1mg at bedtime, and Alprazolam 0.25 mg every 6 hours as needed for anxiety. The review recommended decreasing Seroquel 100 mg at bedtime to Seroquel 75 mg at bedtime. It should be noted no additional Psychotropic Medication Reviews or GDRs were located for Resident 35 after this date. On 4/18/25 at 10:42 AM, a nursing note documented Physician Visit: [name redacted] visited the resident in the morning. Nurse informed his anxiety, pacing and restless in the afternoon. The following order. Increase Seroquel to 50 mg po [by mouth] at noon. On 4/20/25 at 8:57PM, a provider progress note documented staff report, patient is experiencing increased agitation during afternoon and evening hours consistent with sundowner syndrome. Staff notes that symptom severity varies day to day, with the patient being more difficult with certain staff members than others. Additionally, the note revealed Follow-up Plan: #Sundowner Syndrome/Agitation Increase afternoon Seroquel dose from 25mg to 50mg at noon. Continue morning Seroquel dose at 25mg. Monitor response to medication adjustment. It should be noted that the antipsychotic medication Seroquel did not have a documented appropriate indication for long-term use for a resident with a diagnosis of dementia. On 4/13/26 at 3:03 PM, an interview was conducted with the DON who stated he was unable to locate additional Psychotropic Medication Reviews for resident 35. The DON stated resident 35 was receiving Seroquel for the diagnosis delirium due to known physiological condition. 4. Resident 7 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, anxiety, dementia, type 1 diabetes mellitus, vitiligo and hyperlipidemia. Resident 7's current physician's orders were: Ordered on 1/30/26, Haloperidol 0.5 mg tablet prn for anxiety Ordered on 11/11/25, hydroxyzine HCl [hydrochloride] 25 mg tablet prn for restlessness. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ordered on 1/2/26, Seroquel 25 mg once a day at 8:00 AM for anxiety disorder due to known physiological condition. Ordered on 2/11/26, Seroquel 75 mg twice daily at 12:00 PM and 8:00 PM. There was no diagnosis associated with this medication. Ordered on 11/11/25, Trazodone 100 mg tablet at bedtime for insomnia. There was no monitoring of hours of sleep. There was no behavior monitoring located in resident 7's medical record. There were no psychotropic meetings located in resident 7's medical record. There were no rationales from the physician for the use of the antipsychotic medications. On 4/9/26 at 10:39 AM, an interview was conducted with the DON. The DON stated staff monitored residents for behaviors that might be controlled with non-pharmalogical interventions. The DON stated staff first look for pain or other things associated with the behavior prior to starting psychotropic medications. The DON stated when a resident was ordered a psychotropic medication it was reviewed by the psychotropic committee and a GDR was attempted. The DON stated resident 7 did not have a psychotropic meeting documented in the medical record. The DON stated behavior monitoring would be documented in progress notes. The DON stated each medication required a corresponding diagnosis. The DON stated resident 7 was admitted with some psychotropic medications, but were not effective with her behaviors. The DON stated resident 7 was having paranoia, agitation and fearfulness. The DON stated Seroquel was started and seemed to be effective. The DON stated psychotropic medications should have a 14 day limit if they were prn. The DON stated hydroxyzine was prn and he was unable to find documented rationelle by the physician. 5. Resident 50 was admitted to the facility on [DATE] and readmitted after a hospital stay on 1/24/26 with diagnoses, which included but were not limited to, major depressive disorder, generalized anxiety, and insomnia. A physician's order dated 1/24/26, documented hydroxyzine HCl tablet; 25 mg; Amount to Administer: 25 mg; oral Every 6 Hours - PRN Q6H [every 6 hours] as needed for anxiety or itching. The physician order was open ended. The hydroxyzine was not limited to 14 days and the physician had not documented a clinical rationale to extend the hydroxyzine beyond 14 days. The January, February, March, and April 2026 Medication Administration Record (MAR) was reviewed. The following medications did not have behavior monitoring, hours of sleep tracking, or adverse side effect monitoring. Clonazepam 0.5 mg twice a day, sertraline 100 mg daily, and trazodone 25 mg daily at bedtime. On 4/7/26 at 12:39 PM, an interview was conducted with RN 1. RN 1 stated that behavior monitoring would be on the resident MAR and the behavior monitoring should be connected to the medications. RN 1 stated a text box for behaviors would appear when she administered the medication but she was unsure where the information went or how to retrieve it. RN 1 stated that sometimes there would be a physician's order to track and monitor behaviors. RN 1 stated that nonpharmacological interventions (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were not on her charting. On 4/7/26 at 1:28 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that she would only do nonpharmacological interventions if the nurse asked her to. On 4/7/26 at 1:29 PM, an interview was conducted with the DON. The DON stated that resident 50 did not have behavior charting added to the medications and he could not find a justification to continue the hydroxyzine.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, observation, and record review, the facility did not ensure that allegations of abuse and neglect were reported immediately to the State Survey Agency (SSA) and other agencies. Specifically, for 4 of 32 sampled residents, the facility did not report allegations of abuse to Adult Protective Services (APS) and the facility did not report when a resident eloped from the facility to the SSA. Resident Identifier: 3, 41, 47 and 58. Findings included: 1. Resident 41 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's, chronic venous hypertension, and dementia. An incident report form submitted to the SSA revealed on 2/17/26 at 10:00 AM, The resident was assessed promptly by the attending nurse following identification of the contusion. The report documented multiple that possible causes were being evaluated. The resident will continue to be closely monitored and a follow-up report will be submitted upon completion of the diagnostic work up and further investigation findings. According to the incident report resident 41 had severe dementia. Upon conclusion of the investigation, appropriate interventions and corrective actions will be implemented based on the findings to prevent recurrence and ensure resident safety. A follow-up report outlining the investigation results and any actions taken will be completed and submitted accordingly. No documentation could be found that APS was notified of resident 41's injury of unknown origin. On 4/9/26 at 1:15 PM, an interview was conducted with the Administrator (ADM). The ADM stated she did not report the contusion to APS. 2. Resident 47 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease, arthritis, pain, psychotic disorder with hallucinations, major depressive disorder, and dementia with psychotic disturbance. Resident 47's medical record was reviewed 4/8/26 through 4/13/26. A nursing progress note dated 5/17/25 revealed Doing rounds, Patient wasn't in room. Initiated code green, unable to locate resident in facility, authorities notified, resident located safely. Family notified and updated. A nursing progress note dated 5/18/25 at 9:16 PM, .This past week on 5/17 he wandered out of the facility and the police dispatch got in contact with the facility to say they found him. He is now being monitored every 30 to an hour to monitor his activity. WCTM [will continue to monitor]. A nursing progress note dated 5/28/25 at 7:46 PM revealed, [Resident 47] transferred from Wing 3 on Friday, the 23rd, due to wandering around the Facility. He stayed in room [ROOM NUMBER] with his wife because no room was available but planned to move to room [ROOM NUMBER] after another resident D/C [discharge] on Tuesday if he has verbal aggression or anxiety with his wife. So the nurse moved him to room [ROOM NUMBER] on Tuesday 27th. He had to wander and ambulate ad-lib with a secured wing . On 4/9/26 at 1:15 PM, an interview was conducted with the ADM. The ADM stated she did not report (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the elopement to the SSA. 3. Resident 58 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included dementia, insomnia, fracture of right femur, and pain. On 1/27/26 at 1:20 pm, the facility reported to the SSA that on 1/27/26 at 1:07 pm, resident 58's family member noticed a bruise on resident 58's inner right thigh. The facility abuse investigation documentation was reviewed. No documentation could be found that APS was notified of resident 58's injury of unknown origin. On 4/9/26 at 1:15 PM, an interview was conducted with the ADM. The ADM stated that her investigations included interviews with the resident and witnesses, and she would report to law enforcement, the Ombudsman, and APS depending on the situation and what the allegation entailed. The ADM stated that she reported to APS when the incident involved a resident's family member or if there was a significant injury. The ADM stated that she did not report allegations of abuse or neglect to APS. 4. Resident 3 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included cerebral infarction, hemiplegia of the left nondominant side, pseudobulbar affect, epilepsy, and chronic pain. On 5/4/24 at 8:28 pm, the facility reported that on 5/02/24, the resident reported that the Certified Nurse Assistant (CNA) had provided rough care during a brief change. The facility abuse investigation documentation was reviewed. The Form 358 documented that no other agencies were notified. On 4/9/26 at 1:15 PM, an interview was conducted with the ADM. The ADM stated resident 3 made an allegation of staff roughness. The ADM stated that she did not notify APS of the allegation and she was not sure why. The ADM stated that she did not have a firm understanding of the requirements for notifying APS.