

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER Stonehenge of Cedar City		STREET ADDRESS, CITY, STATE, ZIP CODE 333 West 1425 North Cedar City, UT 84721	
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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, for 3 of 30 sampled residents, the facility did not treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Specifically, residents reported they had incontinent episodes waiting for staff to answer their call lights. Resident 55 was cited at a harm level because she stopped drinking because staff were too busy to help her to the bathroom. Resident identifiers: 34, 54 and 55. Findings Included: 1. Resident 55 was admitted to the facility on [DATE] with diagnoses which included periprosthetic fracture hip fracture, hemiplegia and hemiparesis following cerebral infarction, artificial hip joint, major depressive disorder and anxiety. On 3/23/26 at 2:14 PM, an interview was conducted with resident 55. Resident 55 stated there were not enough staff, especially from 6:00 PM until 6:00 AM because there were 3 CNA's for the whole facility. Resident 55 stated the CNA's can't get to everyone in the 3 different hallways. Resident 55 stated sometimes she rang the call light and had to wait for a long time. Resident 55 stated she had incontinent episodes when she first came because she was unable to hold it. Resident 55 stated one time she waited 35 minutes for staff to respond to her call light. Resident 55 stated she was unable to use her leg so she had to wait for staff assistance to the bathroom. Resident 55 stated when she was incontinent due to staff delays in response to her call light, it made her feel miserable because she does not usually pee the bed. Resident 55 stated she was afraid to drink much because they [staff] are so busy. Resident 55 stated she was going to tell the Administrator to come stay the night and see what staff do. Resident 55's medical record was reviewed 3/23/26 through 3/26/26. A LN - Bowel and Bladder Evaluation dated 2/17/26 revealed resident 55 was continent and there was no need to complete the evaluation. According to CNA documentation in the tasks section resident 55 had incontinent bladder episodes on 2/27/26, 3/1/26, 3/2/26 and 3/3/26. According to the progress note dated 2/17/26, 2/23/26, 3/16/26, and 3/23/26 resident 55 was continent of bladder. A care plan dated 2/17/26 revealed resident 55 was at risk of bowel/bladder incontinence related to impaired mobility. An intervention revealed INCONTINENT: Check as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes. On 3/25/26 at 3:30 PM, an interview was conducted with CNA 3. CNA 3 stated resident 55 was cognitive and was continent of bowel and bladder. CNA 3 stated resident 55 required assistance to the bathroom and usually used the call light for assistance. On 3/25/26 at 3:35 PM, an interview was conducted with LPN 1. LPN 1 stated resident 55 was alert and oriented to person, place, time and situation (A&Ox4) with some forgetfulness. LPN 1 stated resident 55 was continent of bowel and bladder. LPN 1 stated the nurses were provided report from the hospital nurse and would ask the patient upon admission their bowel and bladder status. LPN 1 stated if the resident was not alert and oriented, the nurse would ask a care taker the questions. LPN 1 stated for the first 72 hours checks were done every 2 hours to determine if they were continent or incontinent. 2. Resident 54 was admitted to the facility on [DATE] with diagnoses which included trochanteric fracture of left femur, fall on same level, chronic pain, lupus, and epilepsy. On 3/23/26 at 1:53 PM, an interview was (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 0550 Level of Harm - Actual harm Residents Affected - Few	there were a couple residents on a toileting program. CNA 1 stated there were no residents on the 100 hallway on a toileting program. CNA 1 stated not all residents were on rounds every 2 hours and those residents used their call lights for assistance. CNA 1 stated there was a resident who was normally continent of bowel and bladder but had an incontinent bowel movement episode. CNA 1 stated that particular resident was not scheduled to be checked every 2 hours. CNA 1 stated the resident was not at the facility anymore. CNA 1 stated she was not aware of which residents were continent and on rounds in the 100 hallway. On 3/26/26 at 9:37 AM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 55 was forgetful and repeated herself but was alert and oriented x 4 with some forgetfulness. The DON stated resident 55 would be able to voice a concern. The DON stated she was not sure if resident 55 was continent or incontinent. The DON stated resident 54 was alert and oriented x4 with some forgetfulness. The DON stated she was not sure if resident 54 was continent or incontinent. The DON stated resident 54 was recently readmitted but was continent during her last admission. The DON stated resident 34 was alert and oriented x 4 but was forgetful. The DON stated resident 34 was continent of bladder and bowel.		

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, for the 10 of 30 sampled residents, facility did not have sufficient nursing staff with appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psycho-social well-being of each resident. Specifically, for 10 out of 30 sampled residents, multiple residents voiced concerns with call light wait times and not receiving assistance with the bathroom which led to incontinent episodes. In addition, concerns with regards to staffing issues and long call light times were raised as grievances and during resident council meetings on repeated occasions. This will be cited at harm level. Resident identifiers: 3, 6, 8, 10, 16, 21, 34, 54, 55 and 56. Findings included: Resident Interviews 1. Resident 55 was admitted to the facility on [DATE] with diagnoses which included periprosthetic fracture hip fracture, hemiplegia and hemiparesis following cerebral infarction, artificial hip joint, major depressive disorder and anxiety. On 3/23/26 at 2:14 PM, an interview was conducted with resident 55. Resident 55 stated there were not enough staff, especially from 6:00 PM until 6:00 AM because there were 3 CNA's for the whole facility. Resident 55 stated the CNA's can't get to everyone in the 3 different hallways. Resident 55 stated sometimes she rang the call light and had to wait for a long time. Resident 55 stated she had incontinent episodes when she first came because she was unable to hold it. Resident 55 stated one time she waited 35 minutes for staff to respond to her call light. Resident 55 stated she was unable to use her leg so she had to wait for staff assistance to the bathroom. Resident 55 stated when she was incontinent due to staff delays in response to her call light, it made her feel miserable because she does not usually pee the bed. Resident 55 stated she was afraid to drink much because they [staff] are so busy. Resident 55 stated she was going to tell the Administrator to come stay the night and see what staff do. Resident 55's medical record was reviewed 3/23/26 through 3/26/26. According to CNA documentation in the tasks section resident 55 had incontinent bladder episodes on 2/27/26, 3/1/26, 3/2/26 and 3/3/26. On 3/25/26 at 3:30 PM, an interview was conducted with CNA 3. CNA 3 stated resident 55 was cognitive and was continent of bowel and bladder. CNA 3 stated resident 55 required assistance to the bathroom and usually used the call light for assistance. On 3/25/26 at 3:35 PM, an interview was conducted with LPN 1. LPN 1 stated resident 55 was alert and oriented to person, place, time and situation (A&Ox4) with some forgetfulness. LPN 1 stated resident 55 was continent of bowel and bladder. LPN 1 stated the nurses were provided report from the hospital nurse and would ask the patient upon admission their bowel and bladder status. LPN 1 stated if the resident was not alert and oriented, the nurse would ask a care taker the questions. LPN 1 stated for the first 72 hours checks were done every 2 hours to determine if they were continent or incontinent. 2. Resident 54 was admitted to the facility on [DATE] with diagnoses which included trochanteric fracture of left femur, fall on same level, chronic pain, lupus, and epilepsy. On 3/23/26 at 1:53 PM, an interview was conducted with resident 54. Resident 54 stated there were not enough staff and she had to wait an hour for her call light to be answered. Resident 54 stated staff did not make it in time to take her to the bathroom. Resident 54 stated she peed in her brief because there were not enough staff to help her to the bathroom. Resident 54 stated a night nurse reported she had told management there were not enough staff. Resident 54 stated she did not like laying in her wet brief. Resident 54's medical record was reviewed 3/23/26 through 3/26/26. According to the Certified Nursing Assistant (CNA) tasks for the last 30 days, resident was incontinent of bladder once a day from 3/14/26 through 3/24/26. On 3/25/26 at 3:31 PM, an interview was conducted with CNA 3. CNA 3 stated resident 54 was fairly cognitive. CNA 3 stated sometimes resident 54 will ask for the same thing within 5 minutes but was cognitive for the most part. CNA 3 stated resident 54 was continent of bowel and bladder. CNA 3 stated residents were generally checked on every 2 hours and then checked on before meals. (continued on next page)		

