STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465116	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Logan	1480 North 400 East Logan, UT 84341

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 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 interview and record review, 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' choices. Specifically, for 3 out of 46 sampled residents, a resident experienced a change in condition after a fall, was not provided treatment for 2.5 hours, and ended up passing away. Another resident complained of hip pain after a fall and was not sent to the hospital for 10 hours. These examples will be cited at harm. In addition, a resident was not provided treatment when he was experiencing low oxygen saturation levels. Resident identifiers: 74, 86, and 90. Findings included:HARM1. Resident 90 was admitted to the facility on [DATE] with diagnoses which included, paroxysmal atrial fibrillation, difficulty in walking, and muscle weakness.The facility reported to the State Survey Agency (SSA) on 6/12/24, that resident 90 was found on the floor in her bathroom at 1:30 PM, and she stated she did not hit her head. Neurological checks were initiated and no changes or abnormal vitals were identified until 8:30 PM. Resident 90 was sent to the Emergency Department due to nausea, vomiting, and confusion where she subsequently passed away.A review of resident 90's medical record revealed the following:a. On 6/11/24 at 1:32 PM, a nursing note documented, pt. [patient] calling for help from bathroom. pt. found on floor next to soilet [sic] in soiled clothing. pt immediately assisted back onto toilet, changed into clean clothing, neuros [neurologicals] started, and vitals. vitals and neuros are baseline for pt. pt. denies hitting head and no signs of injury present. pt. has a current UTI [urinary tract infection], poor lighting in bathroom, and no grippy socks were on. maintenance informed of the poor lighting, grippy socks placed, call light clipped to pt. with education to use that when needing to transfer, and pt. placed back into chair.b. On 6/11/24, neuro checks began at 1:15 PM. At 8:00 PM, the neuro sheet documented resident 90's blood pressure as 171/80 and heart rate was 106. At an unknown time the neuro sheet documented resident 90's level of consciousness as lethargic-slow to respond to verbal stimuli, hand grasps as weakness, and speech as slurred. c. On 6/12/24 at 1:40 AM, a nursing note documented, At 2030 [8:30 PM] pt started c/o [complaining of] HA [headache] and reported that she did hit her head at the time of the fall-bp [blood pressure] 123/59. 2100 [9:00 PM] neuros again checked 145/77. She was c/o nausea, vomiting, and was not following simple cues. 2130 [9:30 PM] BP assessed again 171/80. pthad [sic] left sided weakness for grip strength. Nurse contacted PA [physician assistant] and he reported that since her focal point has deficits et [and] that she has weakness, that needed [sic] to send her out. Called pt son et reported finding et he reported to send to ER [emergency room] for CT [computed tomography] Scan. EMTS [emergency medical technicians] called and pt was sent out at 2230 [10:30 PM] .A review of resident 90's Facility Reported Investigation interviews revealed the following:a. Registered Nurse (RN) 4's interview documented, I first saw [resident 90] for her 1900 [7:00 PM] neuro check. All checks and vitals were WNL [within normal limits]. At about 2000 [8:00 PM] the CNA [Certified Nursing Assistant] notified me she was complaining of a headache. I notified [name redacted] the wing nurse of the headache concerned [sic] due to her fall earlier in the day. [Name redacted] stated that she got in report that [resident 90] did not hit her head when she fell earlier in the day. I prepared her 2000 meds [medications] adding Tylenol for the headache. I then (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 0684 Level of Harm - Actual harm Residents Affected - Few	administered her meds and did the 2000 nuero [sic] checks. They were all WNL, but her blood pressure was starting to elevate. She conversed with me appropriately. I spent several minutes with her at the time administering her breathing treatment. I asked the CNAs to get her an ice pack to see if it helped her headache. At about 2100 [9:00 PM] the CNA notified me that [resident 90] had vomited. I immediately went in and assessed her. Her LOC [level of consciousness] had changed concerningly although she would still respond to me. She would not open her eyes. She followed commands to grip my hands. Right hand was strong, no grip at all with the left. I immediately notified [name redacted] the wing nurse and she started the notification process of all appropriate parties. I instructed the CNAs to clean [resident 90] up. She vomited once more right before the EMTs arrived.b. RN 5's interview documented, As I was receiving report for shift change, I was informed that pt [resident 90] had taken a fall earlier in the day and was on neuros. I asked many questions to see where they fell, if head was hit and behavior change from normal. Med nurse and swing aides gave answers, fell in bathroom and hit head and was recently complaining of headache. Once report was finished, I entered the room to immediately check on pt. Pt name was called many times and arm stimulation was used before pt responded. Pt kept saying yes to all questions and requests regardless of questions or tasks asked. Pt was unable to open eyes or respond as normal. Med nurse was notified who informed me to notify and give all information to the charge nurse. Charge nurse was notified and call Non-emergency line and requested transportation for pt. Med nurse called on radio that pt was throwing up and needs immediately [sic] attention. Swing aide and I rushed to the room to assist pt. As assisting EMTs arrived and took over. Charge nurse, swing aide and I stayed in room to assist and comfort roommate. EMT's stated BP was out of range and no response of puplies [sic]. Pt was assisted on stretcher and EMTs transported to hospital.A review of resident 90's hospital CT scan records revealed, Head CT: This examination is abnormal. There is a very large holohemispheric right cerebral convexity subdural hematoma, most pronounced along the right frontal lobe and subinsular cortex. This subdural hematoma measures 3.2 cm [centimeters] in maximum thickness. There is an additional right parafalcine subdural hematoma measuring up to 16mm [millimeters] in thickness-posteriorly. There is effacement on the right lateral ventricle. There is a leftward shift of the septum by approximately 21 mm. There is developing moderate right and left uncal and subfalcine herniation. [It should be noted that resident 90 was on anticoagulant medication and her International Normalized Ratio level was 3.5 on 6/11/24 at 10:51 PM.]On 2/5/26 at 10:58 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that she expected staff to reach out to the Director of Nursing or herself about any changes in condition that residents may have. The ADON stated that the medical provider made the decisions on when to send a resident to the hospital. On 2/6/26 at 5:02 PM, the facility provided additional information regarding resident 90. It should be noted that the additional information did not include why there was a 2.5 hour delay in sending resident 90 to the hospital once she began experiencing a change in condition. Resident 90 passed away on 6/12/24 at 1:48 AM. 2. Resident 86 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinsonism, muscle weakness, difficulty walking and sepsis. The facility reported to the SSA that resident 86 was found on the floor on 6/8/25, complaining of pain and an x-ray confirmed there was a fracture. A nursing progress note revealed resident 86 had a fall on 6/5/25. Resident 86 was moved closer to the nurses station. A nursing progress note from Licensed Practical Nurse (LPN) 1 dated 6/8/25 at 9:26 AM, revealed, Pt had fall this morning at approximatly [sic] 0645 [6:45 AM]. Pt found lying flat on ground next to bed and stated she had L [left] hip pain. Pt assessed no new bruising or redness noted at the time of fall. Pt unable to tell nurse where she was trying to go or what she needed. Pt at baseline. Nuro [sic] and vital check started. Pain medication administered and family Management and MD [medical doctor] notfified [sic]. Order placed for L hip xray. On 6/8/25 at 9:37 AM, a nursing progress note revealed Pt bed placed at lowest position, replaced personal socks with non slip socks, personal items and call light placed in reach. On 6/8/25 at 10:55 AM, a nursing progress note revealed, Pt stated the cna hit (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	her while nurse and cna were moving her up in bed. Pt was not hit by CNA the movement in bed using the draw sheet made her uncomfortable. On 6/8/25 at 7:04 AM, oxycodone 5 milligrams was administered with a pain level of 5. On 6/8/25 at 1:06 PM, oxycodone 5 milligrams was administered for left hip pain. The medication was documented as being ineffective with pain relief. On 6/8/25 at 4:59 PM, a nursing progress note revealed Pt discharged to [local] hospital via ambulance, due to left femoral neck fracture at 6/8/2025 1650 (4:50 PM). MD, family and unit manager notified. Copy of POLST [physician order for life sustaining treatment] Emergent discharge and Quality imaging results sent with ambulance staff. Pt or family unable to sign paperwork copy to be faxed to hospital. Nurse to Nurse report Hospital ER called and updated on PT info condition, baseline, vitals and arival [sic] with left femoral neck fracture. On 6/8/25 at 9:06 PM, a nursing progress note revealed 6/8 Unwitnessed Fall: Patient was found lying supine on the floor adjacent to her bed following an unwitnessed fall. She reported pain localized primarily to the left hip but was unable to confirm any head impact. A comprehensive head-to-toe assessment revealed no visible bruises, lacerations, or hematomas on the head. Neurological examination indicated pupils equal, round, and reactive to light, with bilateral hand-grip strength consistent with her baseline. Examination of the left hip showed mild erythema without evidence of bruising, swelling, or deformity. No additional abnormalities were noted on supporting extremities. Vital signs were within normal limits. The patient received her prescribed analgesic in conjunction with her scheduled morning medications. The attending physician, nursing management, and the patient's daughter . were promptly notified. A STAT [immediately] X-ray of the left hip was ordered per their direction. At the time of the fall, the patient was not wearing non-slip socks; her personal socks were immediately replaced with non-slip footwear. The orthopedic boot had been removed for comfort while resting and had not yet been reapplied. The room was free of clutter, with personal items and the call light within reach, and the bed was in its lowest position. The patient had been assisted with toileting less than 30 minutes prior to the incident. Post-fall, the patient was educated on the importance of using her orthopedic boot for ankle support and instructed to use the call light for assistance before mobilizing. Fall-risk assessment and care plan will be reviewed and updated to reflect this event. Resident 