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not have evidence of a thorough investigation in response to allegations of abuse, neglect, exploitation, or mistreatment. Specifically, for 4 of 32 sampled residents, there were no thorough investigations into bruising on residents with dementia, Certified Nursing Assistants (CNA)'s being rough during a brief change and a resident eloping from the facility. Resident identifiers: 3, 41, 58, 72 Findings included: 1. Resident 41 was admitted to the facility on [DATE] with diagnosis of Alzheimer's, chronic venous hypertension, and dementia. An incident report form submitted to the State Survey Agency (SSA) revealed on 2/17/26 at 10:00 AM, The resident was assessed promptly by the attending nurse following identification of the contusion. The report documented multiple that multiple possible causes were being evaluated. The resident will continue to be closely monitored and a follow-up report will be submitted upon completion of the diagnostic work up and further investigation findings. According to the incident report resident 41 had severe dementia. Upon conclusion of the investigation, appropriate interventions and corrective actions will be implemented based on the findings to prevent recurrence and ensure resident safety. A follow-up report outlining the investigation results and any actions taken will be completed and submitted accordingly. The investigation was an email provided by the Director of Nursing (DON) dated 2/20/26 at 8:09 AM revealed [Resident 41] moved the bed in his room, and while moving it received a scratch on his abdomen from the headboard. The nurse [name removed] assessed the scratch and put a dressing on it. When assessed by [name removed] NP [Nurse Practitioner] on Tuesday 2/17/26 it was noted that the bruising was from the headboard and the redness was consistent with contact dermatitis from dressing that was placed on it. She ordered Keflex. [Name removed] NP followed up with [resident 41] on Thursday (2/19) and redness was diminished, and [resident 41] is doing well. It should be noted that no additional documentation of the facility investigation could be located. On 4/9/26 at 1:14 PM, an interview was conducted with the Administrator (ADM). The ADM stated that her investigations included interviews with the resident and witnesses. The ADM stated that based on the investigation she would either substantiate or unsubstantiate the allegation. The ADM stated that the DON spoke to the NP and she relied on that information for her investigation. The ADM stated that in January 2026 she completed a Quality Assurance and Performance Improvement (QAPI) plan for the abuse process after realizing her abuse investigations were not thorough. The ADM stated she did not have any additional information for the investigation and conclusion regarding resident 41 which occurred in February 2026. The ADM stated resident 41's injury was consistent with moving his bed. The ADM stated she relied on the DON's email as the investigation. The ADM stated she interviewed staff but did not have documentation of the interviews. 2. Resident 58 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included dementia, insomnia, fracture of right femur, and pain. On 01/27/26 at 1:20 pm, the facility reported to the SSA that on 1/27/26 at 1:07 pm, resident 58's family member noticed a bruise on resident 58's inner right thigh. On 1/27/26 at 2:34 PM, a progress note documented, Patient is Alert and oriented with some confusion, .Patient had a care conference this morning. Patient [family memeber](present on phone (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	call) reported that patient is bruised on the right inner thigh. This nurse did not had [sic] any information/report about patient's new bruise. After care conference nurse assessed the patient and found the big bruise on the right inner thigh. The bruise starts from 2 inches away from her right groin and continues to her right popliteal area. Bruise is about 12-16 inches long and 5-6 inches wide. Upon inquiry resident reported that she does not know how and when it started. On 1/28/26, a NP note documented that resident 58 reported a new bruise and denied any injury or fall. The assessment documented a large dark contusion to the posterior right thigh, appears to be where a chair might hit the back of her leg while seated. The plan documented that the NP discussed the risk for bruising due to Eliquis. The facility abuse investigation documentation was reviewed. The documentation consisted of an email from the DON to the ADM that documented, [name omitted], NP assessed [resident 58] bruising and noted that the size, shape and location of the bruise is consistent with a hard sit-down/transfer to the toilet. It should be noted that no additional documentation of the facility investigation could be located. On 4/9/26 at 1:15 PM, an interview was conducted with the ADM. The ADM stated that she interviewed the nurses, who were unable to determine the origin of Resident 58's bruise The ADM stated that she did not have any documentation of the staff interviews. The ADM stated that the DON looked at the bruise and the NP assessed the injury. The ADM stated that the NP determined the bruising was consistent with a hard sit down on the toilet. 3. Resident 3 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included cerebral infarction, hemiplegia of the left nondominant side, pseudobulbar affect, epilepsy, and chronic pain. On 5/04/24 at 8:28 pm, the facility reported to the SSA that on 5/02/24, the resident reported that the Certified Nurse Assistant (CNA) had provided rough care during a brief change. The facility abuse investigation documentation was reviewed. The Form 358 documented resident 3's allegation that the CNA was rough with her and that, during a brief change, had stated please don't do that, it hurts. The form documented that the CNA responded Let's just see what I can do. The form documented resident 3's felt that the CNA was impatient during the care and threw her left leg onto her right foot. The report documented that no visible injuries had occurred and there were no witnesses to the incident. It should be noted that no additional documentation of the facility investigation could be located. On 4/9/26 at 1:15 PM, an interview was conducted with the ADM. The ADM stated resident 3 had an allegation of staff roughness. The ADM stated that she knows she conducted an investigation but did not have documentation of the investigation. 4. Resident 72 was admitted to the facility on [DATE] and discharged on 6/29/24 with diagnoses which included, but were not limited to, vascular dementia and dementia in other diseases classified elsewhere, mild, with anxiety. The facility abuse investigation documentation was reviewed. The Form 358 documented on 6/28/24 at 6:00 PM, staff discovered resident 72 missing when attempting to administer his medications. The (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	form documented that an immediate search was initiated, and five minutes later, 911 was contacted for assistance. The form documented that law enforcement subsequently located resident 72, returned him to the facility, and an assessment confirmed resident 72 was unharmed.The form documented that resident 72's wife was notified of the incident and was relieved he was found so quickly. The form documented that resident 72 was due to be discharged tomorrow, following a five day respite stay. It should be noted that no additional documentation of the facility investigation could be located. On 4/13/26 at 11:39 AM, an interview was conducted with the ADM. The ADM stated that she could not locate the investigation Form 359. The ADM stated that she did not do an investigation because resident 72 eloped on day four of a five-day respite stay. The ADM stated that resident 72 eloped from the locked unit by following some visitors out the exit, staff did an internal search before determining that he got outside. The ADM stated that staff called 911, and law enforcement brought resident 72 back quickly. The ADM stated that she was sure the facility put interventions in place to make sure residents did not elope again, but was unable to provide documentation of what the staff did. The ADM stated she felt like they captured the incident with resident 72 in Form 358

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that when they transferred a resident that it was documented in the resident's medical record and that the information contained the contact information of the practitioner responsible for the care of the resident; resident representative information; Advanced Directive information; all special instructions for ongoing care; comprehensive care plan goals; and all other necessary information to ensure a safe and effective transition of care. Specifically, for 3 of 32 sampled residents, the facility did not document in the residents' medical record the information that was given to the receiving provider, notify the Ombudsman, and provide the bedhold policy when residents were transferred to a hospital. Resident identifier: 3, 6, and 50. Findings included: 1. Resident 50 was admitted to the facility on [DATE] and readmitted after a hospital stay on 1/24/26 with diagnoses, which included but were not limited to, fluid overload. On 1/21/26 at 7:04 AM, a nursing progress note documented Resident came back from dialysis around 1730 [5:30 PM]. He was upset and crying. He received NORCO and hydroxyzine at 1800 [6:00 PM]. Around 1820 [6:20 PM] resident had called ems [emergency medical services] on his personal phone. Resident was trying to wheel himself out the door and did not accept help. EMS translator stated he complained of pain in his whole body. EMS took him to [name redacted]. Daughter was notified. The note did not document what information was sent to the receiving provider. On 4/8/26 at 12:28 PM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated if a resident was going out to the hospital for an emergency situation she would call EMS and help the resident with their care until they were sent out. RN 2 stated that she would print off the packet which included the resident's Physician Orders for Life-Sustaining Treatment, some progress notes, and the Continuity of Care Document that included the resident's medications and diagnoses. RN 2 stated that she would call the emergency room (ER) with a report. RN 2 stated that she would document objectively what happened in a progress note why the resident left. RN 2 stated the bed hold policy might be in the standard admission packet that the admission coordinator would complete. On 4/8/26 at 2:26 PM, an interview was conducted with the Social Services Director (SSD). The SSD stated that she was unable to find the notification to the Ombudsman form for resident 50. The SSD stated that resident 50 came back from Dialysis and called 911 himself and the SSD stated that she thinks the notification was missed. 