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F 0725 Level of Harm - Actual harm Residents Affected - Few	CNA 3 stated residents used their call lights in between those times if they needed to use the restroom. On 3/25/26 at 3:33 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated resident 54 was able to hold a conversation and knew why she was admitted to the facility but had some confusion. LPN 1 stated resident 54 was continent of bowel and bladder. LPN 1 stated there were no residents on a bowel and bladder retraining program in the 100 hallway. [It should be noted resident 54, 55 and 34 resided in the 100 hallway.] 3. Resident 34 was admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy, acute respiratory failure with hypoxia, pneumonia, urinary tract infection and end stage renal disease with dialysis. On 3/23/26 at 2:34 PM, an interview was conducted with resident 34. Resident 34 stated she had been left on the toilet and had to get herself off the toilet and back to bed because there were not enough staff. Resident 34's medical record was reviewed 3/23/26 through 3/26/26. According to tasks for the previous 30 days. Resident 34 was continent of bowel except on 3/24/26 and had 2 incontinent of bladder episodes on 3/20/26 and 3/21/26. On 3/25/26 at 3:28 PM, an interview was conducted with CNA 3. CNA 3 stated resident 34 was continent of bowel and bladder. CNA 3 stated resident 34 was cognitively aware. CNA 3 stated no residents had complained of an accident waiting for staff. On 3/25/26 at 3:34 PM, an interview was conducted with LPN 1. LPN 1 stated resident 34 was alert and oriented x 4. LPN 1 stated resident 34 was soft spoken and quiet but definitely oriented. LPN 1 stated resident 34 was continent of bowel and bladder. On 3/25/26 at 3:14 PM, an interview was conducted with CNA 1. CNA 1 stated there was a resident who was normally continent of bowel and bladder but had an incontinent bowel movement episode. CNA 1 stated the resident was not scheduled to be checked every 2 hours. CNA 1 stated the resident was not at the facility anymore. CNA 1 stated she was not aware of which residents were continent and on rounds in the 100 hallway. 4. On 3/23/26 at 1:18 PM, an interview was conducted with resident 8. Resident 8 stated that with the new ownership a lot of CNAs no longer work at the facility. Resident 8 stated that she had to wait a long time for call lights to be answered and there was not enough staff to assist the residents. 5. On 3/23/26 at 1:10 PM, an interview was conducted with resident 10 and she stated that she often had long wait times, up to 45 minutes, when she used her call light. 6. On 3/23/26 at 1:33 PM, an interview was conducted with resident 6 and he stated that it frequently took a long time for staff to answer the call lights. Resident 6 stated that the call light wait time was really long during the change of shift. 7. On 3/23/26 at 2:09 PM, an interview was conducted with resident 3. Resident 3 stated that she was the Resident Council President. Resident 3 stated that during resident council meetings, the residents had complained that, ever since the facility changed ownership, getting call lights answered took longer. Resident 3 stated that she was told by the residents that it took 30 to 40 minutes before they had their call lights answered. Resident 3 stated that more CNAs were needed for the night shift, as only two CNAs were scheduled and occasionally only one more came in for a swing shift. Resident 3 stated that there were not enough CNAs to be able to handle the needs of all the residents during the evening and bedtime hours. 8. On 3/23/26 at 2:08 PM, an interview was conducted with resident 21's family member. The family member stated staff were really busy and when resident 21 put on his call light, he had to be patient and wait. 9. On 3/23/26 at 2:23 PM, an interview was conducted with resident 56. Resident 56 stated over the weekend there were not many staff. Resident 56 stated he was mostly independent so he was able to wait for staff. 10. On 3/23/26 at 1:24 PM, an interview was conducted with resident 16. Resident 16 stated he did not have function in his left arm and he had to wait for his call light to be answered for about 10 minutes. Call light observations: 11. On 3/23/26 at 1:30 PM, an observation of a call light activated for room [ROOM NUMBER] was made. At 1:38 PM, the call light for room [ROOM NUMBER] was answered. It should be noted the call light was alarming for 8 minutes before it was answered. 12. On 3/24/26 at 10:08 AM, an observation of a call light activated for room [ROOM NUMBER] was made. At 10:18 AM, another alert went out over the facility's alert system. At 10:21 AM, the call light for room [ROOM NUMBER] was answered. It should be noted that the call light was alarming for 13 minutes before the call light was answered. 13. On (continued on next page)		

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F 0725 Level of Harm - Actual harm Residents Affected - Few	3/24/26 at 10:13 AM, an observation of a call light activated for room [ROOM NUMBER] was made. At 10:23 AM, another alert went out over the facility's alert system. At 10:24 AM, the call light for room [ROOM NUMBER] was answered. It should be noted that the call light was alarming for 11 minutes before the call light was answered. 14. On 3/24/26 at 2:49 PM, an observation of a call light activated for room [ROOM NUMBER] was made. At 2:58 PM, the call light for room [ROOM NUMBER] was answered. It should be noted that the call light was alarming for 9 minutes before the call light was answered. 15. On 3/24/26 at 2:50 PM, an observation of a call light was activated for room [ROOM NUMBER] was made. At 2:58 PM, the call light for room [ROOM NUMBER] was answered. It should be noted that the call light was alarming for 8 minutes before the call light was answered. Staff Interviews: 16. On 3/25/26 at 3:35 PM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated CNA staffing depended on census but she was not aware of the exact numbers. RN 3 stated she had staff complain of not being able to answer call lights timely. RN 3 stated staff also complained of not being able to complete charting when the census was higher. RN 3 stated that since the ownership change, CNA's hours were cut back a little. 17. On 3/24/26 at 1:57 PM, an interview was conducted with Staff Member 1 and they stated that they were asked to work a lot of overtime because a lot of staff quit in November. Staff Member 1 stated that they were not always able to finish showers due to being understaffed. Staff Member 1 stated that resident 10 had an incontinent episode because she had to wait too long for them to answer the call light. Staff Member 1 did not know how long resident 10 had to wait but that resident 10 told them that she was waiting about 45 minutes until they answered her call light. Staff Member 1 stated this incident occurred during the day shift. Staff Member 1 stated resident 10 could not get up on her own and required assistance to go to the bathroom. 