86 was readmitted to the facility with hospice services and passed away on 6/15/25. On 2/4/26 at 12:13 PM, an interview was conducted with Administrator (ADM) 1. ADM 1 stated she started on 6/16/25, and was unable to find additional information for resident 86's fall and change in condition. On 2/11/26 at 1:18 AM, a phone interview was conducted with LPN 1. LPN 1 stated after a fall he completed an initial assessment which included evaluating for a major injury and then neuro checks and vital signs were done for 72 hours. LPN 1 stated if a resident was on blood thinner, then a CT scan would be needed. LPN 1 stated resident 86 sustained a fall and complained of more pain in her hip and an x-ray was ordered. LPN 1 stated initially resident 86 complained of pain but not a significant amount of pain. LPN 1 stated he could not remember if the x-ray was ordered stat and if it was done at the facility or the hospital. LPN 1 stated he did not know why resident 86 was not sent to the emergency room for 10 hours after complaining of pain to the hip, but it was probably because he did not have a physician's order to send resident 86 to the hospital. LPN 1 stated he wanted to see if the resident's pain could be controlled at the facility. LPN 1 stated resident 86 had severe pain only with movement like rolling in bed or moving. LPN 1 stated he remembered her being in pain but did not remember any concerns of a CNA hitting her when repositioning her in bed. POTENTIAL FOR HARM 3. Resident 74 was admitted to the facility on [DATE] with diagnoses which included muscular dystrophy, obstructive sleep apnea, and dysphagia. The facility reported to the SSA on 12/28/25, that a nurse was not attending to resident 74 when his oxygen saturations (sats) were at 35% and a heart rate in the 100s. Resident 74 appeared gray-blue in color with an ashen appearance. A nurse reported to administration that resident 74's nurse had neglected him by not treating the low sats. A CNA had told the nurse that earlier in the evening resident 74's sats were in the 40s and 50s. After resident 74 did a cough assist and was placed on oxygen, his sats improved to 93%. Resident 74's medical record was reviewed 2/4/26 through (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2/12/26. Resident 74's sats from 10/2/25 through 11/30/25, were above 90% on room air. A physician's order dated 10/27/25, and discontinued on 12/21/25, revealed to offer cough assist treatment every shift for airway management. On 12/1/25 at 6:17 AM, resident 74's sats were 80%. At 10:38 AM, a secured conversation via text message between facility staff and the provider revealed that the provider would like the facility to obtain a chest x-ray and a laboratory value for the resident. There was no documentation of treatment provided for low sats until 4 hours later. The next sats documented were on 12/5/25. A physician's order dated 10/2/24, revealed Bilevel Positive Airway Pressure (BIPAP) to be applied every night when sleeping but to hold from 12/1/25 through 12/28/25. It should be noted that there was no documentation located to indicate why the BIPAP order was to be held during this time frame. On 12/2/25 at 8:35 AM, the x-ray results revealed possible bronchitis and continue to offer cough assist. A nursing progress note dated 12/3/25 at 2:03 AM, revealed Alert Charting- Resident on alert charting related to a Change of Condition Hypoxia. every shift for change of condition for 3 Days Document in progress note how the resident is doing post their change of condition for 72 hours after no hypoxia concerns this shift. A physician's order dated 12/3/25, revealed cough assist treatment. Cough assist present on home setting. Registered Nurse (RN) to hold mask in place for patient to complete 4 coughs. The frequency was every shift for airway management. A secure conversation via text message between a nurse and physician on 12/4/25 at 5:36 PM, revealed resident 74 had called the nurses station 10 times. The nurse talked to resident 74 about that behavior and not getting consistent and solid sleep and that would affect his health in a negative way. The nurse asked resident 74 about a medication for sleep aide and resident 74 was agreeable. The physician ordered melatonin 3 milligrams (mg) every night. It should be noted there were no sats documented that night. On 12/6/25 at 3:21 AM, sats were 88% and at 5:37 AM, sats were 76%. There were no follow up sats. On 12/7/25 at 4:00 AM, sats were 86%, at 5:00 AM sats were 86%, at 6:34 AM sats were 75%, and at 3:54 PM sats were 90% on room air. Resident 74 refused cough assist and told the nurse it was as needed according to the orders-administration note. On 12/10/25 at 5:00 AM, sats were 85%. There were no follow up sats. On 12/17/25 at 5:38 AM, sats were 85%. There were no follow up sats. On 12/19/25 at 5:51 AM, sats were 65% and at 6:16 AM, sats were 65%. There were no follow up sats. On 12/26/25 at 5:52 AM, sats were 51%. There were no follow up sats. Cough assist was done at 12:58 PM. There was no follow up documentation after resident 74 had sats at 51%. On 12/27/25 at 5:40 AM, sats were 48%, at 6:26 AM, sats were 94%. On 12/28/25 at 4:32 AM, a nursing progress note revealed, resident has not slept for any length of time that would be considered restful despite being given a dose of melatonin at HS [hours of sleep]; has been highly [sic] using his phone to call for assistance in repositioning in bed only to call again within minutes to be repositioned again; offered oral pain med multiple times this shift with resident declining offered med; has also been noted to be randomly talking in jibberish [sic] as if there is someone present in the room that in reality is not there; will continue to monitor sleep and behaviors On 12/28/25 at 5:00 AM, sats were 47% and at 5:59 AM sats were 93%. Cough assist treatment was completed at 1:35 AM. On 12/28/25 at 7:32 AM, a secure conversation via text message between facility staff and a medical provider revealed resident 74 was requiring 4 liters of oxygen after being found at 47% oxygen sats on room air. Resident 74 was very pale and cyanotic in lips, according to the message. A nurses note dated 12/28/25 at 5:31 PM, revealed, . Family looking for Bi pap and will bring it in if they find it. On 12/28/25, resident 74 was started on Amoxicillin-Pot Clavulante tablet 875-125 MG every 12 hours until 1/5/26, for bacterial infection/pneumonia. On 12/30/25, a physician's note revealed resident 74 had aspiration pneumonia. On 2/4/26 at 9:22 AM, an interview was conducted with resident 74. Resident 74 stated he used oxygen and staff monitored his oxygen levels. Resident 74 was observed to have oxygen being administered via a nasal cannula. On 2/9/26 at 1:48 PM, a phone interview was conducted with CNA 9. CNA 9 stated sats were checked every morning at 5:00 AM, for residents. CNA 9 stated resident 74 refused oxygen when he was first admitted to the facility. CNA 9 stated resident 74 was normally in the 70s and 80s for sats during the night. CNA 9 stated one night resident 74 was (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	hot and cold, calling for help every 15 minutes throughout the 8 hour shift. CNA 9 stated he was calling to get adjusted like blanket on, blanket off, and then he said it was hard for him to breathe. CNA 9 stated resident 74's oxygen was in the 40s so she sat down with him and discussed using respiratory therapy to help him get his oxygen up. CNA 9 stated resident 74 was blue in the face and pale, so CNA 9 told him that he would die if he did not use oxygen. CNA 9 stated the resident agreed to oxygen that night. CNA 9 stated when she noticed resident 74 turning blue she was in the middle of helping the resident use the urinal, so she finished helping him and then took the garbage in his room out. CNA 9 stated she then informed the nurse that his sats were low and he was blue. CNA 9 stated she was told by the nurse to get an oxygen concentrator, so she did and his sats increased to above 90%. On 2/4/26 at 1:53 PM, an interview was conducted with RN 6. RN 6 stated sats were taken daily between 3:00 PM and 5:00 PM, by the CNA's. RN 6 stated it was not standard to have sats checked during the night shift. RN 6 stated if a resident had low sats, it was standard to provide oxygen and then recheck saturations. RN 6 stated resident 74 dropped in sats and another nurse and CNA were checking on him. RN 6 stated resident 74 had pneumonia. RN 6 stated that the monitor to check sats did not work on all of resident 74's fingers. RN 6 stated resident 74 did not wear oxygen until after he was diagnosed with pneumonia. RN 6 stated a CNA reported that the resident's sats were at 47% sats oxygen was started. RN 6 stated if a resident's oxygen saturations were below 80% she would provide oxygen and report it to the DON, physician, and family. On 2/4/26 at 9:28 AM, an interview was conducted with the ADM and Director of Nursing (DON). The DON stated she received a phone call from a nurse on 12/28/25 that resident 74 was having oxygen issues and his nurse did not act fast enough. The DON stated there was an investigation started. The ADM stated she was unable to determine if there was neglect. The ADM stated she did not look at previous oxygen levels.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that a resident received care consistent with professional standards of practice, to prevent pressure ulcers and did not develop pressure ulcers unless the individual's clinical condition demonstrated that they were unavoidable. Specifically, for 1 out of 46 sampled residents, a resident was admitted to the facility with surgical wounds and Moisture Associated Skin Damage (MASD) and was discharged with a stage 4 pressure ulcer. This example will be cited at a harm level. Resident identifier: 89. Findings included: Resident 89 was admitted to the facility on [DATE] and discharged on 7/24/24 with diagnoses which included infection and inflammatory reaction due to internal left knee prosthesis, Methicillin resistant Staphylococcus aureus infection, and osteomyelitis. A form titled Clinical admission Documentation dated 3/28/24, revealed resident 89's skin was clean/dry/intact with surgical wounds. The wounds were breakdown on proximal posterior left lower extremity r/t [related to] brace, breakdown on coccyx r/t MASD. It should be noted there was no other information regarding the wounds above. There were no measurements or descriptions of the wounds. A physician's order dated 3/28/24 until 5/3/24, revealed that resident 89 had a knee immobilizer and the frequency was twice daily. There was no information on what was to be done with the knee immobilizer twice daily. It was signed off by a nurse twice daily on the Medication Administration Record. A nurses note dated 3/28/24, revealed Pt [patient] has some breakdown r/t friction from leg brace, pillowcase barrier applied. Pt also has MASD on coccyx, barrier cream applied. Pt has 2 wound vac's to LLE [left lower extremity] r/t surgical wounds and infection. Care plans initiated on 3/29/24, revealed resident 89 had skin impairment of surgical wound to left hip/upper thigh. Another care plan revealed [Resident 89] will have no unaddressed alteration to skin integrity, through next review. A Braden Scale for Predicting Pressure Sore Risk dated 3/29/24, revealed resident 