

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Monument Healthcare Stonecreek		STREET ADDRESS, CITY, STATE, ZIP CODE 523 North Main Street Bountiful, UT 84010	
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 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 observation, interview, and record review, the facility did not ensure each resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Specifically, for 1 out of 40 sampled residents, the facility did not implement pressure ulcer interventions to prevent infection and new ulcers from developing. This will be cited at a harm level. Resident identifier: 3. Findings included: Resident 3 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included pressure ulcer of sacral region stage 4, pressure ulcer of right buttock stage 4, pressure ulcer of left buttock stage 4, and pressure ulcer of left heel. Resident 3's Minimum Data Set (MDS) completed on 3/26/26 showed a Brief Interview of Mental Status (BIMS) score of 99. A score of 99 indicated the resident was unable to complete the assessment. Resident 3's MDS section GG mobility indicated that resident 3 was dependent on staff for rolling, transferring from bed to chair, personal hygiene, putting on and taking off footwear, upper body dressing, and toileting hygiene. The following observations were made of resident 3: a. On 6/22/26 at 12:55 PM, there were multiple dry brownish-red discolorations on the sheets near resident 3's feet. Resident 3 was positioned on her back with the head of the bed slightly elevated. Resident 3's heels were on top of the mattress. Resident 3 had bandages dated with 6/21 to both of her heels that were peeling off the skin and sticking to the sheet of the bed. b. On 6/23/26 at 7:49 AM, there were multiple dry brownish-red discolorations on the sheets near resident 3's feet and the sheets appeared to be the same as the day before. Resident 3 was positioned on her back with the head of the bed slightly elevated. Resident 3 had bandages dated with 6/21 to both heels and the left heel bandage was stuck to the top of the sheet. Resident 3's heels were resting on top of the mattress. There were no off-loading boots or pillows observed. c. On 6/23/26 at 11:26 AM, resident 3 was on her back with the head of her bed positioned at approximately 30-degree angle. Resident 3's feet were up on top of a pillow with the heels resting directly on the pillow. d. On 6/24/26 at 7:19 AM, resident 3 was positioned on her back with the head of the bed slightly elevated. Resident 3's sheets had multiple dry brownish-red discolorations near the feet. Resident 3 had both heels on top of a pillow. Resident 3's right heel had two bandages attached to the heel and stuck to the pillow. It should be noted that resident 3 was not observed wearing compression socks or heel booties on 6/22/26 through 6/24/26. A review of resident 3's physician orders revealed: a. On 5/20/26, Ensure Heel booties to bilateral heels while in bed every day and night shift for heel booties. b. On 5/20/26, R [right] heel pressure sore: Cover site with border foam dressing QAM [every morning] and PRN [as needed]. Check dressing placement q [every] shift. every day and night shift for R heel PU [pressure ulcer]. c. On 6/4/26, Compression stockings to BLE [bilateral lower extremities]. On in the AM [morning], off at HS [night]. every day and night shift. d. On 6/6/26, RIGHT HEEL UNSTAGEABLE PRESSURE (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 0686 Level of Harm - Actual harm Residents Affected - Few	ULCER (DRY STABLE ESCHAR): Cleanse, pat dry, Apply skin prep to periwound, apply Betadine to wound bed, cover with calcium alginate, then apply bordered gauze cover dressing. Special Instructions: Maintain offloading boots in place bilaterally. Unable to float due to inability to keep patients BLE on pillow every day shift.e. On 6/15/26, OOB [out of bed] to chair as much as possible every day and night shift.A review of resident 3's progress notes revealed:a. On 3/16/26 at 2:03 PM, an admission evaluation note documented, .SKIN CHECK: Impairments noted: Sacrum - pressure site to buttocks approximately 6x2 cm [centimeter] in dimensions, odorous, with skin noted to be dark in color, scant to no drainage, Groin - multiple small open areas to buttock, scant to no drainage noted, . b. On 3/20/26 at 1:00 AM, an encounter note documented, .Wound care is concerned with her wound on her bottom and wants to get an MRI [magnetic resonance imaging] to r/o [rule out] osteomyelitis. We are going to try and get this done as soon as possible.c. On 4/1/26 at 11:37 PM, a skin check note documented, Skin: Resident has an external device. External device(s) description: wound vac [vacuum] . Skin issue education: Signs and symptoms of infection. Skin issue education: Dressing change(s). Skin issue education: Care of skin issue(s). Skin issue education: Turn every 2 hours. Skin issue education: Change clothing/ briefs. Skin issue education: Treatment of skin issue. Additional skin issue education documentation: Education on the need for wound vac and keeping itworking [sic] properly. Skin issue notification: Wound nurse. Additional skin issue notification documentation: wound has been an on going [sic] problem.d. On 4/2/26 at 1:00 AM, an encounter note documented, .Wound care is concerned with the wound on her bottom and wants to get an MRI to r/o osteomyelitis. She does have a wound vac in place. We are going to try and get this done as soon as possible.e. On 4/3/26 at 3:54 PM, a skin note documented, Skin Issue: #001: : New skin Issue. Location: Buttocks - generalized. Issue type: Pressure ulcer/ injury. Progress: Deteriorating: .f. On 4/5/26 at 4:42 PM, an order note documented, obtain anaerobic and aerobic swab from sacral wound: r/o infection to sacral wound site/wound bed.g. On 4/6/26 at 2:07 PM, a progress note documented, New orders from [name redacted] to start Doxycycline 100 mg [milligram] po [by mouth] bid [twice daily] for wound.h. On 4/9/26 at 11:12 AM, an infection note documented, Wound Culture results received and show streptococcus constellatus, streptococcus anginososa and pseudomonas aeruginosa. NP [nurse practitioner] reviewed results and changed antibiotic to levofloxacin 750mg x 14 days. Doxycycline discontinued. Contact precautions are in place. MRI scheduled to r/o osteomyelitis on 4/15 [26].i. On 4/11/26 at 10:05 AM, an alert charting note documented, Alert note : Wound to sacrum dsq [dressing] changed as ordered, dressing was saturated with foul odor, wound is deep with slough to parts of wound bed, resident crying in pain during dsq change despite being medicated prior, continues on Levaquin PO for infection to wound, no ASE [adverse side effects] noted or reported at this time.j. On 4/17/26 at 11:59 AM, a skin note documented, .Skin Issues Note: Education:- Frequent brief checks/changes are to essential to ensure affected area remains clean and dry- Ensure area is completely dryprior [sic] to application of wound care product.- Recommend frequent offloading and repositioning to alleviate pressure from affected area.- Monitor for s/s [signs and symptoms] of infection (i.e. warmth, erythema, purulent drainage, increased pain, etc).k. On 4/21/26 at 10:33 AM, a progress note documented, MD [medical doctor] ordered for patient to be sent to [name redacted] ER [emergency room] since patient has refused last 2 attempts for MRI.Pt [patient] continues to refuse to eat an adequate amount for healing wounds and confusion and aggitation [sic] have increased in the last few days. Pt is on the last 2 days of pseudomonas treatment for sacrum wound.l. On 5/21/26 at 1:00 AM, an encounter note documented, [resident 3] was seen for readmission H&P [history and physical] today. She was sent to the hospital for possible osteomyelitis [sic] in her sacrum. It is now down to the bone and no treatment other than dressings were sent with her. She (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	also developed a pressure ulcer to her left heel while there.m. On 5/27/26 at 1:12 PM, an electronic Medication administration record (eMar) note documented, 1. SACRAL PRESSURE ULCER - STAGE IV [4] WITH BONE EXPOSURE: Cleanse, pat dry, apply wound vac to area per instructions. every day shift every Mon [Monday], Wed [Wednesday], Fri [Friday] Wound vac has been ordered per [name redacted] ADON [Assistant Director of Nursing]. Awaiting shipment. Instructed to provide wound care per other TAR [Treatment Administration