2. Resident 6 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, acute posthemorrhagic anemia, constipation, and gastrointestinal hemorrhage. A review of resident 6's progress notes revealed: a. On 9/3/25 at 8:59 PM, a note documented, [Recorded as Late Entry on 09/03/2025 09:05 PM] At 1910 [7:10 PM] This nurse went into assess resident and to get o2 [oxygen] saturation levels.Resident did report he was having a hard time breathing and wasn't feeling well after dialysis. Listened to residents lungs and he had diminished bases and the right upper lobe sounded course. Gave resident a treatment of his albuterol inhaler, oxygen levels did increase slightly to 82%. Asked resident if he would like to go to the hospital since he was reporting he wasn't feeling well and had low oxygen levels. Resident agreed that he would like to be seen in the ER. EMS contacted and in (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	route Daughter [name redacted] contacted VM [voicemail] left. b. On 9/7/25 at 8:36 PM, a note documented, Patient was sleeping and SpO2 [oxygen saturation] was ranging 70%-85% while on supplemental oxygen bled into bipap at 4L [liters] with no improvement in o2 saturation. Patient was alert but very lethargic, reported shivers and feeling cold. Patient initially was hesitant to be sent but was educated on current condition and risks. Patient ultimately consented to transfer. Patient is full code. EMS was activated and arrived at 1855 [6:55 PM]. Resport [sic] given to EMS, including patient's recent hospital discharge yesterday. c. On 9/19/25 at 3:54 PM, a note documented, Resident called this nurse in at 1000 [10:00 AM]. He reported N/V [nausea and vomiting] and did not want to go to dialysis. He stated he wanted to go to the ER. [Facility] transportation was called and they took him to [local hospital] ER. Report was given to ER nurse. d. On 10/27/25 at 4:13 PM, a note documented, [Resident 6] went to the ER today at 0945 [9:45 AM] via [facility] transportation. [Resident 6] was not feeling well so he canceled dialysis. Later the nurse talked to the dialysis center and they suggested that [resident 6] go to the ER because of his GI [gastrointestinal] bleed and low levels of red blood cells. Social services will be available to [resident 6] and his family as needed. e. On 11/6/25 at 10:05 PM, a note documented, pt [patient] has some critical values form [sic] the lab drawn CBC [complete blood count], Hct [hematocrit]=19.9, Hb [hemoglobin]=5.9. this nurse notified the pt about the critical values and recommended to go to hospital at this time. pt refused multiple times during the eve shift. This nurse notified Dr. [name redacted] and Dr. [name redacted] about the pt situation and recommended pt going for transfusion, pt denied all the times. This nurse also called family and notified about the pt situation. Pt BP [blood pressure] is very low range 90/49 so this nurse talked to pt and recommended to go to hospital due to his critical condition. Finally pt decided to go to hospital for treatment and left SNF [skilled nursing facility] @2215 [10:15 PM]. f. On 12/30/25 at 6:25 PM, a note documented, At 1500 [3:00 PM] resident requested to go to the ER d/t [due to] not feeling well. Resident has been vomiting all day and is stated he felt very constipated. He insisted on going to the ER. [Facility] transported resident to [local hospital] ED [emergency department]. The notes did not document what information was sent to the receiving provider. On 4/7/26 at 12:33 PM, an interview was conducted with the SSD. The SSD stated that the Ombudsman and bed hold notifications were missing for resident 6 because she was not informed of the notification requirement until October 2025; after she became aware of the requirement she began sending the Ombudsman notification when a resident was discharged to the hospital. 3. Resident 3 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included cerebral infarction, pseudobulbar affect, epilepsy, chronic pain, Parkinsonism, type II diabetes mellitus, hypertension, and hemiplegia of the left nondominant side. On 4/7/26 at 9:36 AM, an interview was conducted with resident 3. Resident 3 stated that she went to the hospital for a bowel obstruction. On 2/12/26 at 12:11 PM, the progress note documented that resident 3 noticed blood in her brief and (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	experienced nausea. The resident was transferred to the ER. The note did not document what information was sent to the receiving provider. On 4/8/26 at 8:49 AM, an interview was conducted with RN 1. RN 1 stated that when they sent a resident to the hospital they called the ER and gave a report. RN 1 stated that they do not fill out a transfer summary. RN 1 stated that they send the Medication Administration Record, Physician Order for Life Sustaining Treatment, face sheet, and emergency contact list to the receiving provider. RN 1 stated that she did not document this information anywhere in the resident medical record. RN 1 stated that she did not include a bed hold policy when she transferred a resident because that was not her department. On 4/8/26 at 9:46 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that for any transfer to the ER the nurse should print a continuous care document that contained the resident face sheet, medication list, and all the information needed for the receiving provider. The DON stated that he was not sure if the information that was provided to the receiving provider was documented in the resident medical record. The DON stated that the discharge information did not include a bed hold policy and that was given upon admission in the admission packet. The DON stated the Social Service Director (SSD) was responsible for notifying the Ombudsman of any resident transfers or discharges.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, for 2 of 32 sampled residents, the facility did not ensure that each resident received adequate supervision and assistance devices to prevent accidents. Specifically, a resident eloped from the facility after being identified as wandering prior and the same resident sustained falls with no new interventions. In addition, another resident eloped from the facility. Resident identifiers: 47 and 72. Findings included: 1. Resident 47 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease, arthritis, pain, psychotic disorder with hallucinations, major depressive disorder, and dementia with psychotic disturbance. FALLS On 4/8/26 at 10:19 AM, a concurrent observation and interview were made of resident 47. Resident 47's door was shut , and the resident was observed to be laying in bed with his walker about 2 steps away from his bed. Resident 47 stated if he needed help he used the button. Resident 47's call light was wrapped around the head board and not within reach. Resident 47 was observed to try and find the call light but he was unable to locate it. At 10:43 AM, the call light continued to be out of reach, his walker was 2 steps away from the bed and his door remained shut. At 11:06 AM, resident 47's door continued to be shut, his walker was about 2 steps away from bed and the call light was not within reach. On 4/9/26 at 2:20 PM, a concurrent observation and interview were made of resident 47. Resident 47 was observed in his room with the door closed. Resident 47 was laying in bed with a walker next to the bed and the call light was under the bedspread and resident 47 was laying on top of the bedspread. Resident 47 stated if he needed help he went down to the office to call for someone. Resident 47 was observed to look for the call light and was unable to find the call light. At 2:43 PM, resident 47 was observed in the hallway with his walker. Resident 47's medical record was reviewed 4/8/26 through 4/13/26. Resident 47 sustained 15 falls from 7/6/25 until 4/13/26. Resident 47's progress notes and care plans were reviewed and revealed the following: Resident 47 was found on the floor on 7/6/25 and the intervention was educated resident to call for assistance if he's feeling weak. Resident 47 fell in the shower on 8/30/25 and the intervention was assessed shower equipment. Resident 47 was found on the floor on 9/10/25 and the intervention was educated resident to have staff help him pick things up off the ground. It should be noted on 7/6/25 the intervention was educated resident to call for assistance if he's feeling weak. Resident 47 was found on the floor on 11/5/25 and sustained a laceration to his right eyebrow. Resident 47 was transported to the hospital and received stitches. The intervention was to encourage the resident to leave a light on in his room when it's dark. Resident 47 was found on the floor walking to the dining room on 11/30/25. Resident 47 sustained (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bruising to his left elbow and the top layer of skin slightly peeled off the 2nd, 3rd, 4th knuckle of left hand. The intervention was the staff investigated the area to see if there was a tripping hazard and nothing was noted. Resident 47 was found on the floor in front of his recliner on 12/6/25. There was intervention. On 4/13/26 at 11:56 AM, an interview was conducted with the Director of Nursing (DON). The DON stated there was no intervention after the fall on 12/6/25. Resident 47 was found on the floor in his room on 12/9/25. The intervention was to remind the resident to keep his walker with him. Resident 47 was found on the floor on 1/22/26. There was no interventions. Resident 47 was found on the floor on 1/27/26. The intervention was to keep walker close to bed which was an intervention developed on 12/11/25. Resident 47 was found on the floor on 2/3/26. The intervention was to have an outpatient therapy evaluation. Resident 47 was found on the floor on 2/5/26. There was no new intervention. Resident 47 was found on the floor three times on 2/28/26. The new intervention was to encourage the resident to try using his four rollator walker. Resident 47 was found on the floor 3/11/26. There was no new intervention. Resident 47 fell in the restroom on 3/20/26. There was no new intervention. Resident 47 fell on the floor in the living room pushing his wheelchair on 3/26/26. The new intervention was to encourage to engage in activities prior to dinner. On 4/9/26 at 2:22 PM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated resident 47 had falls and to prevent those falls, he tried to constantly engage resident 47. RN 3 stated resident 47 could use his call light. RN 3 stated resident 47 sometimes transferred himself and he was able to transfer himself but then became unsteady when walking. RN 3 stated staff needed to keep resident 47's door open, so they could frequently peek in there. On 4/9/26 at 2:47 PM, an interview was conducted with Certified Nurse Assistant (CNA) 5. CNA 5 stated interventions to prevent falls were things like a low bed and if a resident was a fall risk they had a fall mat next to their bed. CNA 5 stated if there was a fall mat then the bed needed to be lowered to the floor. CNA 5 stated she tried to keep resident 47 out of his room and in activities where he could be watched. CNA 5 stated staff tried to keep resident 47 from being by himself in his room with the door shut. CNA 5 stated resident 47's bed should be in the low position. CNA 5 stated staff made regular rounds, like checking resident 47 every 15 to 30 minutes. CNA 5 stated resident 47 was able to use a call light and knows how to get a call light if he needed it. CNA 5 stated staff needed to place the call light where it was reachable for the resident. CNA 5 stated staff make sure he went to activities. On 4/13/26 at 11:56 AM, an interview was conducted with the Director of Nursing (DON). The DON (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated after a resident fell, the resident was assessed for an injury. If there was no injury, then