89 was at high risk for developing pressure sores. A physician's order dated 3/29/24 until 7/24/24, revealed barrier cream to buttocks/peri-area as needed and apply with each incontinent episode until discharge. There were no signatures on the Treatment Administration Record that the treatment was done. Care plans further revealed on 4/11/24, resident 89 had skin impairment to the sacrum. A nursing note dated 4/12/24, revealed that resident 89 had wound care rounds completed for surgical wounds and the patient was wearing a brace to his left lower extremity. A physician's order dated 4/12/24, revealed treatment to his Gluteal cleft cleanse wound and apply medihoney to wound bed and secure with dressing three times a week. A daily skilled charting dated 4/14/24, revealed resident 89 had a surgical wound with no other skin issues documented. A care plan dated 4/22/24, revealed left inner thigh skin impairment and over the counter powder was ordered to be applied. A physician's order dated 4/29/24, revealed the left great toe was to be cleansed and skin prep applied twice daily. A physician's order dated 4/30/25, revealed for the Sacrum to remove the old dressing. Cleanse wound with wound cleanser or normal saline. Apply medihoney to wound bed. Secure with cover dressing. Complete 3 times weekly and as needed if soiled or dislodged. There was no documentation regarding the wound. A care plan dated 5/2/24, revealed resident 89 had actual skin impairment to his left great toe and left posterior calf. A nurses note dated 5/2/24, revealed the wound care provider documented a new wound to the left posterior calf noted by an aide post shower this morning. There was also a great toe wound noted. There were no wound measurements or description of the wound. Physician orders for wound treatment to the left posterior calf started on 5/4/24, until discharge. A nurse's note dated 5/13/24, revealed a wound to the left posterior calf. The area was still black and the surrounding skin was pink and intact. A nurse's note dated 5/18/24, revealed wound to left toe cleaned and wound was showing improvement. It should be noted that no objective data was documented to show the wound improvement. A nurse's note dated 5/19/24, revealed a wound was cleansed, betadine applied, left open to air. It should be noted that the note was not specific to which wound. A nurses note dated (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	5/20/24, revealed hip surgery was canceled due to a wound on the back of leg. A nurse's note dated 5/22/24, revealed a wound to the left great toe was open to air. A nursing note dated 5/26/24, revealed Wound to calf is open with yellow slough on top, moderate yellow drainage et [and] foul ordor [sic]. Surrounding tissue is intack [sic] et pink. A daily skilled charting dated 6/11/24 revealed resident 89 had other for skin integrity. There was no other information. The first weekly skin assessment was dated 6/19/24, new onset left calf skin impairment. A physician's note dated 6/23/24, revealed stage 4 ulcer of left shin. It should be noted that prior documentation had the wound located on the calf and not the shin. The documentation made it unable to determine if two wounds were located with one the left calf and one on the left shin. Weekly skin assessments dated 6/26/24, 7/3/24, and 7/12/24, revealed skin was pink, dry, warm, intact. The locations listed on the assessments were left calf and ankle posterior. A nurse note dated 6/27/24, revealed that resident 89 had surgical site on left anterior thigh reopen and left posterior calf was progressing well. A physician's note dated 7/1/24, and 7/4/24, revealed resident 89 had a stage 4 ulcer of left shin which was managed by wound care. A physician's note dated 7/11/24, revealed resident 89 had a Stage 4 ulcer on Left hip treated with calcium alginate dressings. It should be noted this was another skin breakdown area. It should be noted that this was the first documentation of a stage 4 PU on the left hip. Prior documentation described the left anterior thigh as a surgical site only. A physician's note dated 7/21/24, revealed resident 89 was seen for wound debridement. The treatment plan revealed a pressure ulcer of right hip stage 4. There were no wound treatments for the right or left hip in the Medication Administration Record. A physician's note dated 7/23/24, revealed . He [resident 89] has been receiving wound care for a Stage 4 pressure ulcer on the posterior left lower leg. It should be noted that resident 89 was admitted with breakdown on proximal posterior left lower extremity r/t brace and breakdown on coccyx. Resident 89 further developed wounds and there was no documentation of interventions used to prevent skin breakdown. Resident 89 was admitted with a knee immobilizer and developed a stage 4 pressure ulcer on his calf that the immobilizer was on. Additionally, resident 89's left hip surgical site degraded and was classified as a stage 4 pressure ulcer and there were no interventions to prevent further skin breakdown. Resident 89 developed skin breakdown to his toe and there were no interventions to prevent the skin breakdown. In addition, there was no documentation of when resident 89 developed skin breakdown to his sacrum area. On 2/11/26 at 3:10 PM, the Administrator was asked for additional information regarding what the facility was doing to prevent skin breakdown. The Administrator stated she did not have documentation beyond what was in the resident's medical record. The Administrator was unable to provide additional information.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that the environment remained as free of accident hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents. Specifically, for 2 out of 46 sampled residents, a resident sustained a fall with a head injury while left unsupervised in the shower. This will be cited at a harm level. Additionally, a resident was involved in a motor vehicle accident that resulted in injuries while being transported in the facility vehicle, and the facility hot water temperatures registered as high as 130 degrees inside resident rooms. Resident identifiers: 32 and 44. Findings included: HARM 1. Resident 44 was admitted to the facility on [DATE] with diagnoses which included malignant neoplasm of the large intestine and rectum, muscle weakness, orthostatic hypotension, and moderate protein-calorie malnutrition. On 2/11/26 at 2:55 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 44 just had a fall in the shower room and sustained a head laceration. RN 1 stated that the wound did not need sutures or steri strips to close and they were applying pressure. RN 1 stated that resident 44 was left unattended in the shower room. RN 1 stated that resident 44 used to be a set up assist for showers, but had recently had a decline and change in condition. RN 1 stated that the aides were not aware of the change in condition and decline and that resident 44 needed assistance with showering. RN 1 stated that she provided education to the aides and informed them that resident 44 was not to be left alone in the shower room, especially since it was so slippery in there. Resident 44's medical records were reviewed. On 2/11/26 at 3:16 PM, resident 44's Nurses Note documented, Pt [patient] walked out of shower room and stated he fell. Fall was unwitnessed. Pt was lethargic and walked with cane. Pt fully dressed but had no footwear. Pt was assisted to nearby chair. Pt stated he slipped on water and hit his head. Pt stating his R [right] side is also hurting but was hurting prior to fall as well. Pt was assessed fully. VS [vital signs] WNL [within normal limits]. Neuro [neurological] checks initiated. Cut present to back of head, wound care completed. No bruising noted anywhere on body. Hospice team, PA [Physician Assistant], ADON [Assistant Director of Nursing], and EC [emergency contact] were notified. AC [alert charting] completed and wound care orders in place. CNA [Certified Nursing Assistant] educated not to leave resident unattended in shower room and increased rounding to be done on pt. On 2/11/26 at 3:32 PM, resident 44's Nurses Note documented, Morphine changed to Q4h [every 4 hours] per hospice. Resident 44's bathing task for the last 30 days revealed that the staff identified on 1/15/26, that the resident required supervision or touching assistance with bathing, and on 1/31/26, that the resident required partial to moderate assistance with bathing. Resident 44's First Responder Report documented that the resident reported pain to the right side of his head after his fall. The resident reported that the wet surface contributed to the fall. The report (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	documented that the resident was placed in shower at 2:20 PM, and was last checked on at 2:40 PM. The report documented contributing factors to the fall was left alone in the shower, no supervision, and no use of the call light. The report documented that the resident had previous falls and the author was unsure if there were any fall interventions in place prior to the fall. It should be noted that the author of the report was the resident's nurse. On 2/11/26 at 2:45 PM, the neurological assessment was initiated. The assessment did not contain documentation for level of consciousness, movement, hand grasps, pupil size and reaction, and speech for the 4:00 PM, 4:30 PM, 5:00 PM, and 5:30 PM, time slots. Resident 44's care plan had a focus area for at risk for falls secondary to advanced age and weakness that was initiated on 9/9/25. Interventions identified on the care plan prior to the fall on 2/11/26, were to encourage the use of the call light, encourage the resident to keep the bed in the lowest position, and to keep the room free of clutter and tripping hazards. On 2/12/26 at 9:02 AM, an interview was conducted with resident 44. Resident 44 stated that he slipped while taking a shower and the CNA was not in the room with him. Resident 44 stated that he did not usually need one CNA and he was very confident. Resident 44 stated that it hurt his right side and he hit his head. The resident was observed with a bandage on his head. Resident 44 stated that he normally showered on his own. Resident 44 stated that he had recently started using a cane for ambulation. Resident 44 was observed grunting in pain and reported a pain of 3/10 that was located on his right side where he fell. Resident 44 stated that he had not used a shower chair before and he did not use the cane in the shower room. Resident 44 stated that the CNAs set up the shower room for him but they did not stay with him. They never had to. On 2/12/26 at 9:11 AM, an interview was conducted with CNA 2 and CNA 3. CNA 3 stated that the alerts on the kardex would tell them if a resident had a change of condition and it was also passed off in change of shift report. CNA 3 stated that resident 44 required supervision for ambulation and he used a cane. CNA 3 stated that resident 44 was currently not feeling well and needed a little extra help. CNA 3 stated that resident 44 required stand by assistance for showers and he had always been that way. CNA 3 stated that they did not leave resident 44 alone in the shower room and they were to stay with him at all times. CNA 3 stated that this had always been resident 44's assistive needs for a shower. On 