18. Grievances were reviewed and revealed the following: a. On 10/15/25, Left waiting on my bed for the CNAs to take me to breakfast which happens all the time. I am sick of not being on time for my breakfast or all of my meals, for that matter. This is ridiculous!!! You need more staff. Steps taken to investigate the grievance was Resident Advocate checked call light response time. Call light was on at 8:15 AM, resident did not get to breakfast until 9:30 AM. The summary of findings/conclusion was Call light response time left resident waiting for over one hour. Resident advocate informed DON. DON educated staff on call light response time goal of 5-6 minutes not one hour. DON will continue to monitor & [and] improve response times with nursing staff. b. On 11/10/25, Resident reports dissatisfaction with call light response. Resident asked CNA for a snack from the resident fridge that is hers, and CNA initially agreed to bring it, but the request was not fulfilled. Resident states this made her feel ignored & frustrated. The Summary of Findings/Conclusion were Resident was informed staff are reminded to follow-through on all call light requests. CNA's will ensure timely delivery of requested items in the future. c. On 11/21/25, Resident feels there are not enough CNAs on the floor, especially during evening. and call light times are too slow, they do not get to me fast enough. The Summary of findings/conclusion was DON reviewed staffing schedule. Staff was fully staffed. DON sees no need to add any additional staff. Nursing staff instructed to prioritize call light response times. Follow up visit to confirm call light response times. d. On 12/17/25, I am sick of the call light not being answered in a timely manner. I have been here waiting for 2 & a half hours. My brief has needed changed for that whole time. Summary of findings/conclusion: Resident advocate checked call light response system. Resident's call light was on for 15 minutes (not 2 & half hours). Staff made a goal to answer call lights within 5-6 minutes and if not before and we since reached this goal of 6 minutes. e. On 1/5/26, Resident was left on the toilet for almost 3 hours. Resident was helped onto the toilet at 6:10 AM and CNA's did not return until 9:00 AM. Resident stated sitting on the toilet that long hurt his back and bum. Resident stated this was unacceptable & this cannot happen again because it is really unfair. The summary of findings/conclusion was .CNA's will make sure, reminder resident is checked on more frequently when toileted. f. On 1/28/26, Resident's spouse & resident feels staff response to call lights has been slow since resident got here and requires more timely assistance. The summary of (continued on next page)		

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F 0725 Level of Harm - Actual harm Residents Affected - Few	findings/conclusion: After investigating RA (Resident Advocate) did find that staff needs to be aware in their call light responses. RA notified DON. DON trained & educated staff to ensure quicker call light response times. Resident verbalized understanding and both the resident & spouse are satisfied with plan for quicker response times and thanks the staff for listening to their concern. g. On 2/3/26, ?The CNAs didn't answer my call lights. I have been waiting for 45 minutes.' The summary of findings/conclusion: Resident Advocate checked call light response system. Resident's call light was on for 10 minutes (not 45 minutes). Staff made a goal to answer call lights within 5-6 minutes or if not before. h. On 2/5/26, Resident expressed concern that call light response times are too slow- Resident reported feeling that help was not available promptly. The Summary of findings/conclusion was Resident was informed that no call light was activated during the reported time. Staff reinforced proper call light use & resident verbalized understanding. On 3/26/26 at 8:27 AM, an interview was conducted with the RA. The RA stated there was a trend of call light response grievances when we had the change in ownership. The RA stated the new ownership decreased the staff. The RA stated she and the DON were tracking call light response times. The RA stated the goal was to be under 5 minutes average. The RA stated there was a time when a call light had gone for as long as 40 minutes. The RA stated the average call light response time was 10 minutes and had decreased to about 6 minutes. The RA stated the DON made assignments for CNA's and gave CNA's a sense of ownership for their hallway to answer call lights quicker. 19. Resident council notes were reviewed and revealed the following: a. On 1/23/25: .[Name of resident] said his call light sometimes takes a long time to answer and he had an accident because it was too long. A How will you address these concerns? was provided with Reminded CNAs that call lights are a priority. b. On 4/30/25: .Residents get upset when there is only one CNA in the dining room at dinner to help residents eat and get back to their rooms. A How will you address these concerns? was provided with Certain CNAs are assigned to be in the dining room at meal times. Will remind them to be in the dining room. c. On 7/30/25: .[Name of resident] wishes the CNAs would finish with one resident before going to help another resident or starting something else. A How will you address these concerns? was provided with Remind CNA to finish helping the resident's [sic] they are working with before starting another task. d. On 9/24/25: .Call lights taking a long time to get answered. A How will you address these concerns? was provided with Remind CNAs that call lights are the first priority before doing other tasks. e. On 10/22/25: .Call lights taking a long time to get answered. A How will you address these concerns? was provided with Remind CNAs that call lights are the first priority before doing other tasks. f. On 11/19/25: .1. Call lights taking a long time to get answered 2. Residents want more CNAs in the dining room at mealtimes. A How will you address these concerns? was provided with 1. Remind CNAs that call lights are the first priority before doing other tasks. Working to resolve. 2. Two CNAs are assigned to be in the dining room. Restorative CNA is also helping in the dining for breakfast and lunch. g. On 12/24/25: .1. [Resident name] is upset about getting left on the toilet for so long 2. Residents are not happy about getting to breakfast so late A How will you address these concerns? was provided with 1. Have reminded CNAs to finish current tasks before going on to another task. 2. New CNA assignments have been made. Hoping this will help improve call light times and getting residents to meals on time. h. On 1/28/26: .[Resident name] says the call lights are still taking a long time especially when she's in the bathroom. The CNAs put her on the toilet and they don't come back for a long time. A How will you address these concerns? was provided with New CNA assignments have been made which will hopefully reduce the call light times. 20. A review of the Facility Assessment revealed: .Acuity Several factors are considered when determining staffing needs based on acuity. These include MDS [Minimum Data Set] Section GG data, PDPM [patient driven payment model] case-mix, special treatments and conditions, and resident support and care needs. Other individual factors may be considered, as needed. For skilled residents, much of this data is combined to establish our quality metric for each individual resident. For long-term care residents, the primary sources of information needed to assist in the calculation of acuity included special treatments and (continued on next page)		

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F 0725 Level of Harm - Actual harm Residents Affected - Few	conditions [sic] medical conditions and co-morbidities, and the extent to which resident support and care needs are needed for the individual resident. Staffing Plan, Posted Staffing Information, and Staff Assignments The staffing plan, using census and the criteria described previously, will be used to create the baseline staffing plan that will address resident needs, expected outcomes, quality measures, and acuity at any given time in the Facility. It will be created using a range for staffing levels. The baseline staffing plan will be added as a QAPI [Quality Assurance Performance Improvement] plan to review, refine, and revise staffing levels on a quarterly basis as data comes available. The Facility reports direct care hours through the Centers for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ). Staffing schedules are maintained and are adjusted to accommodate vacations, sick time, and fluctuations in census and resident care needs. All departments have the ability to flex hours to meet an increase or decrease in census. If necessary, the Facility has contracts in place for temporary agency personnel for nursing Based on our resident population and their care needs, we have made a good faith effort and approach to ensure we have sufficient and qualified staff to meet the needs of our residents at any given time. The Facility periodically interviews residents for preferences on waking and sleep times, shower schedules, etc. Should an individual identify, or express preferences related to individual choice, cultural needs, or other factors, their plan of care is adjusted to meet their person-centered care preferences when able. If the Facility is unable to meet a request, the resident is advised, and the Facility will collaborate with the resident and/resident representative to achieve the best solution or compromise possible. Individual Staff Assignment The Facility considers the fluctuation in census, acuity levels, resident needs or preferences, staff competencies and skill sets when determining staffing schedules and assignments and staffs accordingly. The Facility has consistent assignments for direct care nursing staff (licensed nurses and nursing assistants) and therapists, to the extent possible, for the purpose of continuity of care. Staffing