an incident report was started, staff looked at the reason for the fall, a new intervention was added to the care plan and the resident was monitored for 72 hours. The DON stated resident 47 did not have interventions after each of the falls. The DON stated all staff had access to care plans. The DON did not have additional information to add when notified that resident 47's door was shut, the call light was out of reach and the walker was out of reach. ELOPEMENT Resident 47's progress notes revealed the following entries: On 5/13/26 a Care Conference Note revealed, .Fall Risk: Wandering a lot more. Need to keep an eye on him.Social Services: Mood/Behaviors: [Resident 47] is doing okay. He has been wandering a lot more looking for his family. On 5/17/25 at 12:03 PM a nursing note revealed, Doing rounds, Patient wasn't in room. Initiated code green, unable to locate resident in facility, authorities notified, resident located safely. Family notified and updated. On 5/18/25 a weekly nursing note revealed, .This past week on 5/17 he wandered out of the facility and the police dispatch got in contact with the facility to say they found him. He is now being monitored every 30 to and [sic] hour to monitor his activity. WCTM [will continue to monitor]. On 4/13/26 at 11:56 AM, an interview was conducted with the DON. The DON stated he did not have an incident report for resident 47's elopement. The DON stated he usually did an incident report and would report an elopement to the State Survey Agency and conduct an investigation. The DON stated staff watched the camera footage and watched him go out a door on wing 4. The DON stated resident 47 was wandering prior to the elopement. The DON stated staff talked to resident 47's daughter about moving him to the secured unit but the daughter did not want resident 47 and his wife together in the secured unit. The DON stated after the elopement, resident 47 was moved to the secured unit. The DON stated he did not know where the police located resident 47. 2. Resident 72 was admitted to the facility on [DATE] and discharged on 6/29/24 with diagnoses which included, but were not limited to, vascular dementia and dementia in other diseases classified elsewhere, mild, with anxiety. On 6/24/24, an Elopement Risk Assessment was completed. The questions on the form were all answered yes. In addition, the form documented Care plan for high risk for elopement. Differentiate strategies for the cognitively intact v. cognitively impaired individuals Educate staff and enter notation on CNA [Certified Nursing Assistant] kiosk charting Utilize wander detection systems Add the name of the resident with the wander detection system on the kiosk Assess whether resident is appropriate candidate for Memory Lane Implement 15 minute checks as appropriate (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Move resident closer to nurses' desk as appropriate. It should be noted that an individualized care plan was not initiated. On 6/24/24 at 8:46 PM, a Nursing progress note documented . He wandered in this unit and wanted to get out of this building. On 6/26/24 at 5:53 AM, a Nursing progress note documented . Wandered halls a little after 1 until 3, needed constant redirection to stay out of other residents [sic] rooms. On 6/28/24 at 2:46 PM, a Nursing progress note documented . He had to wander around the wing, and staff redirected him with positive results. On 6/28/24 at 7:30 PM, a Nursing progress note documented Resident was found having left the building after the alarm went off, this nurse contacted family and police, he was shortly found after with no injuries, family was contacted and he was brought back with happy affect. The facility Incident Report documented the incident happened on 6/28/24 at 5:15 PM. Resident 72 was found to have left the building after the alarm was sounded. The nurse contacted law enforcement and family, resident 72 was shortly found after and brought back to the facility. Resident 72 sustained no injuries, he was brought back by the Director of Nursing (DON). Resident 72 had a good affect and was pleasant and cooperative. The facility Form 358: Facility Reported Incidents was reviewed. A detailed account of the incident documented Staff went to give [name redacted] his pills and they could not find him. They started searching right away. 5 min [minutes] into the search, they called 911 to have them assist. A few min. later, the police located him and he was brought back to the facility. He was assessed for any injuries and was found to be un-harmed. His wife was notified of the incident and was relieved he was found so quickly. He is due to be discharge tomorrow after a 5 day respite stay. It should be noted that an investigation was not conducted to determine how resident 72 eloped from the facility. On 4/13/26 at 11:34 AM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated resident 72 went out of the locked unit and the alarm went off. RN 3 stated when he heard the alarm he opened the door to the hallway to see who went out. RN 3 stated that he could not see anyone in the hallway so he determined the resident was still on the unit. RN 3 stated there was a patio on the unit and the gate was chained. RN 3 stated at the time the chain was missing. RN 3 stated that he contacted the DON, law enforcement, and resident 72's family. RN 3 stated he thought it was before dinner when resident 72 was found approximately before 4:00 PM or 4:30 PM. RN 3 stated they found resident 72 walking down the road. RN 3 stated that resident 72 was assessed for injury and he was fine. RN 3 stated that he thought maybe resident 72 had pulled the gate chain off but was unsure. RN 3 stated the gate chain was wrapped around the gate and not locked. On 4/13/26 at 11:50 AM, an interview was conducted with RN 4. RN 4 stated the two patio areas and the back door that was fenced in on the unit did not have an alarm. RN 4 stated there were two emergency exits on the unit that would alarm. RN 4 stated the back door that went to the back fenced area was always locked. An observation was conducted of the back door and it was locked. On 4/13/26 at 12:47 PM, an interview was conducted with the DON. The DON stated that resident 72 eloped and the next day resident 72 discharged home. The DON stated that resident 72 was at the facility for a respite stay. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/13/26 at 12:58 PM, an interview was conducted with the Minimum Data Set (MDS) Coordinator. The MDS Coordinator stated a behavior care plan on admission was initiated for all residents. The MDS Coordinator stated that resident 72 was at the facility for a respite stay and if resident 72 was at the facility longer a complete care plan would have been done. The MDS Coordinator stated a care conference would be held the first week after admission and a comprehensive care plan would have been completed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 did not 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. Specifically for 3 out of 32 sampled residents, Enhanced Barrier Precautions (EBP) was not implemented for a resident with an indwelling medical device. Additionally, hand hygiene was not performed during wound care for a resident and there was cross-contamination during dining when a Certified Nursing Assistant (CNA) touched a chair and then a resident's food. Resident identifiers: 6, 17, and 28. Findings Included: 1. Resident 6 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included end stage renal disease, dependence on renal dialysis, and type 2 diabetes with diabetic chronic kidney disease. Resident 6's medical record was reviewed 4/6/26 through 4/13/26. On 4/6/26 at 12:23 PM, a concurrent observation and interview were conducted with resident 6. Resident 6 stated that he had dialysis on Mondays, Wednesdays, and Fridays. Resident 6 stated that he had a fistula that did not work so he had a different type of catheter that was used. Resident 6 stated that he was incontinent of urine on occasion and staff only wore gloves when caring for him. Resident 6 was observed to have a central venous catheter that was used for dialysis. There was no EBP signage observed for resident 6. On 4/8/26 at 9:00 AM, an interview was conducted with CNA 3. CNA 3 stated that EBP was for residents with urinary catheters or an infectious disease and gowns and gloves should be worn when providing care for the resident. On 4/8/26 at 9:04 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that EBP was required for residents that had indwelling medical devices such as a Peripherally Inserted Central Catheter (PICC) lines, urinary catheters, wounds, or nasogastric tubes. RN 2 stated that gowns and gloves should be worn when providing close personal contact which would include transferring, foley care, and changing briefs. RN 2 stated that resident 6 did not have an indwelling device, but had a port that was under his skin. RN 2 stated that a central venous catheter was not an indwelling medical device. On 4/8/26 at 9:17 AM, an interview was conducted with CNA 2. CNA 2 stated that resident 6 was sometimes incontinent of urine and would be assisted in the morning to have a brief change. CNA 2 stated that resident 6 was not on EBP. On 4/8/26 at 9:55 AM, an interview was conducted with RN 1. RN 1 stated that she was not sure what kind of device resident 6 had for dialysis. RN 1 stated that resident 6 wore a brief for breakthrough incontinence. On 4/9/26 at 9:44 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that EBP was required for residents that had an Intravenous (IV) catheters, foley or suprapubic catheters, and open wounds. The DON stated that he was not sure if resident 6 required EBP. The DON stated that he was not sure how resident 6 received his dialysis. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/9/26 at 10:15 AM, a follow-up interview was conducted with the DON. The DON stated that resident 6 did have a central line and was placed on EBP. 2. Resident 28 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included mixed incontinence, neuromuscular dysfunction of bladder, and multiple sclerosis. On 4/6/26 at 2:07 PM, a concurrent observation and interview were conducted with resident 28. Resident 28 stated that she had wounds on her buttocks. On 4/13/26 at 11:09 AM, an observation of resident 28's wound care was conducted with RN 3. The following was observed: On 4/13/26 at 11:09 AM, RN 3 donned a gown. On 4/13/26 at 11:10 AM, RN 3 washed his hands and donned gloves. On 4/13/26 at 11:11 AM, RN 3 cleansed both wounds with wound spray and gauze. On 4/13/26 at 11:12 AM, RN 3 placed a clean bandage over the lower wound. The bandage did not stick to the skin. On 4/13/26 at 11:13 AM, RN 3 removed the bandage and doffed gloves. RN 3 walked to the cabinet in the resident's room and retrieved more bandages. RN 3 donned gloves and dried the wound with gauze. On 4/13/26 at 11:14 AM, RN 3 applied bandage to both wounds. On 4/13/26 at 11:15 AM, RN 3 doffed gown and gloves and washed hands. On 4/13/26 at 11:17 AM, an interview was conducted with RN 3. RN 3 stated that once he removed his gloves, best practice would be to wash or sanitize his hands before applying new gloves. RN 3 stated that resident 28's wounds appeared to be related to moisture and skin tears. On 4/13/26 at 11:48 AM, an interview was conducted with the DON. The DON stated that hand hygiene should be performed after removing gloves and before applying new gloves. A review of the facility's wound policy revealed: Wound Care Level III Purpose The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation 1. Verify that there is a physician's order for this procedure. 