2/12/26 at 9:41 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that any resident change in condition should be communicated by the nurse to the aides, and then in report. The ADON stated that the resident assistance needs should also be communicated the same way. The ADON stated that neurological checks were initiated for an unwitnessed fall or a fall with a hit to the head. The ADON stated that the licensed nurse would do the actual neuro check and the CNA would take the vital signs. The ADON stated that the nurses were assessing for any change from baseline and any indication of complications with a strike to the head such as brain bleed or a concussion. The ADON stated she was not sure why resident 44's neuro assessment was incomplete. The ADON stated that resident 44 was taken to the shower room and left unattended and had an unwitnessed fall. The ADON stated that that staff should have stayed with the resident in the shower room. POTENTIAL FOR HARM 2. Resident 32 was admitted to the facility on [DATE] with diagnoses which included paraplegia, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	unspecified injury of Thoracic (T)7-T10, and post traumatic stress disorder. On 2/10/26 at 11:43 AM, an interview was conducted with resident 32. Resident 32 stated that she had an accident in the facility van. Resident 32 stated that the Transportation Driver (TD) was late to pick her up for the scheduled appointment. Resident 32 stated that while driving to the appointment the TD went off the road and through a fence. Resident 32 stated that she was thrown from her wheelchair and her seatbelt was not secured properly. Resident 32 stated that she hit the armrest and sustained bruising to her ribs and then landed on the floor of the van. Resident 32 stated that the TD was drowsy while driving. Resident 32's progress notes revealed the following: a. On 11/7/24 at 11:09 AM, the note documented, ED [emergency department] Note: Note reviewed, resident evaluated following MVA [motor vehicle accident]. X-rays and CT [computed tomography] scans completed. No new orders, recommend to follow-up with a trauma orthopedist. b. On 11/7/24 at 2:29 PM, the note documented, New orders for norco 5/325 1 tab [tablet] Q [every] 6 hours PRN [as needed], Chest, bilat [bilateral] lower extremities, Hip and Right shoulder X-ray. Per house MD [Medical Doctor]. c. On 11/7/24 at 3:08 PM, the note documented, Patient involved in car accident on 11/7, assessment performed once returned to facility. Neuro: . -headache generalized and rated 7/10 Skin/Integumentary. -bruising/redness to right forehead -bruising/redness to right cheek -redness and irritation to right shoulder -redness/bruising to right knee Musculoskeletal/ROM [range of motion]: . -bilateral upper extremities ROM limited due to pain -pain in right shoulder worse than left -neck movement limited due to pain Abdomen: . -pain in all four quadrants (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-increase in pain in upper quadrants around ribs Respiratory: . -tachypnea/shallow respirations due to rib/abd pain -educated on breathing techniques to assist with pain -lung sound present but slightly diminished in right upper lobe -oxygen levels >92% RA [room air] Psychological/Emotional: . -patient distraught upon arrival back to facility -she states she feels like crying at any moment -feelings of emotions arising from past car accident that left her paralyzed Pt states when the car crash took place she did not want to be taken by ambulance to the hospital, patient states she requested to be brought back to [facility] for assessment and if her health requires it she will agree to go to the hospital via ambulance. Xrays ordered for bilateral lower extremities, patient is concerned that she may have broken something in her lower extremities but is unable to feel it. Xrays to bilateral ribs (all views), Xray to right upper shoulder due to decreased ROM and severe pain. d. On 11/7/24 at 4:14 PM, the note documented, Since pain medication administered, patient has continued to have an increase in pain and her headache has gone from a 7/10 to 10/10. Patient being transferred to emergency room for further diagnostic testing and evaluation. e. On 11/9/24 at 10:14 PM, the note documented, Pt. stated that she is having increased pain to her R ribs/side due to that being the side that took the brunt of impact during the accident. f. On 11/14/24 at 4:39 AM, the note documented, at bedtime resident was reporting increased pain to rib and flank area at bedtime-pain improved after Norco, Ibuprofen, Tylenol and topical pain relieving cream; was crying and anxious at bedtime as well but that improved after HS [bedtime] meds as scheduled; does have some bruising to flank/hip area that appears to be fading that occurred with MVA she was in last week. On 11/7/24, the hospital discharge handout documented the diagnoses from the visit were motor vehicle collision, multiple contusions, shoulder contusion, elbow contusion, wrist contusion, and femur fracture. It should be noted that the femur fracture was evaluated and determined to be an incomplete healed fracture. Resident 32 was referred to a trauma orthopedist for a follow up of the unhealed fracture. The facility Incident report Physical Asset Dodge Caravan documented that the TD could not explain what happened. I was getting off and the next thing I know there were branches and trees and I was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	in a sand bank of some sort. The report documented that resident 32 was evaluated by Emergency Medical Services and was found out of her chair during the assessment. The report documented that the TD was taken for a drug screening per policy and then suspended from all driving privileges. On 11/13/24, the After Action Accident Report documented that the TD was permanently removed from driving privileges. On 12/11/24, the After Action Accident Report documented that the vehicle was determined to be a total loss. On 1/9/25, the After Action Accident Report documented that Human Resource and the Administrator terminated the TD's employment due to the MVA. The transportation logs were reviewed from November 2024 through January 2025. The logs documented the residents that were transported during that time period but did not document who the transportation driver was for each resident transported. The personnel file for the TD was reviewed. No documentation could be found for any training that was provided to the TD related to safely securing a resident during transportation or education on transporting residents. The date of hire for the TD was 4/13/23, and date of termination was 1/9/25. On 2/11/26 at 10:38 AM, an interview was conducted with the Administrator (ADM). The ADM stated that they had been using a sister company for resident transportation since June 2025. The ADM stated that the transportation van was housed at the facility for resident transfers. The ADM stated that some facility staff still provided occasional resident transportation when the other service provider was not available. The ADM stated that the Director of Nursing and the Patient Care Coordinator (PCC) were the two facility staff members that still provided resident transportation. The ADM stated that the driver training was provided by the corporate office and included defensive driving tactics, a ride a long, and a competency assessment. The ADM stated that this Included demonstrating how to safely secure a resident in the van that was transported in a wheelchair or a stretcher, how to safely load and unload a resident in the van, and safe driving practices. On 2/11/26 at 10:47 AM, an interview was conducted with the PCC. The PCC stated that he was still on the facility car insurance and he transported a resident last Saturday. The PCC stated that the previous TD handled all resident transportation. The PCC stated that the TD was terminated after he had an accident in the van. The PCC stated that the TD was exiting the freeway and lost control of the vehicle. The PCC stated that the TD later reported that he had fallen asleep while driving. On 2/12/26 at 10:48 AM, a follow-up interview was conducted with the ADM. The ADM stated that the TD had not received any education for driving the facility van. On 2/12/26 at 1:45 PM, the ADM stated that all drivers were provided training on transportation in June 2025 and this was after the TD's termination. The ADM stated that the TD could have transported residents prior to his termination. The ADM stated that she was not aware of any education that was provided to staff after the accident with resident 32. The ADM stated that she could not confirm if the TD transported residents after the accident or if education was provided to staff after the accident on how to safely transport and secure residents in a wheelchair. The ADM stated that the TD was the only driver employed with the building at the time and he was most likely still driving residents after the accident. 3. WATER TEMPERATURES It should be noted that all temperatures were in degrees Fahrenheit and were obtained using a digital probe thermometer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The surveyors' thermometers were calibrated in ice water on 2/9/26 at 9:00 AM. On 2/9/26 at 9:23 AM, room [ROOM NUMBER], occupied by two residents, had a sink in the room with a water temperature of 130.2. On 2/9/26 at 9:46 AM, room134, occupied by two residents, had a sink in the room with a water temperature of 119.4. On 2/9/26 at 9:50 AM, room [ROOM NUMBER], occupied by two residents, had a sink in the room with a water temperature of 129. On 2/9/26 at 10:10 AM, room [ROOM NUMBER], occupied by one resident, had a sink in the room with a water temperature of 127.4. On 2/9/26 at 10:18 AM, room [ROOM NUMBER], occupied by one resident, had a sink in the room with a water temperature of 123. On 2/9/26 at 10:25 AM, room [ROOM NUMBER], had a sink in the room with a water temperature of 126.6. The resident stated the water would get hot quickly. On 2/9/26 at 10:35 AM, room [ROOM NUMBER], had a sink in the room with a water temperature of 128 degrees. On 2/9/26 at 11:01 AM, room [ROOM NUMBER], occupied by one resident, had a sink in the room with a water temperature of 118.2. On 2/9/26 at 12:04 PM, room [ROOM NUMBER], occupied by one resident, had a sink in the room with a water temperature of 123.9. On 2/9/26 at 2:29 PM, room [ROOM NUMBER], had a sink in the room with a water temperature of 125.2. The resident stated that sometimes the water was too hot in the shower room and she would have to tell the staff to turn down the hot water. On 2/10/26 at 8:46 AM, room [ROOM NUMBER], had a sink in the room with a water temperature of 126.6. On 2/10/26 at 8:46 AM, room [ROOM NUMBER], occupied by one resident, had a sink in the room with a water temperature of 125.2. On 2/10/26 at 9:07 AM, public restroom [ROOM NUMBER], had a sink in the restroom with a water temperature of 123. On 2/10/26 at 9:24 AM, room [ROOM NUMBER], occupied by one resident, had a sink in the room with a water temperature of 118.9. On 2/12/26 at 10:08 AM, an interview was conducted with the Maintenance Director. The Maintenance Director stated that he used a digital thermometer to test water temperatures weekly. The Maintenance Director stated that the building was broken down by four quadrants and each quadrant was tested weekly. The Maintenance Director stated that he would test every area a (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	resident could put their hands in. The Maintenance Director stated that he would test the resident sinks, dining room sink, therapy gym sink, the front two bathrooms, the showers, the salon, and the activities room. The Maintenance Director stated the water heaters were set slightly above 120 so the hot water was able to reach the end of the building. The Maintenance Director stated when the staff started running the water in the shower rooms the resident room water temperatures would fluctuate. The Maintenance Director stated he had a few rooms that were running high so he had a mixing valve on order. The Maintenance Director stated that the dining room sink had a mixing valve. An observation of water temperatures was conducted with the Maintenance Director. On 2/12/26 at 10:19 AM, room [ROOM NUMBER] had a sink water temperature of 131. The North water heater was observed to be set at 130. The Maintenance Director stated that the North water heater did not have a mixing valve. On 2/12/26 at 10:25 AM, room [ROOM NUMBER] had a sink water temperature of 120.7. The South water heater operating set point was observed to be set at 125 and the tank was reading 122. The Maintenance Director stated the South water heater did not have a mixing valve. The Maintenance Director stated he was getting mixing valves for all the sinks that were running high temperatures.