needs for each shift are determined and adjusted as necessary based on key strategies. During Normal Operations1. Resident Acuity and Census: Regularly assess the acuity levels and needs of residents using tools like the Minimum Data Set (MDS) and Resident Assessment Instrument (RAI). Track the number of residents and their care requirements to determine the appropriate sta`ng levels.2. Shift Planning: Use a scheduling plan to determine shift scheduling based on resident needs, sta` availability, and skill mix. Build `exibility into schedules to accommodate unexpected changes in resident needs or sta` availability.3. Communication: Conduct daily/shift huddles and shift-to-shift report to review resident needs and adjust sta`ng as necessary. Implement feedback mechanisms for sta` to report changes in real time to a change in resident condition that may require sta`ng adjustments outside of the established communication processes. On 3/25/26 at 1:16 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that staffing coverage was based off of the current census of residents in the facility, not acuity. The DON stated that the facility was currently fully staffed. The DON stated that when the new corporation took over for the facility on 11/1/25, staffing was cut back. On 3/26/26 at 9:41 AM, a follow-up interview was conducted with the DON. The DON stated there had been a lot of issues with call lights since staffing was cut. The DON stated that they have trained CNAs about call lights being answered was the first priority. The DON stated that they continue to educate staff and the facility goal is to answer call lights in under six minutes. The DON stated that she thinks the call light average was as high as 10 minutes. On 3/26/26 at 9:57 AM, an interview was conducted with the Administrator (ADM). The ADM stated that with the previous company the facility was staffed a lot higher and call lights were not a big issue. The ADM stated that staffing was based on the facility census and acuity was taken into consideration. The ADM stated that the facility floor nurses had been educated that they also needed to respond to call lights and not just the CNAs.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, the facility failed to make prompt efforts to resolve grievances that residents might have. Specifically, grievances regarding staffing issues were not resolved. Findings included: A review of the grievances revealed the following: 1. On 10/15/25, Left waiting on my bed for the CNAs [Certified Nursing Assistant] to take me to breakfast which happens all the time. I am sick of not being on time for my breakfast or all of my meals, for that matter. This is ridiculous!!! You need more staff. Steps taken to investigate the grievance was Resident Advocate checked call light response time. Call light was on at 8:15 AM, resident did not get to breakfast until 9:30 AM. The summary of findings/conclusion was Call light response time left resident waiting for over one hour. Resident advocate informed DON [Director of Nursing]. DON educated staff on call light response time goal of 5-6 minutes not one hour. DON will continue to monitor & [and] improve response times with nursing staff. 2. On 11/10/25, Resident reports dissatisfaction with call light response. Resident asked CNA for a snack from the resident fridge that is hers, and CNA initially agreed to bring it, but the request was not fulfilled. Resident states this made her feel ignored & frustrated. The Summary of Findings/Conclusion were Resident was informed staff are reminded to follow-through on all call light requests. CNA's will ensure timely delivery of requested items in the future. 3. On 11/21/25, Resident feels there are not enough CNAs on the floor, especially during evening, and call light times are too slow, they do not get to me fast enough. The Summary of findings/conclusion was DON reviewed staffing schedule. Staff was fully staffed. DON sees no need to add any additional staff. Nursing staff instructed to prioritize call light response times. Follow up visit to confirm call light response times. 4. On 12/17/25, I am sick of the call light not being answered in a timely manner. I have been here waiting for 2 & a half hours. My brief has needed changed for that whole time. Summary of findings/conclusion: Resident advocate checked call light response system. Resident's call light was on for 15 minutes (not 2 & half hours). Staff made a goal to answer call lights within 5-6 minutes and if not before and we since reached this goal of 6 minutes. 5. On 1/5/26, Resident was left on the toilet for almost 3 hours. Resident was helped onto the toilet at 6:10 AM and CNA's did not return until 9:00 AM. Resident stated sitting on the toilet that long hurt his back and bum. Resident stated this was unacceptable & this cannot happen again because it is really unfair. The summary of findings/conclusion was .CNA's will make sure, reminder resident is checked on more frequently when toileted. 6. On 1/28/26, Resident's spouse & resident feels staff response to call lights has been slow since resident got here and requires more timely assistance. The summary of findings/conclusion: After investigating RA (Resident Advocate) did find that staff needs to be aware in their call light responses. RA notified DON. DON trained & educated staff to ensure quicker call light response times. Resident verbalized understanding and both the resident & spouse are satisfied with plan for quicker response times and thanks the staff for listening to their concern. 7. On 2/3/26, ?The CNAs didn't answer my call lights. I have been waiting for 45 minutes.' The summary of findings/conclusion: Resident Advocate checked call light response system. Resident's call light was on for 10 minutes (not 45 minutes). Staff made a goal to answer call lights within 5-6 minutes or if not before. 8. On 2/5/26, Resident expressed concern that call light response times are too slow-Resident reported feeling that help was not available promptly. The Summary of findings/conclusion was Resident was informed that no call light was activated during the reported time. Staff reinforced proper call light use & resident verbalized understanding. On 3/26/26 at 8:27 AM, an interview was conducted with the RA. The RA stated when a resident had a grievance, they knew to talk to her. The RA stated she asked what happened and used a grievance form to document. The RA stated if it is something like a call light time, she discussed it with the Director of Nursing (DON) to determine how to resolve grievances. The RA stated she made sure there was a follow-up to every grievance. The RA stated she liked to resolve grievances the same day. The RA stated there was a trend of call light (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	response grievances when they had the change in ownership. The RA stated the new ownership decreased the staff. The RA stated she and the DON were tracking call light response times. The RA stated the goal was to be under 5 minutes average. The RA stated there was a time when a call light had gone for as long as 40 minutes. The RA stated the average call light response time was 10 minutes and had decreased to about 6 minutes. The RA stated the DON made assignments for CNA's and gave CNA's a sense of ownership for their hallway to answer call lights quicker.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, for 4 of 30 sampled residents, the facility failed to ensure that a complete copy of the discharge/transfer documentation was maintained in the clinical record and a resident did not have a discharge summary. Specifically, the facility failed to document the discharge location, document what paperwork was sent with a resident to the hospital, a reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter) and complete a discharge summary. Resident identifiers: 1, 2, 50 and 52. Findings included: 1. Resident 1 was admitted to the facility on [DATE] and discharged [DATE] with diagnoses which included pneumonitis due to inhalation of food and vomit, dysphagia, and chronic kidney disease, stage 3. Review of resident 1's medical record was completed on 3/23/26 through 3/26/26. On 3/21/26 at 12:27 pm, a Discharge Nursing Note revealed, Patient was admitted to [name redacted] on 01/27/2026 for aspiration PNA [pneumonia]. Daughter was there during discharge ppw [paperwork] and teaching. Medications were sent with patient and faxed to [name redacted] Pharmacy. It should be noted that the facility did not document the discharge location. On 3/26/26 at 8:44 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that she believed the discharge progress note covered all the required discharge information for resident 1. The DON stated that she was unable to locate resident 1's discharge paperwork in the medical record. 