2. Review the resident's care plan to assess for any special needs of the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. For example, the resident may have PRN orders for pain medication to be administered prior to would [sic] care. 3. Assemble the equipment and supplies as needed. Date and initial all bottles and jars upon opening. Wipe nozzles, foil packets, bottle tops, etc., with alcohol pledget before opening,as necessary. (Note: This may be performed at the treatment cart.) Equipment and Supplies The following equipment and supplies will be necessary when performing this procedure. 1. Dressing material, as indicated (i.e., gauze, tape, scissors, etc.); 2. Disposable cloths, as indicated; 3. Antiseptic (as ordered); and 4. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed). Steps in the Procedure 1. Arrange the supplies so they can be easily reached. 2. Wash and dry your hands thoroughly. 3. Position resident. 4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves and gown, and any other PPE that may be appropriate. 7. Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound. 8. Remove dry gauze. Apply treatments as indicated. 9. Dress wound. [NAME] tape with initials, time, and date and apply to dressing. 10. Discard disposable items into the designated container. Discard all soiled laundry, linen, towels, and washcloths into the soiled laundry container. Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly. 11. Reposition the bed covers. Make the resident comfortable. Use supportive devices as instructed. 12. Place the call light within easy reach of the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	13. Wipe reusable supplies with alcohol as indicated (i.e., outsides of containers that were touched by unclean hands, scissor blades, etc.). Return reusable supplies to resident's drawer in treatment cart. 14. Take only the disposable supplies that are necessary for the treatment into the room. Disposable supplies cannot be returned to the cart. 15. Wash and dry your hands thoroughly. 16. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them that they may now enter the room. Documentation The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition. 6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 7. How the resident tolerated the procedure. 8. Any problems or complaints made by the resident related to the procedure. 9. If the resident refused the treatment and the reason(s) why. 10. The signature and title of the person recording the data. Reporting 1. Notify the supervisor if the resident refuses the wound care. 2. Report other information in accordance with facility policy and professional standards of practice. 3. Resident 17 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which consisted of spastic quadriplegic cerebral palsy, dysphagia, and borderline intellectual functioning. On 4/6/26 at 12:08 PM, an observation was made of resident 17 during the lunch meal service. Resident 17 was assisted with dining by Certified Nurse Assistant (CNS) 4. CNA 4 was observed to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	don gloves to assist resident 17 with his meal. CNA 4 then pulled out a chair with her gloved hands. CNA 4 then touched resident 17's chicken nuggets with the same gloved hands to feed the resident. On 4/06/26 at 1:05 PM, an interview was conducted with CNA 4. CNA 4 stated that she wore gloves to protect the resident and she would not want anyone to touch her food while she was eating. CNA 4 stated that gloves should be changed anytime she touched anything that had a potential for cross contamination. CNA 4 stated that she should have changed her gloves after she touched the chair and before she touched resident 17's food. On 4/13/26 at 2:58 PM, an interview was conducted with the DON. The DON stated that for dining assistance staff were to sanitize in between touching a resident and resident items and before handling resident utensils and cups. The DON was informed of CNA 4 and resident 17's dining observation. The DON stated that CNA 4 should have sanitized their hands prior to touching the resident's food.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that the resident right to self-administer medications was clinically appropriate and safe. Specifically for 2 out of 32 sampled residents, residents were observed to have medications in their rooms and were not evaluated to determine if they were safe to self-administer medications. Resident identifiers: 6 and 28. Findings included: 1. Resident 6 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, acute posthemorrhagic anemia, constipation, and gastrointestinal hemorrhage. Resident 6's medical record was reviewed 4/6/26 through 4/13/26. On 4/6/26 at 12:19 PM, an observation was made of an opened bottle of Pepto-Bismol on resident 6's dresser. On 4/7/26 at 9:04 AM, an interview was conducted with resident 6. Resident 6 stated that he had administered Pepto-Bismol to himself for an upset stomach. Resident 6 stated that he last had Pepto Bismol about one week ago. It should be noted that no documentation that Resident 6 had been evaluated to self-administer medication was located in the medical record. 2. Resident 28 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included mixed incontinence, neuromuscular dysfunction of bladder, and multiple sclerosis. Resident 28's medical record was reviewed 4/6/26 through 4/13/26. On 4/6/26 at 2:07 PM, a concurrent observation and interview were conducted with resident 28. Resident 28 had nystatin powder and a tube of mupirocin ointment on a table. Resident 28 stated that she had wounds on her buttocks and would apply the nystatin powder or mupirocin to her wounds. Resident 28 stated that a Certified Nursing Assistant (CNA) would apply the nystatin powder with brief changes. It should be noted that no documentation that Resident 28 had been evaluated to self-administer medication was located in the medical record. On 4/8/26 at 9:51 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that medications for residents could not be left at bedside and she observed residents swallow their medications before leaving the room. RN 1 stated that for residents to self-administer medications there needed to be a physician's order to keep medications at bedside. RN 1 stated that nystatin powder was considered a medication and was usually stored in the resident's bathroom. RN 1 stated that Pepto-Bismol was a medication and residents should not have it in their room. RN 1 stated that mupirocin ointment was a medication and should not be in a resident's room. RN 1 stated that she was not aware of any residents that were able to self-administer medication. On 4/8/26 at 12:30 PM, an interview was conducted with RN 2. RN 2 stated that residents could keep medications at their bedside if there was a physician order. RN 2 stated that she did not know of any residents that were able to self-administer medications. On 4/9/26 at 9:44 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that there was a form that he got from the internet that he filled out if residents were capable of self-administering medications. The DON stated that this form was not kept in the residents' medical record. The DON stated that staff would know which residents could self-administer medications because nurses would just know. The DON stated that there was not a physician's order for residents to self-administer medications. The DON stated that nystatin powder, mupirocin ointment, and Pepto-Bismol were all medications. The DON stated that there were not any residents in the facility that were able to self-administer medications.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not maintain evidence demonstrating the results of all grievances for a period of no less than three years from the issuance of the grievance decision. Specifically, for 1 out of 32 sampled residents, a resident's family member reported a missing purse, wallet, and glasses, but the facility did not document a prompt resolution or follow-up. Resident identifier: 5. Findings included: Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included heart failure, Sjogren's syndrome, and Non-Hodgkin lymphoma.On 4/6/26 at 12:19 PM, an interview was conducted with resident 5's family member. The family member stated that resident 5 lost her purse, driver's license, and credit cards when she was first admitted to the facility. The family member stated that facility staff never located the purse. On 4/6/26 at 8:46 AM, an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated that if a resident notified her about missing property or items she would look around the resident's room. CNA 2 stated she would inform the Director of Nursing (DON) or Assistant Director of Nursing (ADON) about any missing property. On 4/8/26 at 8:50 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that if a resident reported missing personal items then she would look around the resident's room. RN 2 stated that she thought the social worker had grievance forms for residents, but she was not sure. On 4/8/26 at 9:22 AM, an interview was conducted with the Social Services Director (SSD). The SSD stated that resident 5's missing purse occurred a while back and the facility searched for the purse, but never found it. The SSD stated that she spoke with resident 5's daughter, who informed her that she was not worried about the purse. On 4/8/26 at 9:42 AM, a follow-up interview was conducted with the SSD. The SSD stated that she did not have resident 5 fill out a grievance form and she was unable to locate a form that she may have completed regarding the missing purse. On 4/8/26 at 12:28 PM, a follow-up interview was conducted with the SSD. The SSD stated that she located a spreadsheet with information regarding the grievance. The SSD stated that on 6/15/25 resident 5's family member reported that resident 5 lost her purse, wallet, and glasses and believed they were stolen. The SSD stated that she could not locate a written resolution to the grievance. On 4/13/26 at 1:08 PM, an interview was conducted with the Administrator (ADM). The ADM stated that grievances were usually brought up in resident council or given verbally. The ADM stated that the SSD contacted resident 5's daughter, notified her of the missing purse, and ended the investigation. The ADM stated that there was not a written grievance or a written resolution to the grievance.