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, there was undated food in the refrigerator and freezer, expired items in dry storage, expired items in the resident refrigerator, and the sanitizer bucket was not testing at the required sanitation levels. Findings included:1. On 2/9/26 at 8:21 AM, an initial tour of the kitchen was conducted. The following observations were made:a. Multiple cups with different liquids with lids were undated in the refrigerator.b. An opened bag of frozen vegetables that was undated in the freezer. c. An opened bag of buns was undated in the freezer.d. An opened bag of corndogs with an opened date of 12/5/25, was open to air.e. Cans of evaporated milk with an expiration date of 1/26/26, were located in dry storage.f. Three sandwiches with a use by date of 2/6/26, were located in the resident refrigerator.g. A pepperoni and cheese snack pack with an expiration date of 2/4/26, was located in the resident refrigerator.On 2/9/26 at 8:49 AM, an interview was conducted with the Dietary Manager (DM). The DM stated that the drinks in the refrigerator should be dated. The DM stated that the frozen vegetables were thrown in a box and staff had forgotten to date the bag. The DM stated that the bag of corn dogs should be closed and not open to air. The DM stated that the cans of evaporated milk should be discarded because they were expired. The DM stated that kitchen staff were responsible for the resident refrigerator and all expired items should be thrown out. 2. On 2/11/26 at 11:24 AM, a follow-up tour of the kitchen was conducted. The following was observed:a. The sanitation bucket was tested and resulted at 75 parts per million (PPM). The DM stated that the level should be at 100 PPM. The DM stated that the sanitation bucket must not have been changed prior to the start of lunch and that she would talk with her staff about this. The DM stated that at 75 PPM surfaces were not being sanitized correctly.b. Fresh vegetables, potato salad, and ranch cups were not dated inside of the refrigerator.On 2/11/26 at 11:30 AM, a follow-up interview was conducted with the DM. The DM stated that the vegetables, potato salad, and ranch cups should all be dated and that she again would talk with her staff about dating items.

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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, in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility did not have evidence of a thorough investigation. Specifically, for 9 out of 46 sampled residents, residents with fractures, a motor vehicle accident involving a resident, allegations against staff regarding care and abuse, a resident that self harmed, and an allegation against a spouse of abuse were not thoroughly investigated to determine if there was abuse or neglect. Resident identifiers: 32, 38, 86, 87, 88, 91, 92, 93, and 95. Findings included:1. Resident 86 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia, major depressive disorder, epilepsy, and unsteadiness on feet. The facility reported to the State Survey Agency (SSA) on 6/8/25, that resident 86 sustained a fall and complained of pain. There was an x-ray done and resident 86 sustained a fracture. Resident 86 had poor cognition and safety awareness. There was no investigation provided by the facility to determine if there was abuse or neglect. On 2/4/26 at 12:13 PM, an interview was conducted with Administrator (ADM) 1. ADM 1 stated she was unable to find an investigation into resident 86. ADM 1 stated she started as the Administrator on 6/16/25. At 12:54 PM, ADM 1 was interviewed and stated she found stacks of paper on her desk when she started and found abuse investigation paperwork. ADM 1 stated since June 2025, all abuse investigations should be in the medical record. 2. Resident 32 was admitted to the facility on [DATE] with diagnoses which included paraplegia, unspecified injury of Thoracic (T)7-T10, and post traumatic stress disorder. On 2/10/26 at 11:43 AM, an interview was conducted with resident 32. Resident 32 stated that she had an accident in the facility van. Resident 32 stated that while driving to the appointment the Transportation Driver (TD) went off the road and through a fence. Resident 32 stated that she was thrown from her wheelchair and her seatbelt was not secured properly. Resident 32 stated that she hit the armrest and sustained bruising to her ribs and then landed on the floor of the van. Resident 32 stated that the TD was drowsy while driving. Review of the facility abuse investigations revealed no documentation of the incident. On 2/11/26 at 11:07 AM, an interview was conducted with the [NAME] President of Physical Assets (VPPA). The VPPA stated that she did an investigation into the accident and sent over an incident report of the Physical Asset Dodge Caravan. It should be noted that none of the information contained in the incident report was specific to abuse or neglect. On 2/12/26 at 10:48 AM, an interview was conducted with the ADM 1. ADM 1 stated that she only had the physical asset investigation that was sent over by the VPPA. ADM 1 stated that was the only documentation on the incident. ADM 1 stated that she had no additional investigation documentation for this incident. 3. Resident 38 was admitted to the facility on [DATE] with diagnoses which included, fibromyalgia, paraplegia, muscle weakness, and spinal stenosis. The facility reported to the SSA on 1/7/25, that resident 38 reported to the Director of Nursing that their brief was not being changed when asked. There was no investigation provided by the facility to determine if there was abuse or neglect. 4. Resident 87 was admitted to the facility on [DATE] with diagnoses which included, fracture of head of right femur, cellulitis of right lower limb, and difficulty walking. The facility reported to the SSA on 12/23/24, that resident 87 reported that Certified Nursing Assistant (CNA) 4 was moving blankets around resident 87's leg and that CNA 4 hit resident 87 in the calf. Resident 87 also stated that CNA 4 tossed a remote control at her. There was no investigation provided by the facility to determine if there was abuse or neglect. 5. Resident 88 was admitted to the facility on [DATE] with diagnoses which included, left hip osteoarthritis, and acute pain. The facility reported to the SSA on 11/12/24, that resident 88 reported that during a brief change that CNA 4 hit her hand away. There was no investigation provided by the facility to determine if there was abuse or neglect. 6. Resident 91 was admitted to the facility on [DATE] with diagnoses which included paraplegia, lymphocytic leukemia, and neuromuscular dysfunction of bladder. The facility reported to the SSA on 2/12/25, that resident 91's daughter stated that resident 91's wound (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was not being cared for in line with doctors orders. There was no investigation provided by the facility to determine if there was abuse or neglect. 7. Resident 92 was admitted to the facility on [DATE] with diagnoses which included hydrocephalus, lymphedema, chronic pain syndrome, and generalized anxiety disorder. The facility reported to the SSA on 12/16/24, that resident 92 reported that a CNA asked resident 92 inappropriate questions while providing peri-care. There was no investigation provided by the facility to determine if there was abuse or neglect. 8. Resident 93 was admitted to the facility on [DATE] with diagnoses which included paraplegia, wedge compression fracture of T11-T12 vertebra, major depressive disorder, and suicide attempt sequela. The facility reported to the SSA on 8/1/24, that blood was observed on resident 93's sheets, with the resident stating he had intentionally cut himself. There was no investigation provided by the facility to determine if there was abuse or neglect. 9. Resident 95 was admitted to the facility on [DATE] with diagnoses which included polyneuropathy, dementia, and cerebral infarction. The facility reported to the SSA on 5/1/24, that resident 95 said her husband hit her arm during an argument while he was visiting. There was no investigation provided by the facility to determine if there was abuse or neglect. On 2/4/26 at 12:33 PM, an interview was conducted with ADM 2. ADM 2 stated there was a new system in place for all facility reported incidents (FRI). ADM 2 stated the ADM entered the FRI information into a company system where multiple people were able to look at it and provide feedback on how to investigate the allegation. ADM 2 stated he was unable to find the investigations for residents 38, 86, 87, 88, 91, 92, 93, and 95. On 2/10/26 at 11:49 AM, an additional interview was conducted with ADM 1, who stated that the facility had begun using a resource titled Investigation Timeline Tool in November 2025, which helped guide all investigations into allegations of abuse or neglect. ADM 1 outlined the standard procedure following an allegation, stating she immediately took steps to ensure resident safety, started gathering information and witness statements from all involved, and reported the incident to the SSA and other appropriate agencies within two hours. ADM 1 also detailed the protocol for staff-involved allegations, stating the staff member was immediately removed from resident care and placed on leave until the investigation was completed; and the staff member was not permitted to resume working at the facility if the allegation was substantiated. ADM 1 stated that the facility implemented interventions based on the investigation's findings and developed a follow-up plan to ensure the interventions were implemented effectively. ADM 1 stated that the corporate team reviewed the facility investigations for thoroughness, and the facility was required to submit a review of its findings to the SSA by Day 5.