2. Resident 50 was admitted to the facility on [DATE] with diagnoses which included chronic heart failure, thrombophilia, and pleural effusion. Review of resident 50's medical record was completed on 3/23/26 through 3/26/26. On 1/27/26 at 7:09 AM, a Nursing Note revealed, Pt [patient] c/o [complained of] not getting enough breaths to breath [sic]. O2 [oxygen] sats [saturation] would not get above 90% on 5 LPM [liters per minute] NC [nasal cannula]. MD [Medical Doctor] notified. Pt sent to ED [Emergency Department] for further evaluation via ambulance. Pt left building @ [at] 0709am [7:09 AM]. It should be noted that the facility failed to record which documents accompanied resident 50 during his hospital transfer, and this information was missing from his medical record. It should also be noted that the facility did not have a transfer notice for resident 50 located in his medical record. On 3/26/26 at 8:44 AM, an interview was conducted with the DON. The DON stated that resident 50 was discharged to the hospital and did not return to the facility. The DON stated that she believed the discharge progress note covered all the required discharge information for resident 50. The DON stated that resident 50 may not have had any discharge paperwork since he went to the hospital. (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 2 was admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy and acute cystitis with hematuria. Review of resident 2's medical record was completed on 3/23/26 through 3/26/26. On 3/21/26 at 12:43 AM, a Discharge Nursing Note revealed, [name redacted] was admitted to [name redacted] on 1/23/2026 for cystitis, DM2 [diabetes mellitus type 2] and metabolic encephalopathy. discharged with [name redacted] HH [Home Health], transported by his daughter [name redacted]. She was also present for discharge PPW. He does have a rash on his inner thighs, which required a clotrimazole for tx [treatment]. He was sent home with all medications, including the cream. Medication sheet was faxed to [name redacted] Pharmacy. Patient left with all personal belongings, a copy of discharge ppw and medication. All questions were addressed. It should be noted that the facility did not document what documentation or medication was sent with the resident. On 3/26/26 at 8:44 AM, an interview was conducted with the DON. The DON stated that she believed the discharge progress note covered all the required discharge information for resident 2. The DON stated that she was unable to locate resident discharge paperwork in the medical record. On 3/26/26 at 9:10 AM, an interview with Licensed Practical Nurse (LPN) 1 was conducted. LPN 1 stated that when a resident needed to be discharged from the facility, she would contact the physician with the resident's status and obtain an order for transport. LPN 1 stated that she would contact the charge nurse at the receiving facility and give a report on the resident. LPN 1 stated that she would enter a progress note for the resident which included: information relayed to the physician regarding the resident's status or change in condition, and how the resident was transported, with the time of transport and the reason. LPN 1 stated that she would provide a copy of the resident's face sheet and physician's orders to the transport team. LPN 1 stated that she did not recall if a copy of the transfer packet was made for the facility. LPN 1 stated that when a resident returned from an outside facility, she would collect the paperwork that was sent with the resident, enter a progress note, and then place the paperwork into the medical records basket. On 3/25/26 at 1:59 PM, an interview with the Social Services Director (SSD) was conducted. The SSD stated that the discharge planning process began upon a resident's admission, at which time the Interdisciplinary Team met with the family. The SSD stated that when evaluating a resident for discharge, the team assessed the resident's specific needs, including Durable Medical Equipment, home health services, and any insurance coverage to ensure a safe transition. The SSD stated that she would oversee that the physician had conducted a face-to-face exam and that all necessary orders and follow-up appointments were included in the discharge paperwork. The SSD stated she would provide a Notice of Medicare Non-Coverage two days prior to the discharge and again on the actual date of discharge, while explaining the appeal process to the resident. The SSD stated that she would send a discharge notice to the Ombudsman's office and provide an emergency transfer notice when applicable. The SSD stated that she would oversee the upload of physician orders and ensure that the nursing staff had scanned the Discharge Plan of Care along with the complete discharge packet to the resident's medical record. The SSD stated that she would follow up with home health services after the resident's discharge to ensure those services were initiated. (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/26/26 at 9:24 AM, a follow-up interview was conducted with the DON. The DON stated that she located resident 1's and resident 2's discharge paperwork in Medical Records waiting to be scanned and attached to the medical chart. The DON stated that she expected medical records to be scanned and attached to the residents medical chart within 48 hours from receipt of the documentation. The DON did not provide the discharge information that she located. 4. Resident 52 was admitted to the facility on [DATE] and discharged on 2/19/26 with diagnoses which included displaced fracture to right femur, fall, diabetes mellitus, anxiety and cirrhosis of liver. Resident 52's medical record was reviewed 3/23/26 through 3/26/26. A nursing note dated 2/19/26 at 4:06 PM revealed, Patient discharged this afternoon after speaking with social worker and admin (Administrator). Sent patients home gabapentin home with her 20 tabs[tablets]counted with [name removed] RN [Registered Nurse]. It should be noted there was no discharge summary with a recapitulation of the resident's stay. On 2/19/26 at 7:05 PM, an electronic Medication Administration Record Administration Note revealed Pt[patient] left facility via family members car to go home and not come back to facility. On 3/24/26 at 2:48 PM, an interview was conducted with the DON. The DON stated there was a discharge packet that nurses used. The DON stated the Resident Advocate arranged for any supplies, like oxygen and started the discharge packet. The DON stated when the resident was ready to discharge, the nurse went through the packet, went over the medications and appointments. The DON stated if the resident wanted to take medications home, then the nurse removed the stickers and sent it to the pharmacy to bill the resident. The DON stated the nurse helped the resident to the car and made a discharge note. The DON stated resident 52 should have had a discharge summary in addition to the notes.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, for 5 of 30 sampled residents, the facility did not provide each resident with food and drink that was palatable, attractive, and at a safe and appetizing temperature. Specifically, there were individual resident complaints resident council minutes and grievances regarding the food palatability. In addition, the test tray was not palatable, attractive or served at an appetizing temperature. Resident identifiers: 8, 21, 24, 46 and 54. Findings included: 1. On 3/23/26 at 1:53 PM, an interview was conducted with resident 54. Resident 54 stated the food was so/so and it was bland. Resident 54 stated if she did not like what was served, staff did not offer her something different. Resident 54 stated she did not like dark meat but felt like she only got dark meat. 2. On 3/23/26 at 2:08 PM, an interview was conducted with resident 21's family member. The family member stated resident 21 did not have a good appetite and he either eats it or doesn't. The family member stated the chicken was served dry and needed more moisture on the food. 3. On 3/23/26 at 1:23 PM, an interview was conducted with resident 8. Resident 8 stated that the food was horrible and looked nasty. Resident 8 stated that the food did not taste good. 4. On 3/23/26 at 2:40 PM, an interview was conducted with resident 24. Resident 24 stated that the food was disgusting and she did not want to eat it. 5. On 3/23/26 at 3:51 PM, an interview was conducted with resident 46. Resident 46 stated, food, not good. 6. On 3/25/26 at 4:47 PM, a test tray was requested. The last tray was plated and put into the cart at 4:48 PM. The test tray was placed in the cart at 4:49 PM. At 4:50 PM, the cart was taken to the 100 hallway. Certified Nursing Assistant (CNA) 1 was observed to tell the dietary aide she would pass the trays. At 4:51 PM, the first tray was delivered to room [ROOM NUMBER]. The last tray was delivered at 5:01 PM to room [ROOM NUMBER]. The test tray temperatures were obtained at 5:10 PM. The chicken tender was 128.6 degrees Fahrenheit. The tater tots were 115.8 degrees Fahrenheit. The carrot coin salad was 49.2 degrees Fahrenheit. The plate was observed to have a light brown chicken tender, light brown tater tots with an orange carrot salad in a bowl on the side. There was a serving of white cake and apple juice. There was no plate warmer between the plate and the plastic base. The tater tots had a mushy texture and were cold to the taste. The chicken tender was dry, tough to chew and was salty to the taste. 