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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 observation, interview and record review, for 1 of 32 sampled residents, the facility did not develop and implement comprehensive person-centered care plans for each resident. Specifically, a resident's care plan was not updated with interventions after each fall. Resident identifier: 47. Findings included: Resident 47 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease, arthritis, pain, psychotic disorder with hallucinations, major depressive disorder, and dementia with psychotic disturbance. On 4/8/26 at 10:19 AM, a concurrent interview and observation were made of resident 47. Resident 47's door was shut. Resident 47 was observed to be laying in bed with his walker about 2 steps away from his bed. Resident 47 stated if he needed help he used the button. Resident 47's call light was wrapped around the head board and not within reach. Resident 47 was observed to try and find the call light but he was unable to find the call light. At 10:43 AM, the call light continued to be out of reach, his walker was 2 steps away from the bed and his door remained shut. At 11:06 AM, resident 47's door continued to be shut, his walker was about 2 steps away from bed and the call light was not within reach. On 4/9/26 at 2:20 PM, a concurrent observation and interview were made of resident 47. Resident 47 was observed in his room with the door closed. Resident 47 was laying in bed with a walker next to the bed and the call light was under the bedspread and resident 47 was laying on top of the bedspread. Resident 47 stated if he needed help he went down to the office to call for someone. Resident 47 was observed to look for the call light and was unable to find the call light. At 2:43 PM, resident 47 was observed in the hallway with his walker. Resident 47 sustained 15 falls from 7/6/25 until 4/13/26. Resident 47's progress notes and care plans were reviewed and revealed the following: 1. Resident 47 was found on the floor in front of his recliner on 12/6/25. There was no intervention. 2. Resident 47 was found on the floor on 1/22/26. There was no new intervention. 3. Resident 47 was found on the floor on 2/5/26. There was no new intervention. 4. Resident 47 was found on the floor 3/11/26. There was no new intervention.5. Resident 47 fell in the restroom on 3/20/26. There was no new intervention. On 4/13/26 at 11:56 AM, an interview was conducted with the Director of Nursing (DON). The DON stated after a resident fell, the resident was assessed for an injury. The DON stated if there was no injury, then an incident report was started, staff looked at the reason for the fall, a new intervention was added to the care plan and the resident was monitored for 72 hours. The DON stated resident 47 did not have interventions after falls on 12/6/25, 1/22/26, 2/5/25, 3/11/26 and 3/20/26. The DON stated all staff had access to care plans. The DON did not have additional information to add when notified that resident 47's door was shut, the call light was out of reach and the walker was out of reach.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined that the facility did not ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences. Specifically, for 1 out of 32 sampled residents, the facility did not address a resident's pain when Semi-Effective pain control was reported by the resident. Resident identifier: 63. Findings included: Resident 63 was admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which included chronic pain, peripheral vascular disease, chronic kidney disease, major depressive disorder, and generalized anxiety disorder. On 4/07/26 at 9:17 AM, an interview was conducted with resident 63. Resident 63 stated she had pain in the right leg and her back. Resident 63 stated that they gave her pain medications and it somewhat helped. It calms down the pain, so it's not as intense, but doesn't take it completely away. Resident 63 reported that her current pain level was 8/10 on a scale of 1-10. Resident 63 stated that her acceptable level of pain was a 5/10. Resident 63 stated that she had her pain medication this morning and was waiting until 10 AM for her second dose. Resident 63's physician's orders included the following: Acetaminophen Extra Strength (acetaminophen) tablet; 1000 milligram (mg) every 8 hours as needed (PRN). The order was initiated on 9/18/25. Hydrocodone-acetaminophen tablet; 10-325 mg every 4 hours PRN. The order was initiated on 3/16/26. Ibuprofen tablet; 800 mg every 8 hours PRN. The order was initiated on 3/16/26. Resident 63's March 2026 Medication Administration Record (MAR) documented that the hydrocodone was semi-effective (SE) on the following dates: 3/1/26 at 5:35 AM3/1/26 at 9:56 AM3/1/26 at 2:56 PM3/3/26 at 1:46 AM3/426 at 8:47 AM3/11/26 at 5:49 AM3/11/26 at 10:06 AM3/12/26 at 8:56 PM3/13/26 at 1:30 PM3/14/26 at 11:16 AM and 3:12 PM3/15/26 at 8:43 AM and at 3:21 PM3/18/26 at 7:22 AM3/18/26 at 11:46 AM3/23/26 at 5:52 AM3/23/26 at 10:47 AM3/26/26 at 3:47 PM3/28/26 at 10:23 AM3/29/26 at 1:55 PM It should be noted that 20 doses were documented as semi-effective and no documentation could be found of what other treatments were provided to alleviate resident 63's pain. Resident 63 had a care plan initiated for Pain on 1/14/26. The goal of the plan was that the resident's pain would be relieved within 30 minutes of onset. Interventions identified were to divert attention through activities as tolerated; encourage resident to report pain, assess pain each shift both verbal and nonverbal, and work with the Medical Doctor (MD) to manage pain; pain assessment per protocol with pain scale, assess characteristics of pain as well as location and type of pain; pain medications as ordered by physician, and notify MD if medication was not managing pain adequately; and reposition frequently as needed to promote comfort. On 4/07/26 at 2:51 PM, an interview was conducted with Registered Nurse (RN) 5. RN 5 stated that resident 63 had chronic back pain and sometimes had right ankle pain. RN 5 stated that resident 63 had PRN Norco [Hydrocodone-acetaminophen] and ibuprofen for pain. RN 5 stated that the non-pharmacological interventions for pain were repositioning, ice for the ankle, heat with warm blankets, pillows, and elevating feet to relieve the pressure on the back. RN 5 stated that they documented this in resident 63's quarterly pain assessment and sometimes weekly progress notes. RN 5 stated that when pain medication was administered a notification popped up within the first hour after administration to document the effectiveness of that medication. RN 5 stated the SE indicated that the pain medication was somewhat effective. RN 5 stated that if it was documented SE then they would offer repositioning. RN 5 stated that resident 63's pain was never fully alleviated and she had chronic pain. RN 5 stated that she did not notify the Medical Doctor (MD) when resident 63's pain medication was SE. RN 5 stated that resident 63 went to the pain clinic monthly and they prescribed all the pain medication and managed her pain. RN 5 stated that the facility MD did not handle resident 63's pain medication. RN 5 stated that sometimes they would notify the pain clinic that the medication was SE and that would be documented in a progress note. It should be noted that no documentation could be (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	found that the pain clinic was notified of resident 63's SE pain management. On 4/08/26 at 9:53 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that non-pharmacological interventions for pain management were repositioning, distraction, heat or ice. The DON stated that these interventions were not documented in the MAR prior to yesterday. The DON stated that staff should document the effectiveness of the pain medication after administration and he would expect the nurses to assess if the pain was tolerable. The DON stated that it was not currently documented in the progress notes. The DON stated that the nurse should notify the MD if alternate options for pain relief were not effective. Review of the facility policy on Administering Pain Medications documented that the purpose of the procedure was to provide guidelines for assessing the resident's level of pain prior to administering analgesic pain medication. The policy documented the following: General Guidelines1. The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. 2. ?Pain management' is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. 3. Pain management is a multidisciplinary care process that includes the following:a. Assessing the potential for pain;b. Recognizing the presence of pain;c. Identifying the characteristics of pain;d. Addressing the underlying causes of the pain;e. Developing and implementing approaches to pain management;f. Identifying and using specific strategies for different levels and sources of pain;g. Monitoring for the effectiveness of interventions; andh. Modifying approaches as necessary. 4. Cognitive, cultural, familial, or gender-specific influences on the resident's ability or willingness to verbalize pain are considered when assessing and treating pain. Comprehensive pain assessments are conducted upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. 3. Acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained. 4. For stable chronic pain the resident's pain and consequences of pain are assessed at least weekly. 5. When opioids are used for pain management, the resident is monitored for medication effectiveness, adverse effects, and potential overdose. a. Any resident who uses opioids for long-term management of chronic pain is at risk for opioidOverdose.The policy was last revised in October 2022.