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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 disease and infections. Specifically, for 3 out of 46 sampled residents, Enhanced Barrier Precautions (EBP) were not implemented for a resident with a feeding tube, a resident did not have EBP signage or supplies in their room, and cross contamination occurred during lunch when staff fed a resident a sandwich with their bare hands. Resident identifiers: 1, 9, and 47. Findings included: 1. Resident 47 was admitted to the facility on [DATE] with diagnoses which included aphasia following cerebrovascular disease, cerebral infarction, and chronic obstructive pulmonary disease. The following observations were made of resident 47: a. On 2/9/26 at 9:43 AM, resident 47 was not connected to her feeding tube. The end of the tube was not capped and was hanging around the intravenous (IV) pole. b. On 2/10/26 at 8:46 AM, Certified Nursing Assistant (CNA) 5 disconnected the feeding tube from resident 47 and hung it around the pump. CNA 5 was observed to be wearing gloves and did not place a cap on the end of the feeding tube. CNA 5 was not observed to be wearing a gown. c. On 2/10/26 at 8:53 AM, CNA 5 put on gloves and went into the bathroom and brought resident 47 to her bedside. CNA 5 was observed to pick up the feeding tube and connect resident 47 to the tube feeding. CNA 5 was not observed to be wearing a gown. d. On 2/11/26 at 9:51 AM, resident 47's feeding tube was hanging on the IV pole around the pump and was not capped. e. On 2/11/26 at 9:54 AM, resident 47 was assisted from the bathroom by the Restorative Therapy Aide (RTA). The RTA was observed to put on gloves and connect resident 47 to her feeding tube. The RTA was not observed to be wearing a gown. On 2/11/26 at 9:55 AM, an interview was conducted with the RTA. The RTA stated that she helped resident 47 back into bed and connected her feeding tube. The RTA stated that she restarted the feeding tube pump. The RTA stated that she only needed to wear gloves when assisting resident 47. On 2/11/26 at 11:16 AM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated that she only wore gloves when she handled resident 47's feeding tube in any way. RN 3 stated that with EBP precautions she only had to wear gloves. On 2/12/26 at 9:22 AM, an interview was conducted with CNA 6. CNA 6 stated that gowns only needed to be worn for residents that had droplet precautions. CNA 6 stated that she only wore gloves when she assisted residents with tube feeds. CNA 6 stated that when she showered residents with tube feeds she just wore gloves and not a gown because she did not have to worry about being sprayed by the tube feed because it was not running. On 2/12/26 at 9:49 AM, an interview was conducted with the Assistant Director of Nursing (ADON). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The ADON stated that any time staff handled a tube feed they should be wearing gloves. The ADON stated that she was the Infection Preventionist at the facility and as far as she knew only gloves were required. The ADON stated that EBP signs were placed on resident doors to notify staff about what protective equipment they needed to use. The ADON stated that feeding tubes required additional protective equipment but could not recall what was needed. The ADON stated that feeding tubes should have a cap on the end when they were not in use. 2. Resident 1 was admitted to the facility on [DATE] with diagnoses which included anorexia, gastrointestinal hemorrhage, abscess of lung with pneumonia, severe sepsis, and stage three pressure ulcer of sacral region. On 2/9/26 at 9:39 AM, an observation was made of resident 1's urinary catheter. No EBP sign or supplies were observed inside or outside of resident 1's room. On 1/3/26, orders were initiated to ensure EBP were implemented every shift for resident 1's catheter and wounds. An additional observation on 2/12/26 at 9:49 AM, noted no EBP signs or supplies inside or outside of Resident 1's room. On 2/12/26 at 10:00 AM, an interview was conducted with RN 7. RN 7 stated that a resident was to be placed on EBP for an exposed line, a wound, or an infection, noting that EBP provided an extra layer of protection for both residents and staff. RN 7 stated that staff were to wear a gown and gloves if the resident's reason for EBP was exposed, and that EBP policy required a sign on the door and supplies placed in a hanging caddy within the room. An observation of resident 1's room, conducted with RN 7, revealed no EBP sign or supplies present. RN 7 stated that resident 1 should be on EBP due to his catheter. On 2/12/26 at 10:13 AM, an additional interview was conducted with RN 7. RN 7 stated that a EBP sign had been posted on resident 1's door, and the necessary supplies had been placed in his room. RN 7 stated that resident 1 had always been on EBP for his wounds, but she was unsure what had happened to the sign and supplies. 3. Resident 9 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which consisted of multiple sclerosis, paraplegia, dysphagia, and unspecified tremor. On 2/9/26 at 12:25 PM, an observation was made of the meal service in the main dining room. CNA 7 was observed to assist resident 9 with their lunch meal. CNA 7 picked up resident 9's French Dip sandwich and handed it to the resident. CNA 7 was observed to touch resident 9's food bare handed. CNA 7 then obtained a ham and cheese sandwich from the kitchen. CNA 7 touched resident 9's plate and lid and then touched resident 9's wheelchair armrest. CNA 7 removed half of the sandwich from a zip loc bag and handed it to resident 9. CNA 7 was observed to also touch resident 9's ham and cheese sandwich bare handed. On 2/11/26 at 12:33 PM, an interview was conducted with CNA 8. CNA 8 stated that she should never touch the resident's food barehanded and serve it to the resident. On 2/12/26 at 9:58 AM, an interview was conducted with the ADON. The ADON stated that staff should not be touching resident food items barehanded. The ADON stated that they should use utensils instead of touching the food items.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment were reported immediately to the State Survey Agency (SSA). Specifically, for 1 out of 46 sampled residents, a resident was involved in a motor vehicle accident that resulted in injuries while being transported in the facility vehicle and the incident was not reported to the SSA. Resident identifier: 32.Findings included: Resident 32 was admitted to the facility on [DATE] with diagnoses which included paraplegia, unspecified injury of Thoracic (T)7-T10, and post traumatic stress disorder. On 2/10/26 at 11:43 AM, an interview was conducted with resident 32. Resident 32 stated that she had an accident in the facility van. Resident 32 stated that the Transportation Driver (TD) was late to pick her up for the scheduled appointment. Resident 32 stated that while driving to the appointment the TD went off the road and through a fence. Resident 32 stated that she was thrown from her wheelchair and her seatbelt was not secured properly. Resident 32 stated that she hit the armrest and sustained bruising to her ribs and then landed on the floor of the van. Resident 32 stated that the TD was drowsy while driving. Review of the facility abuse investigations revealed no documentation of the incident, and no documentation could be found that the incident was reported to the SSA. On 2/11/26 at 11:07 AM, an interview was conducted with the [NAME] President of Physical Assets (VPPA). The VPPA stated that she did an investigation into the accident. The VPPA stated that she did not report the incident to the SSA and she was not sure if the Director of Nursing or the Administrator had reported it. On 2/12/26 at 10:48 AM, an interview was conducted with Administrator (ADM) 1. ADM 1 stated that she only had the physical asset investigation that was sent over by the VPPA. ADM 1 stated that was the only documentation on the incident. ADM 1 stated that she had no additional investigation documentation for this incident and it did not appear that it was reported to the SSA. [Cross-refer F689]

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the health or safety of an individual in the facility was endangered; the licensee ceases to operate the facility; the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; the transfer or discharge was appropriate because the resident's health has improved sufficiently so the resident no longer needed the services provided by the facility; or the transfer or discharge was necessary for the resident's welfare and the resident's needs cannot be met in the facility. The facility did not ensure that discharged residents' medical records included documentation of the specific resident needs that could not be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the needs. In addition, the facility did not complete a discharge summary that included a post-discharge plan of care. Specifically, for 2 out of 46 sampled residents, a resident was discharged to an ex-spouses house after the physician had documented the resident had potential decline, the hospice nurse was unaware of the discharge, and there was no new discharge summary for the resident. In addition, there was no documentation regarding why a resident was discharged , why the facility was unable to meet her needs, and why she was not readmitted to the facility after being discharged . Resident identifiers: 83 and 94. Findings included: 1. Resident 94 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included liver cell carcinoma, heart failure, and developmental disorder of scholastic skills. On 1/12/24 at 7:04 AM, a provider note stated resident 94 was recently diagnosed with liver cancer, and the oncologist told the patient he had '6-9 months to live, but closer to 6 months' according to the patient. He was admitted to hospice. He does not have a permanent place to live. He now comes to us for comfort management. On 4/11/24 at 6:15 PM, a social services note revealed resident 94's discharge plan was to continue receiving long term care at the facility and that he continues to need skilled nursing and hospice due to end of life diagnosis. On 4/28/24, an active problem titled [resident 94] current status/function requires Long Term Nursing level of care at this time was started on resident 94's care plan. The category was Discharge Plan - Long Term Care Stay. The next care conference date was 7/10/24. It should be noted that no additional information about facility discharge planning could be located in resident 94's medical record. On 5/7/24 at 10:51 AM, a provider note documented evidence of resident 94's potential