7. A grievance dated 1/14/26 revealed that a resident stated meals were served too cold and requested food to be served at proper temperature. Summary of findings included dietary staff reminded to serve meals at proper temperature. Resident informed and verbalized understanding; will continue to monitor meal quality. 8. A grievance dated 1/9/26 revealed resident reports distaste with facility meals, stating there was not enough variety, no fruit options, not enough fruit, and that meals contain too many carbohydrates. The resident expressed concern that the diets were not healthy enough to support recovery and overall well being. Resident Council: 9. Resident Council minutes dated 2/27/25: .New Concerns: 1. [Resident name]-sometimes her hamburger is too raw. 10. Resident Council minutes dated 1/28/26: .New Concerns: .2. Residents don't like the vegetables roasted. They say they sometimes taste burned. 3. [Resident name] said she can't cut or chew the pork chops 4. Some of the residents that eat in their rooms say the food is cold by the time they get it with the CNAs passing trays. On 3/26/26 at 9:19 AM, an interview was conducted with the Dietary Manager (DM). The DM stated he met with the 200 and 300 hallways regularly to hear food complaints. The DM stated the kitchen's hours were cut and they did not deliver trays to residents since the change in ownership. The DM stated dietary delivered the trays to the hallways and the CNA's passed the trays to the residents. The DM stated cold food was because the CNA's were not passing the trays fast enough. On 3/26/26 at 9:58 AM, an interview was conducted with the Administrator. The Administrator stated he knew for a little bit there were complaints about food quality and there was a new budget. The Administrator stated residents liked fruit, so the budget was increased which helped. The Administrator stated there were other food complaints so the menus were changed to accommodate what residents preferred. The Administrator (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated he sampled a tray weekly or more often if there were complaints. The Administrator stated the last reviews were very good.		

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined, for 1 out of 30 sampled residents, that the facility failed to ensure each resident was given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living (ADLs), consistent with the resident's comprehensive assessment and plan of care. This failure included the facility not ensuring that each resident was given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living for dining-eating, including meals and snacks. Specifically, one resident was not provided with bite-sized cut food or opened food containers when they were assessed as requiring this assistance. Resident identifier: 10. Findings included: On 3/23/26 at 1:10 PM, an interview was conducted with resident 10 in her room and she stated that she was unable to cut up her own food because her right arm was broken and only had use of her left hand. Resident 10 lifted up and guided her right arm with her left hand and stated that this was how she was able to use her right arm. A concurrent observation was made, resident 10's lunch was in front of her which had cut up chicken and potatoes on her plate. Her family was in her room and stated that they had to cut up her lunch for her today and that it was not the only time they had to cut it up for her. On 3/24/26 at 7:55 AM, an observation was made of resident 10's breakfast being served to her in her room. After the staff left her room, an observation of her plate was made, her french toast was cut into bite-sized pieces, sausage links were whole, there was food in a bowl with a lid on it, an individual syrup packet that was not opened, and a closed apple juice box that had a straw wrapped in plastic and stuck to the side of the juice box. On 3/24/26 at 12:11 PM, an observation was made of resident 10 who was sitting in her room alone, her lunch was in front of her and the pork cutlet on the plate was cut into long strips. Resident 10 stated that she had pain in her right arm and would have to cut the meat into smaller pieces to eat it. Resident 10's medical record was reviewed on 3/23/26 through 3/26/26. Resident 10 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included fracture of shaft of humerus, right arm; dementia; memory deficit following cerebrovascular disease; polyneuropathy; osteoarthritis; chronic pain syndrome; major depressive disorder; and right artificial shoulder joint. A Significant change in status Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 9 which indicated a moderate cognitive impairment. It further indicated impairment to one upper extremity and required setup or clean-up assistance with eating. The Care Plan Report indicated a Focus of I have an ADL Self Care Performance Deficit r/t [related to] Dementia, Impaired balance initiated on 10/30/25 with the Intervention/Task that included, EATING: I require setup or clean up assistance to eat. A physician's order dated 11/21/25 indicated, REGULAR diet REGULAR texture, Regular consistency. A Nursing progress note dated 2/16/26 at 9:28 AM indicated, This morning when I was giving the resident her morning medications, she reported that since her fall that occurred most recently, her L [left] arm has been hurting a lot. Obviously, her R [right] arm is always in pain, but now her L arm is also hurting significantly, and she reported concern about this. On 3/24/26 at 1:57 PM, an interview was conducted with Certified Nurse Assistant (CNA) 2 who stated that resident 10 could request assistance with cutting her food but that the kitchen was supposed to cut it up for her because it was hard for her to use both hands to cut it up herself. CNA 2 stated resident 10 would move her right arm by guiding it with her left arm. On 3/24/26 at 2:39 PM, an interview was conducted with the Dietary Manager (DM), who stated that it depended on the type of food, but if a resident needed food cut up it would usually be cut up into bite-sized pieces. The DM stated he sometimes cut food into strips, including the pork cutlets. A concurrent review of resident 10's meal card was conducted with the DM; there were no instructions to cut up resident 10's food. The DM stated that there were only two cooks and they knew what the (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's preferences were. The DM stated he thought resident 10 needed her food cut up because she had a hard time chewing. On 3/25/26 at 9:56 AM, an interview was conducted with the MDS Coordinator and she stated that resident 10 needed her food cut up and assistance with taking off lids for meal setup because it would be too hard to do that with the use of one arm. The MDS Coordinator stated that it was not in the orders and that the nurses should have ensured that was being done. On 3/25/26 at 10:10 AM, an interview was conducted with Registered Nurse (RN) 2, who stated that resident 10 needed assistance with setup of meals and that lids should have been removed for her. RN 2 stated that resident 10 was probably not able to cut her own food because she could only use her left hand and that she had frequent pain in her right arm. RN 2 stated resident 10 was on the diet where the kitchen cut up her food but that it was not in her physician orders. RN 2 further stated that resident 10 would not usually ask for help even when she needed it.