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Specifically, for 1 out of 32 sampled residents, a resident receiving dialysis did not have a physician's order for dialysis and communication notes with the dialysis center were missing. In addition, the staff were not monitoring the dialysis fistula and there were no physician orders to monitor the dialysis fistula. Resident identifier: 50. Findings included: Resident 50 was admitted to the facility on [DATE] and readmitted after a hospital stay on 1/24/26 with diagnoses, which included but were not limited to, fluid overload, unspecified, end stage renal disease, chronic diastolic (congestive) heart failure, hypotension, unspecified, hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, dependence on renal dialysis, and type 2 diabetes mellitus with diabetic chronic kidney disease.On 4/7/26 at approximately 11:00 AM, resident 50 was observed near the nurse's station with white coban on his left forearm. The staff asked resident 50 what his dialysis days were. Resident 50 stated he went to dialysis on Monday, Wednesday, and Friday.On 4/8/26 at 11:25 AM, resident 50 was observed sitting on the side of the bed eating lunch. Resident 50 had white coban on his left forearm.A care plan Problem started on 7/29/25, documented Category: Renal DIALYSIS: [name redacted] receives hemodialysis and has potential for complications. The interventions started on 7/29/25, included, a. Address the psychosocial aspects of End Stage Renal Disease (ESRD). The disease and it's treatments cause many concerns about employment, finances, health, and sexual functioning, leading to anger or depression.b. Allow the client to participate in care, as he/she may be well educated about the disease and related care needs.c. Arrange for meals around the Dialysis session. Arrange for an early meal as needed, so save meals if the client can not eat during dialysis. The client has diabetes, make sure insulin and breakfast are given before dialysis.d. If blood work was ordered, coordinate with the Dialysis nurse about who was to draw the blood to prevent unnecessary needlesticks and loss of blood.e. If the client has diabetes and ESRD, and becomes hypoglycemic, give the client apple juice instead of orange juice to avoid excess potassium intake.f. If the client has external dialysis access, confirm with the dialysis nurse or central-line team that they will perform the dressing change. The catheter should be used for dialysis only, due to a high concentration of Heparin used to maintain patency.g. Instruct the client about diet restrictions and advise to avoid foods high in potassium and sodium.h. If post dialysis bleeding occurs at the access site, apply direct pressure to the site for 15 minutes (or longer if necessary) to stop the bleeding. If the bleeding continues, notify the physician. After controlling the bleeding, apply a dressing. Make sure you remove the dressing after 24 hours.i. Monitor for bruising, eye hemorrhage, tarry stools, and signs of anemia. Monitor Hematocrit level for sudden changes and notify physicians of problems.j. Provide water soluble medications after dialysis to avoid being dialyzed out of the system. Check with the physician about holding antihypertensive medications and check with the physician about removing the nitroglycerin patch, if applicable.k. Remind staff to avoid using the client's dialysis access area for administering intravenous (IV) medication, taking blood pressure (BP), or drawing blood.l. Restrict fluids as ordered. Avoid administering continuous infusions of IV fluids. Teach the client to monitor and document fluid intake and output.m. When the client returns from dialysis, assess the access site for bleeding and make sure BP is stable before the client resumes activity.On 7/25/25 at 12:09 AM, a Nursing progress note documented admission Date/Time:: 07/24/2025 05:00 PM General admission Diagnosis/Information:: ESKD [end stage kidney disease] on dialysis, hyperkalemia . Other: fistula .On 7/25/25 at 4:32 PM, a Nursing progress note documented . Pt [patient] has a shunt in his L [left] arm with patent thrill and bruit.On 7/25/25 at 9:13 PM, a Nursing progress note documented . Resident (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	has a shunt in his left arm with a patent thrill and bruit.On 7/26/25 at 12:16 PM, a Nursing progress note documented . Resident has a fistula in his left arm with a patent thrill and bruit.On 7/27/25 at 12:35 PM, a Nursing progress note documented . Resident has a fistula in his left arm with a patent thrill and bruit.On 7/31/25 at 9:39 PM, a Nursing progress note documented . Resident has a fistula in his left arm with a patent thrill and bruit.On 8/1/25 at 3:02 PM, a Nursing progress note documented . Pt has shunt in left arm patent with thrill and bruit. Pt has dressing covering shunt as dialysis was today.On 8/1/25 at 7:18 PM. a Nursing progress note documented . He has a fistula in his left arm with a patent thrill and bruit.On 8/16/25 at 8:28 PM, a Nursing progress note documented . Resident has a fistula on the left arm that has a thrill and a bruit.On 8/17/25 at 7:42 PM, a Nursing progress note documented . Resident has a fistula on the left arm that has a thrill and a bruit.On 8/21/25 at 8:43 PM, a Nursing progress note documented . Resident has a fistula on the left arm that has a thrill and a bruit.On 8/22/25 at 9:48 PM, a Nursing progress note documented . Resident has a fistula on the left arm that has a thrill and a bruit.On 8/23/25 at 6:03 PM, a Nursing progress note documented . Resident has afistula on the left arm that has a thrill and a bruit.On 10/29/25, a Consulting Physicians Progress Notes documented Please Note: If his fistula bleeds, you must apply manual pressure until the bleeding stops. Do not ever wrap coban/tape all the way around the fistula. It can ruin the fistula.On 1/10/26 at 3:21 PM, a Nursing progress note documented . Pt has dialysis MWF [Monday, Wednesday, and Friday] and has a shunt in his L forearm; patent thrill and bruit.It should be noted that there was no other monitoring of the fistula documented in the medical record. There were no physician orders for monitoring of the dialysis fistula. There was no immediate monitoring and documentation of the status of the resident's fistula upon return from dialysis.There were no physician orders for resident 50 to go to dialysis three times a week.There was no ongoing communication and collaboration with the dialysis facility regarding dialysis care and services on 18 occasions.There were no ongoing assessments of resident 50's condition and monitoring for complications before and after dialysis treatments.On 4/8/26 at 9:25 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that assessing a resident was performed by every nurse to make sure the dressing on the fistula was either on or off. RN 2 stated the dialysis center would assess resident 50's fistula and would communicate with them. RN 2 stated if the fistula was bleeding resident 50 would notify them and she would hold pressure on the fistula and communicate to the dialysis center. RN 2 stated that staff would assess the fistula to make sure it was pulsing well and look for any signs or symptoms of infection. RN 2 stated that they did not want the fistula wrapped and she would try to take the dressing off. RN 2 stated the resident would come back from dialysis with the dressing on and she would keep the dressing on until she was sure it had stopped bleeding and then she would remove the bandage. RN 2 stated that it was best practice to have a physician's order for dialysis in the medication administration record. RN 2 stated there were no orders for resident 50's dialysis in the system. RN 2 stated that she would quickly glance at the fistula when she went in resident 50's room. RN 2 stated that resident 50 was not on a fluid restriction. RN 2 was not sure what to assess post dialysis. RN 2 stated the dialysis center would do the pre and post vitals including the blood pressure and weight. On 4/8/26 at 11:08 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that when a resident was admitted with dialysis the dietary staff would meet with the resident, the nursing staff would care for the dialysis site, and the resident would have daily weights for the first three days. The DON stated the first dialysis day after admission was fairly quickly. The DON stated there should be orders for dialysis. The DON stated when assessing the fistula the staff should be looking for signs and symptoms of infection and adverse reactions, monitoring for pain, and assessing for bleeding. The DON stated the staff would assess the fistula before or after dialysis. The DON stated that staff would not assess the fistula for bruit or thrill. The DON stated that resident 50 was not on a fluid restriction and he was unsure why. The DON stated that staff would contact resident 50's primary care physician or get him seen if there were any issues. The DON stated the dialysis center did not (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	send orders for labs to be drawn. The DON stated that staff should remove the coban to assess the fistula site.The facility Dialysis Coordination Agreement that was entered into on 7/14/2016, documented . 1. RESPONSIBILITIES OF DIALYSIS CENTER. The Dialysis Center will provide Dialysis Services to residents of Facility in accordance with each Facility resident's treating physician's orders. the plan of care established by Facility. and in accordance with applicable state and federal laws and the standards of the Joint Commission (if applicable). Dialysis Center shall provide Facility with copies of all appropriate documentation regarding the Dialysis Services at the time the resident is transported from the Dialysis Center back to Facility.2. RESPONSIBILITIES OF FACILITY. The Facility will be responsible for the following: (i) Under the direction Patients physician, Facility will provide a plan of care for all residents receiving Dialysis Services: (ii) Facility will maintain appropriate medical records and will make all such medical records available to Dialysis Center to the extent necessary or appropriate in the providing of the Dialysis Services and maintaining a continuum of patient care: .