decline. The note stated resident 94 reports experiencing frequent dizziness, describing it as a spinning sensation that goes from right to left. He states that he usually sits down to avoid falling when the dizziness occurs. Patient also mentions a significant loss of appetite, which he attributes to his liver cancer. Additionally, the patient complains of stomach discomfort and believes he may be experiencing acid reflux. It should be noted that this provider note did not include any reference to an upcoming facility discharge. On 5/8/24 at 9:14 AM, a hospice skilled nursing visit note showed further evidence of resident 94's potential decline. Patient reports he has only eaten one sausage patty in 2 days because he has no (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appetite and food makes him sick. He reports the right side of his abdomen has been hurting so bad it brings tears to his eyes and he rated that pain at an 8/10. That is new as of this week. He reports feeling so weak he doesn't feel safe going on walks around the building anymore like he used to. It should be noted that this hospice note did not include any reference to an upcoming facility discharge. On 5/15/24 at 9:04 AM, a hospice skilled nursing visit note documented additional evidence of resident 94's potential decline. Decline noted as evidenced by increasing pain and weakness. Patient was ambulating down the hall with a cane today. He normally doesn't use any DME [Durable Medical Equipment] to ambulate but he said he's been feeling weaker and more unsteady lately. He reports the headaches are at a 10/10 intermittently throughout the day and night. Staff report he's asking for morphine every hour as well. Nurse palpated his upper abdomen today and right side is firm and abdomen distended. Nurse observed face and eyes were mildly jaundiced today. Patient reports having more nausea and he's thrown up at least once daily for the past week. He isn't eating more than 25% of 1 meal daily now when he used to eat 100% of 3 meals. It should be noted that this was the morning that resident 94 was discharged from the facility, and that this hospice note did not include any reference to an upcoming facility discharge. On 5/15/24 at 11:21 AM, a hospice chaplain visit note revealed the first mention in resident 94's medical record that the facility initiated his discharge. [Resident 94] said he's being asked to leave the facility but doesn't know where he is going yet. I listened and gave emotional support. I spoke with hospice director and she said living arrangements are being made for him. On 5/15/24 at 3:57 PM, a document titled Transition of Care/Discharge Summary was printed. The discharge summary provided an admit date of 1/12/24, and a discharge date of 5/12/23. [Note: the discharge date for resident 94's 1/12/24 admission was 5/15/24.] The document stated that resident 94's discharge destination was his Recreational Vehicle (RV) with home health services. The discharge goal was resident 94 would continue to get stronger with the home health services. All wet ink signatures on the discharge summary were dated on 5/15/24 at 4:45 PM. The document did not contain information about hospice services. On 5/15/24 at 5:18 PM, a nursing progress note documented [Resident 94] had discharge teaching done and all questions answered. [Resident 94] left in private vehicle with personal belongings. [Resident 94] also had 3 days supply of medications sent with him. On 5/17/24 at 9:53 AM, a hospice communication note documented Nurse was notified this morning that patient is on LOA [leave of absence] and staying at his ex-wife's home currently. On 2/5/26 at 11:45 AM, an interview was conducted with the Social Services Director (SSD). The SSD stated a welcome meeting is held upon a resident's admission to the facility, during which work on the discharge plan begins. The SSD stated she would evaluate whether a resident needs long-term care, assisted living, or independent living, along with any concerns about returning to the community. The SSD stated that she requested a day or two of notice to set up home health or DME, arrange transport, and ensure the team had verified there were no factors that would keep the resident at the facility. The SSD stated that after arrangements had been made she would e-mail nursing so they could prepare for the day of discharge, such as sending prescriptions to the pharmacy, and confirming home health was set up. According to the SSD, resident 94 was very independent, had a terminal diagnosis, and had become threatening to staff and residents, but stated she did not know the specifics, other than he disliked his roommate and let staff know. The SSD stated resident 94 was not given a 30 day discharge notice, and she was not sure why a resident who was documented as (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	declining would be discharged . It should be noted that following the social services note from 4/11/24, referenced prior, which indicated resident 94 was to continue receiving long-term care at the facility, five progress notes documented aggressive behaviors towards staff or residents from resident 94 on 4/27/24, 5/12/24, 5/13/24, and 5/14/24. A review of resident 94's care plan revealed no active problems or interventions related to aggressive behaviors. The provider note from 5/7/24, referenced prior, did not document any concerns regarding aggressive behaviors. A review of resident 94's medical record from 4/11/24 to 5/15/24, revealed no documentation of the hospice provider being contacted regarding behavioral concerns, no medication adjustments to manage those concerns, and no room changes during this time. On 2/9/26 at 1:49 PM, an interview was conducted with the Hospice Director. The Hospice Director stated that resident 94's hospice medical record did not have any information of a planned facility discharge prior to the hospice chaplain note on 5/15/24. On 2/12/26 at 1:05 PM, an additional interview was conducted with the SSD, who stated hospice records indicate resident 94 was discharged to his ex-wife's home. The SSD stated she did not complete the Transition of Care/Discharge Summary document and was unsure why the discharge destination was his RV. The SSD stated that resident 94's original care plan was to remain in the facility and receive long term care. The SSD stated that she was not involved in the process of discharging resident 94, and that it was not normal for her to be uninvolved. The SSD stated that if a resident leaves Against Medical Advice (AMA) the nurses educate the resident about safety risks, have the resident sign paperwork, and if possible notify the SSD so she can set up the appropriate community services. The SSD stated she was unsure if resident 94 left AMA. On 2/12/26 at 1:32 PM, an interview with Administrator (ADM) 1. ADM1 stated that she was not employed at the facility during the time of resident 94's discharge. ADM 1 stated that resident 94's ex-wife informed ADM 1 that following Resident 94's discharge from the facility, he resided at the ex-wife's home for approximately one month before moving to his sibling's home, where he subsequently passed away. On 2/12/26 at 1:51 PM, an interview was conducted with the Regional Social Work Director (RSWD), who stated that after record review she determined that resident 94 had a previous discharge on [DATE], when he was discharged to his RV with home health services. RSWD stated that staff failed to follow the discharge process for Resident 94's 5/15/24 discharge because they used the discharge summary from 5/12/23. The RSWD stated that because the discharge process was not followed the facility did not coordinate the discharge with the hospice nurse and a new discharge summary was not created to indicate an accurate location of where the resident planned to reside. 2. Resident 83 was admitted to the facility on [DATE], discharged to the hospital and readmitted on [DATE] and discharged on 8/27/25 with diagnoses which included diffuse traumatic brain injury (TBI) with loss of consciousness, spastic hemiplegia, major depressive disorder, paraplegia, antisocial personality disorder and suicidal ideations. Resident 83's medical record was reviewed 2/4/26. A nursing progress note dated 8/27/25 at 1:49 PM revealed, Pt [patient] was outside of another pt's room and was using vulgar language towards other pt. Nurse removed pt from situation and discussed (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	taking space from neighbor. Pt was visibly upset about situation but verbalized understanding. Within 2 minutes pt was back outside of neighbors door, this time with an elevated voice. Nurse removed pt from doorway and pt proceeded to kick her chair backwards towards nurse. Pt began to hit nurse with plastic gum packet in her hand. Nurse assisted pt outside to allow her some fresh air and remove her from potential triggers. Pt and nurse had a conversation outside and pt calmed down. Pt expressed her frustrations and stated she would stay away but she needed to go to the bathroom. Nurse brought pt back in building and immediately pt began using vulgar language again and calling all the staff 'fucking bitches.' Pt began to hit staff repeatedly and attempted to tip her wheelchair back. Pt threw plastic gum package at different nurse. DON [Director of Nursing] arrived and pt agreed to go talk privately with her. A Discharge summary dated [DATE] revealed that resident had physical aggression, verbal aggression, unable to manage by staff, history of suicidal ideation. There was no documentation from resident 83's physician regarding why the facility was unable to care for the resident and what interventions were tried. On 2/5/26 at 9:38 AM, an interview was conducted with the Restorative Therapy Aide (RTA). The RTA stated resident 83 was agitated and aggressive with staff. The RTA stated resident 83 was sent to the hospital because she hurt staff, threw glass dishes at staff, and punched staff. The RTA stated staff were afraid to work with resident 83. On 2/5/26 at 11:00 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that resident 83 was blue sheeted (involuntarily committed) to a local hospital because she was very aggressive and hit a Certified Nursing Assistant in the face. The ADON stated the DON and psychiatric nurse took the resident into the parking lot and worked on deescalating her but were unable to. The ADON stated the facility did not feel residents or staff were safe if resident 83 returned to the facility. On 2/5/26 at 11:45 AM, an interview was conducted with the SSD. The SSD stated prior to a resident being admitted to the facility, central intake will review all the information to determine if the resident is the right fit for the facility. The SSD stated resident 83 was blue sheeted to a local hospital because of physical aggression to staff and hurting staff. The SSD stated the mobile crisis unit was unable to deescalate resident 83.The SSD stated resident 83 was wrapping things around her neck really tightly in an attempt to commit suicide. The SSD stated resident 83 had been sent to the hospital for aggression and was readmitted to the facility but continued to have outbursts. The SSD stated police were called and the physician was involved with the discharge. The SSD stated resident 83 was not safe to readmit to the facility and it would have put staff and residents in harm's way. On 2/5/26 at 12:21 PM, an interview was conducted with ADM 1. ADM 1 stated resident 83 had a TBI and would get belligerent with her words. ADM 1 stated resident 83 was very aggressive to staff and made a suicide attempt when she was blue sheeted to the hospital. ADM 1 stated she had been readmitted to the facility after a hospital stay, but was blue sheeted again because she was aggressive, hitting staff, throwing things, trying to wrap things around her neck, and yelling. ADM 1 stated the facility chose not to take her back because she was a danger to herself and staff. ADM 1 was unable to provide documentation from the physician on why the resident was discharged , why the facility was unable to meet her needs, what interventions were tried, and why she was not readmitted to the facility after being discharged .