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistive devices to prevent accidents. Specifically, for 1 out of 30 sampled residents, a high fall-risk resident did not have interventions put in place after falls, and interventions were repeated. Resident identifier: 7. Findings included: Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included unspecified dementia, muscle weakness, and other abnormalities of gait and mobility. Resident 7's medical record was reviewed 3/23/26 through 3/26/26. A review of resident 7's care plan revealed that resident 7 was at risk for falls related to confusion, abnormal gait, and opioid use. A review of resident 7's Minimum Data Set (MDS) dated [DATE] revealed that resident 7 had a Brief Interview of Mental Status (BIMS) score of 3. A score of 0-7 indicated severe cognitive impairment. On 3/24/26 at 2:49 PM, an observation was made of resident 7's room. Resident 7 was not observed to be in the room and her oxygen tubing was observed to be on the floor. On 3/24/26 at 2:52 PM, an observation was made of resident 7 exiting her bathroom unassisted by staff. Resident 7 was observed to be ambulating around her room with a shuffling gait and to get her foot caught in the nasal cannula tubing that was on the floor. A review of resident 7's progress notes revealed the following: a. On 6/16/26 at 11:09 AM, a nurse's note documented, Patient had a [sic] unwitnessed fall at 8 AM this morning. She was transferring from her bed to her recliner for breakfast and fell landing on her right foot and face described by the patient. Nothing broke her fall. She has abrasions and a skin tear to her right eyebrow and nose. Vital signs are stable at this time. Pt [patient] is going to be sent to the insta care to receive facial x-rays and an x-ray on her right foot. Interventions that were initiated after this fall included: Neurological checks for 24 hours, frequent safety checks on resident 7, call light within reach, and to continue interventions on the at-risk plan. [It should be noted that the facility was unable to provide the frequent safety check documentation for resident 7.] b. On 6/25/25 at 11:30 PM, a nurse's note documented, Resident's roommate heard her fall in the bathroom and came out to the nurses desk to alert us of the fall. We went into the bathroom and found [resident 7] on the floor laying on her right side with her face to the ground. She was moaning and asking for help to get up. Pt was carefully help [sic] to a sitting position on the floor, and a full assessment was done on her. Pt has a hematoma on right eyebrow that is new from this fall. Pt still has face bruising from her last fall so needing to monitor her for this. Pt's right shoulder was hurting her and states she can't move it because it hurts. When we would touch her right shoulder she would grimace and ask us to stop touching it because it hurts. Pt was alert and responsive and verbalizes appropriately. She is able to follow my finger and able to follow commands. Her speech is clear and she understands up [sic] when speaking to her. She could squeeze with her left hand but not with her right because of the pain. The interventions that were initiated after this fall were to round on resident 7 and to assist with personal cares every 2 hours. This fall resulted in a right humeral head fracture. c. On 6/27/25 at 4:06 PM, a nurse's note documented, CNA [Certified Nursing Assistant] walked in room as resident slid to knees on floor in front of recliner. Assessed, sling in place to arm, she had moved it so her elbow was further towards back than it had been. Assisted her to reposition arm at side. Color remains pink, cap [capillary] refill < [less than] 3seconds to nail beds, able to move hand and fingers, no increase or change in pain to R [right] arm. She was assisted to stand by staff and set back in recliner. Call light is clipped to her shirt and she was reminded to use it if needing assist. Ice pack placed to [sic] R upper arm. There were no interventions implemented after this fall. It should also be noted that resident 7 had been assessed as having severe cognitive impairment, and therefore may not be able to remember to use her call light to ask for staff assistance. d. On 8/6/25 at 3:38 PM, a nurse's note documented, (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident roommate notified nurse that resident needed help, staff entered room and resident was already standing up from being on her knees on R side of bed. When staff asked what happened, she said she rolled off the bed (Bed was in lowest position near the floor) and reported she was trying to get her 'soda' that activity staff had set on the bedside table. Resident assisted to L [left] side of bed and soda placed near her for her to eat. Call light in reach and bed remains in low position. DON [Director of Nursing] is aware of incident. There were no interventions implemented after this fall. e. On 8/23/25 at 11:27 AM, a nurse's note documented, Resident had an unwitnessed fall at approx. [approximately] 6:45AM. Resident stated that she was trying to get out of bed to make her bed when she lost her balance and fell. When [name redacted] LPN [Licensed Practical Nurse] asked if resident hit her head resident stated that she did. She has a small goose egg on the right side of her head. She also stated that she hit her right lower thoracic part of her back as well as her right hip. The intervention for this fall was for resident 7 to use her call light to ask staff for assistance to use the bathroom and to ensure the call light was within reach of the resident. [It should be noted that the call light within reach of the resident was an intervention used after the fall on 6/16/25. The reminder to use her call light was an intervention used after the fall on 6/27/25. It should also be noted that resident 7 had been assessed as having severe cognitive impairment, and therefore may not be able to remember to use her call light to ask for staff assistance.] f. On 9/24/25 at 6:56 AM, a nurse's note documented, 09/24/2025 [Resident 7] had a fall this morning at 0600 [6:00 AM]. Nurse heard a crash at the nurses station. Nurse and aide found her face down on the floor next to her bed. Patient stated, 'I was trying to make the bed and fell down.' Nurse assessed patient for injuries. Nurse and aide rolled patient to back, sat her up, and lifted her into wheelchair. Patient has two abrasions on forehead and bruising around her nose. No other skin abnormalities or injuries were obtained. Patient reported having a headache. The intervention for this fall was to remind resident 7 to ask for assistance with bed making. It should be noted that resident 7 had been assessed as having severe cognitive impairment and therefore may not be able to remember to ask for assistance with bed making. g. On 11/26/25 at 5:31 PM, a nursing note documented, Staff approached nurses station reporting pt fell in dining rm [room]. Nurses to dining rm. Pt found kneeling on floor in front of walker. Pt only described kneeling et [and] legs are tingling. Denies pain. Pt slowly assisted into chair. Denies hitting head. RN [registered nurse] completed head to toe assessment. No apparent injuries, skin intact et redness to bilateral knees. The intervention for this fall was to remind resident 7 to ask for assistance with transfers. It should be noted that resident 7 had been assessed as having severe cognitive impairment and therefore may not be able to remember to ask for staff assistance with transfers. h. On 2/10/26 at 6:29 PM, a nurse's note documented, Nurse reported per residents roommates visitors, that resident had been on knees on floor, kneeling, she was helped to stand by visitor. When nurse entered room, visitor was standing with resident. Nurse redirected visitor to let staff assist resident. She was assisted to sit on her bed at that time. Resident told nurse she was 'kneeling to pray and couldn't get up off floor'. The intervention initiated for this fall was neurological checks as ordered. [Neurological checks were used as an intervention for the fall on 6/16/25.] It should be noted that neurological checks were not an appropriate intervention to prevent future incidents. i. On 3/14/26 at 11:45 PM, a nurse's note documented, Heard noise from [name redacted] found resident on the floor in her room on her Left side. She was awake and alert she said she was making her bed and fell. The intervention initiated for this fall was to leave the curtain open at night to monitor resident 7. A review of the facility's fall policy titled Assessing Falls and Their Causes revealed: Purpose The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. Documentation When a resident falls, the following information should be recorded in the resident's medical record: 1. The condition in which the resident was found (e.g., resident found lying on the floor between bed and chair). 2. Assessment data, including vital signs and any obvious injuries. 3. Interventions, first aid, or treatment administered. 4. Notification of the physician and family, as indicated. 