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review the facility did not ensure that individuals working in the facility as a nurse aide had completed a training and competency evaluation program within 4 months from date of hire. Specifically, for 1 out of 5 sampled staff members, the facility had employed a Nurse Aide since May of 2025 without them having completed their certification course. Staff identifier: Nurse Aide (NA) 1. Findings included: On 4/13/26, NA 1's personnel file was reviewed. NA 1's date of hire was 5/19/25. NA 1 did not have verification of a completed nurse aide competency and certification course on file. On 4/13/26 at 11:47 AM, an interview was conducted with Human Resources (HR) 1. HR 1 stated that upon hire they provided education to the NA on where they could obtain their certification and how they could be reimbursed by the facility. HR 1 stated that NA 1 was hired in May 2025 and was still working without his certification. HR 1 stated that upon hire NA 1 signed a form acknowledging that he was provided this education and was required to obtain his certification within 4 months from his date of hire. It should be noted that this signed form was not provided to the State Survey Agency (SSA). On 4/13/26 at 2:58 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that he was aware that NA 1 had been working longer than 4 months without obtaining his certification.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that each resident's drug regimen was free from unnecessary drugs. An unnecessary drug was any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicated the dose should be reduced or discontinued; or any combination of the above. Specifically, for 2 out of 32 sampled residents, the facility did not monitor residents' pain management for non-pharmacological interventions and adverse side effects. Resident identifiers: 50 and 58. Findings included: 1. Resident 58 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included dementia, insomnia, fracture of right femur, and pain. Resident 58's physician orders included: Tramadol - Schedule IV tablet; 50 milligrams (mg) oral every 6 hours as needed (PRN). The order was initiated on 10/29/25. Acetaminophen tablet,chewable; 650 mg oral every 6 hours PRN. The order was initiated on 10/29/25. Tylenol PM Extra Strength (diphenhydramine-acetaminophen) tablet; 2 tablets oral at bedtime PRN. The order was initiated on 10/29/25. Resident 58's March 2026 Medication Administration Record (MAR) documented that the Acetaminophen was administered 10 times during the month for pain scores of 2 on the numerical scale of 0-10 and the Wong-Baker FACES scale. Additionally, on 3/13/26 at 11:19 AM, resident 58 was administered Acetaminophen for a pain score of 0 which indicated no pain. Resident 58's March 2026 MAR documented that the Tramadol was administered 15 times during the month for pain scores ranging from 2-4 on the Wong-Baker FACES scale. Additionally, on 3/28/26 the resident was administered Tramadol for a pain score of 0 on the numeric scale which indicated no pain. Resident 58's March 2026 MAR documented that the Tylenol PM was administered 8 times and the reason was documented as pain. It should be noted that resident 58 was administered Tylenol PM on 3/13/26 at 4:22 PM after receiving Acetaminophen on 3/13/26 at 11:19 AM, which was 5 hours after the first dose was administered. Resident 58 was also administered Tylenol PM on 3/18/26 at 5:04 PM, after receiving Acetaminophen on 3/18/26 at 11:59 AM, which was 5 hours after the first dose was administered. No documentation could be found on the MAR for non-pharmacological interventions for pain management and no monitoring was found for Adverse Side Effects (ASE) of the medications. On 4/07/26 at 1:19 PM, an interview was conducted with Registered Nurse (RN) 4. RN 4 stated that they monitored resident 58 for leg pain and documented it in a pain score. RN 4 stated that non-pharmacological interventions for pain were repositioning and having the resident ambulate a bit. RN 4 stated that they attempted this prior to administering pain medication. RN 4 stated that these non-pharmacological interventions would be documented in a nurse's note. It should be noted that no (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation was found of non-pharmacological interventions in resident 58's progress notes. On 4/07/26 at 1:22 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that staff were not documenting on the MAR any non-pharmacological pain interventions and it might be documented in a progress note. The DON stated that non-pharmacological interventions would not be connected to the pain medication in the MAR and there was no way to determine if a non-pharmacological intervention was provided prior to the administration of the pain medication. 2. Resident 50 was admitted to the facility on [DATE] and readmitted after a hospital stay on 1/24/26 with diagnoses, which included but were not limited to, fluid overload. A physician's order dated 1/24/26, documented acetaminophen 500 mg every 6 hours as needed. A physician's order dated 1/24/26, documented hydrocodone-acetaminophen 7.5-325 mg every 6 hours as needed for pain. A physician's order dated 1/24/26, documented Lidocaine Pain Relief adhesive patch 4 % apply one patch daily to the affected area. The January, February, March, and April 2026 MAR was reviewed. Non-pharmalogical pain interventions were not offered to resident 50. On 4/7/26 at 12:39 PM, an interview was conducted with RN 1. RN 1 stated that every shift the nursing staff would assess the resident for pain. RN 1 stated that nonpharmacological interventions were not on her charting. On 4/7/26 at 1:28 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that she would only do nonpharmacological interventions if the nurse asked her to. On 4/7/26 at 1:29 PM, an interview was conducted with the DON. The DON stated that resident 50 did not have nonpharmalogical interventions for pain. Review of the facility policy on Administering Pain Medications documented that the purpose of the procedure was to provide guidelines for assessing the resident's level of pain prior to administering analgesic pain medication. The policy documented the following: General Guidelines 1. The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. 2. 'Pain management' is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. 3. Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465079	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunshine Terrace Skilled Nursing	248 West 300 North Logan, UT 84321

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Recognizing the presence of pain; c. Identifying the characteristics of pain; d. Addressing the underlying causes of the pain; e. Developing and implementing approaches to pain management; f. Identifying and using specific strategies for different levels and sources of pain; g. Monitoring for the effectiveness of interventions; and h. Modifying approaches as necessary. 4. Cognitive, cultural, familial, or gender-specific influences on the resident's ability or willingness to verbalize pain are considered when assessing and treating pain. Comprehensive pain assessments are conducted upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. 3. Acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained. 4. For stable chronic pain the resident's pain and consequences of pain are assessed at least weekly. 5. When opioids are used for pain management, the resident is monitored for medication effectiveness, adverse effects, and potential overdose. a. Any resident who uses opioids for long-term management of chronic pain is at risk for opioid Overdose. The policy was last revised in October 2022.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review it was determined that the facility did not ensure that nurse aides received in-service training for continued competency of no less than 12 hours per year and included dementia management and abuse prevention training. Specifically, for 2 out of 5 sampled employees, the nurse aides did not receive 12 hours per year of continued competency training. Staff identifiers: Certified Nurse Assistant (CNA)1 and Nurse Assistant (NA) 1. Findings included: On 4/13/26, CNA 1 and NA 1's personnel files were reviewed. CNA 1 had a date of hire of 11/10/25, and NA 1 had a date of hire of 5/19/25. CNA 1 and NA 1 did not have any evidence of continued competency training that was at least 12 hours per year. On 4/13/26, Human Resources (HR) 1 provided a staff training schedule for the 5 sampled employee files. The schedule documented that CNA 1 had not received any of the 3 in-service training opportunities since date of hire and NA 1 had not received any of the 6 in-service training opportunities since date of hire. Additionally, none of the documented training included dementia management. On 4/13/26 at 9:57 AM, an interview was conducted with the Director of Nursing (DON). The DON stated training for dementia care included the nurse on the unit talking to the aides about the individual resident needs. The DON stated that at the last staff meeting they talked about behaviors and how to interact with residents. The DON stated that the new hire orientation process did not include dementia care training. On 4/13/26 at 10:34 AM, an interview was conducted with HR 1. HR 1 stated that they have a monthly in-service training, and the concept of annual education did not make sense. HR 1 stated that they just conducted monthly in-service training and not specific annual training. HR 1 stated that they provided on the job training, but did not have evidence that all staff were provided required yearly training for dementia and abuse.