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465116	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Logan	1480 North 400 East Logan, UT 84341

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that the services provided met professional standards of quality. Specifically, for 1 out of 46 sampled residents, a resident's percutaneous endoscopic gastrostomy tube did not have the formula bag labeled with the date and time of the formula preparation, or the nurse's initials who initiated the infusion. Additionally, untrained staff were observed to stop and start the tube feeding and connect and disconnect the tube feeding. Resident identifier: 47. Findings included:Resident 47 was admitted to the facility on [DATE] with diagnoses which included aphasia following cerebrovascular disease, cerebral infarction, and chronic obstructive pulmonary disease. The following observations were made of resident 47: a. On 2/10/26 at 8:46 AM, Certified Nursing Assistant (CNA) 5 stopped resident 47's tube feeding, disconnected the tube from resident 47, and took resident 47 to the bathroom. b. On 2/10/26 at 8:53 AM, CNA 5 brought resident 47 out of the bathroom and wheeled her to the side of the bed. CNA 5 picked up the feeding tube and connected resident 47 to the feeding tube and restarted the tube feeding pump. c. On 2/10/26 at 9:00 AM, resident 47's tube feed was labeled with 2/10. d. On 2/11/26 at 9:28 AM, resident 47's tube feed was labeled with 2/10 @ [at] 1320 [1:20 PM]. e. On 2/11/26 at 9:54 AM, resident 47 was assisted into bed by the Restorative Therapist Assistant (RTA). The RTA connected resident 47's feeding tube and restarted the tube feed. On 2/11/26 at 9:55 AM, an interview was conducted with the RTA. The RTA stated that she helped resident 47 back into bed and connected her feeding tube. The RTA stated that she restarted the feeding tube pump. On 2/11/26 at 11:01 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that nurses were the only staff in the facility that were allowed to stop or start a tube feeding and to connect or disconnect a tube from a resident. RN 2 stated that tube feeds should be labeled with the date, time of administration of the tube feed, and initials of the nurse that started the tube feed. On 2/11/26 at 11:16 AM, an interview was conducted with RN 3. RN 3 stated that only nurses should be stopping or starting the feeding tube pump and connecting or disconnecting tube feeds. RN 3 stated that labels usually came with the tube feed, but she could not find them and so she labeled it with the date only. On 2/12/26 at 8:37 AM, an interview was conducted with CNA 2. CNA 2 stated that CNAs were not supposed to be touching the tube feeds or the pump. CNA 2 stated that if a resident needed to be disconnected for any reason then she would tell a nurse. On 2/12/26 at 9:03 AM, an interview was conducted with the CNA Coordinator. The CNA Coordinator stated that CNAs should not be handling the tube feed or starting and stopping the tube feed because it was out of their scope of practice. On 2/12/26 at 9:49 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that licensed nursing staff should only be handling tube feeds and that no other staff have been trained to handle the tube feeds. The ADON stated that tube feeds should be labeled when it was opened. The ADON stated that she was unsure of what additional information was required when labeling the tube feed formula. The ADON stated that tube feed formulas should be labeled correctly to prevent errors and to ensure staff were administering at the correct time. The ADON stated that she would find out what information was required when labeling tube feed formula. Review of the Lippincott Nursing Procedures documented under Enteral Gastric, Duodenal, and Jejunal Tube Feeding for implementation to Make sure that the enteral formula container is labeled with the patient's identifiers; formula name (and strength if diluted); date and time of formula preparation; date and time the formula was hung; administration route, rate, and duration (if cycled or intermittent); initials of who prepared, hung and checked the enteral formula against the order; expiration date and time; dosing weight (if appropriate); and notation ENTERAL USE ONLY-NOT FOR IV USE. Wolters Kluwer. Lippincott Nursing Procedure. Ninth Edition. Philadelphia, PA. (2023), pp 296.

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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; or for excessive duration; or without adequate monitoring; or without adequate indications of use; or in the presence of adverse consequences. Specifically, for 1 out of 46 sampled residents, a resident's medication was administered when it should have been held per the physician ordered parameters. Resident identifier: 2. Findings included:Resident 2 was admitted on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral vascular accident, acute kidney failure, and idiopathic hypotension. Resident 2 had a physician order for furosemide Oral Tablet 20 milligram, Give 1 tablet by mouth one time a day. Hold for Systolic Blood Pressure (SBP) less than 110 or Diastolic Blood Pressure (DBP) less than 60. Resident 2's Medication Administration Record (MAR) documented that the furosemide was administered when it should have been held for low blood pressures (BP) on the following dates: 1/4/26 (BP 96/64), 1/5/26 (BP 105/65), 1/7/26 (BP 106/68), 1/8/26 (BP 94/58), 1/15/26 (BP 109/85), 1/16/26 (BP 105/70), 1/17/26 (BP 92/60), 1/20/26 (BP 100/69), 1/23/26 (BP 107/68), and 1/20/26 (BP 106/68). On 2/10/26 at 2:10 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 2's furosemide had parameters to hold if SBP was less than 110 and DBP less than 60. RN 1 stated that for any BP outside of those ranges she would hold the medication. On 2/11/26 at 10:22 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that nurses should hold medications based on the parameters, and the best practice would be to check the blood pressure again. The ADON stated that all hold parameters were documented in the MAR.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **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 was allowed to call for staff assistance through the call system from the resident's bed. Specifically, for 1 out of 46 sampled residents, a resident's call light was not accessible to the resident while they were in their bed. Resident identifier: 39. Findings included:Resident 39 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side. On 2/10/26 at 8:48 AM, an observation was made of resident 39 in her bed. Resident 39's call light was clipped to the top of the bedsheet on the left side, out of reach of the resident's right hand. Resident 39 stated that staff were supposed to clip the call light to her shirt on the left side so she could reach it. Resident 39 stated that she had left sided paralysis. Resident 39 then pointed out the signs that were posted in her room that stated to clip the call light to her left chest. A sign was observed on the wall above the resident's head of bed and next to the sink. A grievance form dated 3/13/25, documented that resident 39's spouse called and reported that when he visited the resident on 3/5/25, the resident's call light was out of reach. The corrective actions taken were to place signs above resident 39's bed to remind staff to place the call light and phone on the resident's right side within reach. A grievance form dated 6/5/25, documented that resident 39's husband visited on 6/4/25, and resident 39's call light was out of reach. The corrective action was to replace the signs to remind staff to place the call light clipped to resident 39's left chest. On 3/28/25, resident 39 had a care plan focus area initiated for alterations in Activities of Daily Living (ADL) function secondary to cerebral vascular accident with left sided weakness. On 3/28/25, an intervention was initiated to encourage the resident to use the call light when ADL assistance was needed. On 2/12/26 at 12:36 PM, an interview was conducted with the Social Service Director (SSD). The SSD stated that there had been times that resident 39's husband had come in and found the call light not within reach and not clipped to her left shirt front. The SSD stated that when she investigated the grievance she had also found times when the call light was not within resident 39's reach. The SSD stated that she then followed up with the staff on the floor who placed the call light and nursing management then provided education on the situation. On 2/12/26 at 1:23 PM, an interview was conducted with Certified Nurse Assistant (CNA) 7. CNA 7 stated that resident 39 needed her call light to be clipped to her gown to ensure that she could reach it with her right hand. CNA 7 stated that it would not be okay to have the call light clipped to the top of the bed because resident 39 could not see it or reach it. On 2/12/26 at 1:25 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that resident 39's call light should be within reach. The ADON stated that resident 39 had paralysis to her left side so it needed to be within reach of her right arm.