5. Completion of a falls risk (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment. 6. Appropriate interventions taken to prevent future falls.7. The signature and title of the person recording the data.On 3/25/26 at 8:30 AM, an interview was conducted with Licensed Practical Nurse (LPN)1. LPN 1 stated that she did not put interventions for falls on care plans and thought that the MDS Coordinator did this. LPN 1 stated that new interventions needed to be implemented after a resident had a fall to prevent future falls. LPN 1 stated that a fall was defined as any change in gravity and if she saw a resident on their knees she would consider this a fall. On 3/25/26 at 8:44 AM, an interview was conducted with CNA 1. CNA 1 stated that resident 7 was a fall risk and that she had to round on her every 2 hours. CNA 1 stated that resident 7 was a 1 person transfer and could walk assisted with a walker. CNA 1 stated that she felt more comfortable assisting resident 7 with walking, than having the resident walk alone. CNA 1 stated that she thought the nurses would inform her if resident 7 had any fall interventions that she needed to know about. On 3/25/26 at 10:39 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that there was a fall protocol at the facility and fall charting was completed for 72 hours post-fall. RN 1 stated that resident 7 was a high fall risk and was forgetful. RN 1 stated that resident 7 overestimated her ability to walk unassisted and walked with a shuffled gait that required the use of a walker. RN 1 stated that all interventions needed to be care planned. RN 1 stated that there were times that resident 7's cognition varied and she was unable to use a call light for assistance. RN 1 stated that if a resident was assisted to the ground or if they were found on their knees she would consider that a fall. On 3/25/26 at 1:06 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that a fall was anything with a change of elevation. The DON stated that if a resident was found on their knees then that would be a change in elevation and be considered a fall. The DON stated that neurological checks were performed for 24 hours and fall alert charting was completed for 72 hours after. The DON stated that resident 7 was a fall risk and that she had several falls while in the facility. The DON stated that all fall interventions were care planned and new interventions were initiated after every fall. The DON stated that interventions were created and implemented by the floor nurses and that they were addressed in the daily morning meeting. The DON stated that continuing interventions on the at-risk plan meant that there were not any new interventions implemented. The DON stated that neurological checks were not interventions to prevent falls, but more of an assessment after a fall. On 3/25/26 at 3:22 PM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated that fall interventions were put on the care plan by the staff nurses because they were the ones that cared for the residents. The MDS Coordinator stated that interventions should not be repeated and after each fall a resident should have a new intervention implemented. The MDS Coordinator stated that neurological exams were not interventions. On 3/26/26 at 9:36 AM, a follow-up interview was conducted with the DON. The DON stated that resident 7 was not cognitive enough to use her call light and using the call light as an intervention was not a good one and providing education to resident 7 would not prevent future falls. The DON stated that safety checks were just rounds that were done every 2 hours. The DON stated that there were no interventions for the falls that occurred on 6/27/25 and 8/6/25.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for 2 out of 30 sampled residents, the facility failed to ensure each resident received food prepared in a form designed to meet individual needs. Specifically, two residents received snacks that were not pureed or minced and moist. Resident identifiers: 25 and 37. Findings included: 1. Resident 25 was admitted to the facility on [DATE] with diagnoses which included dementia and Alzheimer's disease. Resident 25's medical record was reviewed 3/23/26 though 3/26/26. A physician's order dated 12/12/25 indicated resident 25 was on a pureed textured diet. A Nursing progress note dated 1/26/26 at 4:59 AM indicated, .gave ham sandwiches and potato chips with chocolate ensure during the night. A Nursing progress note dated 2/1/26 at 3:01 AM indicated, resident is awake and alert gave ham sandwich and potato chips. A Nursing progress note dated 2/7/26 at 11:47 PM indicated, 2300 [11:00 PM] Resident has been awake in living room no sandwiches were available I gave her potato chips. 2345 [11:45 PM] resident appeared to be sleeping calmly at this time. An Activities progress note dated 3/18/26 at 4:33 PM indicated, Resident ate the ice cream cone. On 3/24/26 at 3:49 PM, an interview was conducted with Certified Nurse Assistant (CNA) 2, who stated that resident 25 had a pureed diet because she stopped eating and would let her food sit in her mouth. CNA 2 stated she had seen resident 25 eat cake sometimes. CNA 2 stated resident 25 would receive evening snacks like pudding, jello or graham crackers that could get soggy in her mouth. On 3/25/26 at 10:17 AM, an interview was conducted with Registered Nurse (RN) 2 who stated resident 25 was on a pureed diet because she had dementia and she would keep food in her mouth. RN 2 stated she crushed her medications because she would spit them out when given whole pills. On 3/25/26 at 1:45 PM, an interview was conducted with the Speech Therapist (ST) who stated that he did not screen resident 25 and that she did not have a swallow evaluation. The ST stated that normally he would have liked to do a swallow screen if a resident was downgraded to a pureed diet and that nursing should have contacted him for sure. The ST stated nurses could downgrade a diet if it was for safety, but then they should notify him to evaluate them. The ST stated that if a patient was on a pureed diet, unless there were exceptions, they would need their whole diet to be pureed and that chips and sandwiches were not on a pureed diet. The ST further stated that if a resident was letting food sit in their mouth, then having food that was not pureed would be a choking concern. On 3/25/26 at 2:26 PM, an interview was conducted with the Assistant Director of Nursing (ADON), who stated that they changed resident 25's diet to pureed because she was not eating well on a regular diet as evidenced by her cheeking her food, holding it in her mouth, and not chewing. The ADON stated she, the Director of Nursing (DON), and the nurse practitioner decided to downgrade resident 25's diet to pureed and the resident did well with that. The ADON stated she was aware that resident 25 ate some of her ice cream cone during an activity. On 3/26/26 at 8:46 AM, an interview was conducted with the Activities Director (AD) and she stated resident 25 was given an ice cream cone but that she only ate the softened parts and did not eat the whole ice cream cone. 2. Resident 37 was admitted to the facility on [DATE] with diagnoses which included dementia. Resident 37's medical record was reviewed 3/23/26 though 3/26/26. A BIMS [Brief Evaluation for Mental Status] Evaluation progress note dated 3/19/26 at 9:04 AM indicated resident 37's BIMS score was 3 which indicated a severe cognitive impairment. A physician's order dated 7/17/25 indicated, REGULAR diet MINCED & MOIST- Level 5 texture, Regular consistency, for loose teeth CUT UP FOODS. An Activities progress note dated 2/25/26 at 7:00 PM indicated, .Peanut cluster cooking social.She did enjoy eating the peanut cluster. On 3/26/26 at 8:46 AM, an interview was conducted with the AD who stated she did not know why resident 37 was on a pureed diet but that she was given a bird's nest snack during the activity yesterday, which the resident did not eat. The AD stated the bird's nest snack contained crunchy chow mein noodles with a peep and candy eggs on top. The AD stated that if there was a change in (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's diet she would not know unless the nurse or CNA told her. On 3/26/26 at 9:23 AM, an interview was conducted with RN 2, who stated that resident 37 did not have the mental capacity to chew and that she required a lot of cueing when she ate. RN 2 stated that she did not know if the resident could chew crunchy noodles or candy but if the resident was served a food that was not minced and moist she would be concerned that resident 37 would choke. RN 2 stated she thought all snacks that were provided during activities went through the kitchen and they would make sure it was the ordered diet. On 3/26/26 at 9:38 AM, an interview was conducted with the Dietary Manager (DM) and he stated that Activities did their own snacks and that they did not ensure the residents were getting the correct diets. On 3/25/26 at 2:23 PM, an interview was conducted with the DON who stated they have a speech therapist they can call when a resident needed to be screened but he worked at another job and this facility was not a high priority for him. The DON stated they talked to the doctor about changing diet textures due to the limited availability of the speech therapist. The DON stated that staff were expected to follow the physician's orders.		