Record] until arrived.n. On 5/27/26 at 3:44 PM, an infection note documented, NP gave orders for Levofloxacin 750mg Qd [every day] x 14 days for sacral wound infection and elevated WBC [white blood cells].o. On 5/29/26 at 3:04 AM, an eMar note documented, Wound vac to sacrum: Ensure it is in place and functioning properly each shift, set to 125 mmHg [millimeters of mercury]. Empty chamber if needed. every day and night shift Wound vac is not in place.p. On 5/30/26 at 10:54 AM, an eMar note documented, Wound vac to sacrum: .No wound vac in place, order for wet to dry.q. On 5/30/26 at 8:44 PM, an infection note documented, .Np reviewed wound cx [culture] results and added bactrim treatment along with levofloxacin treatment for sacral wound infection.r. On 5/31/26 at 1:06 AM, an eMar note documented, Wound vac to sacrum: .Wound vac not installed.s. On 5/31/26 at 3:02 PM, an eMar note documented, R heel pressure sore: Cover site with border foam dressing QAM and PRN. Check dressing placement q shift. every day and night shift for R heel PU.t. On 6/1/26 at 1:00 AM, an encounter note documented, .[resident 3] is a [AGE] year-old female with a history of CIDP [chronic inflammatory demyelinating polyneuropathy], GERD [gastroesophageal reflux], dementia/altered mental status, stage IV decubitus ulcer, DVT [deep vein thrombosis] history, hypothyroidism, depression, and chronic pain who has returned to this facility following a recent hospitalization for worsening decubitus ulcer and altered mental status. She continues to have a feeding tube in place. Wound culture results have returned positive for MRSA [methicillin resistant Staphylococcus aureus] and Enterobacter. She is currently on antibiotic therapy including daptomycin, vancomycin, valacyclovir, and Bactrim for wound coverage.u. On 6/1/26 at 12:05 PM, an eMar note documented, Wound vac to sacrum: . No wound vac, dressing changed per orderIt should be noted that the wound vac was ordered on 5/27/26 and was still not available for use as of 6/1/26. This resulted in at least a 5 day delay in treatment. A review of resident 4's wound care visit notes on 6/18/26, documented, .The wound vacuum-assisted closure (wound VAC) was examined and fecal contamination was noted to the wound bed; the wound was soaked with Dakin's solution prior to wound VAC reapplication. Significant time was spent educating facility staff on adequate wound VAC placement with bridging to the left hip and use of colostomy paste dam between the anus and wound bed to decrease risk of fecal contamination. The right heel unstageable pressure ulceration presents with stable, dry, intact eschar with no improvement noted. A new deep tissue injury (DTI) to the left heel was identified for the first time at today's visit.On 6/24/26 at 9:01 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 3 had a wound vac and was seen by an outside wound company. RN 1 stated that resident 3 had a wound near her coccyx and necrotic tissue to a wound on her right heel. RN 1 stated that resident 3 should be wearing off-loading boots. RN 1 stated that resident 3 should be up and out of bed daily. On 6/24/26 at 9:14 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that resident 3 had wound changes done daily. CNA 1 stated that resident 3's bed linens were changed on shower days, but resident 3 screamed a lot so she did not change the sheets. CNA 1 stated that resident 3 got a new heel wound because resident 3 was not wearing unna boots. CNA 1 stated that resident 3 was unable to reposition herself and required facility staff assistance.On 6/24/26 at 10:55 AM, an interview was conducted with Assistant Director of Nursing (ADON) 2. ADON 2 stated that resident 3 should be wearing her booties and compression socks and the nurse was (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	putting them on now. On 6/25/26 at 7:31 AM, a follow-up interview was conducted with RN 1. RN 1 stated that she had not been trained on how to use a wound vac in the facility. RN 1 stated that she thought there were videos to watch, but she had not watched them. RN 1 stated that if she had a problem with a wound vac, she would try and find a nurse that knew how to use one. On 6/25/26 at 9:26 AM, an interview was conducted with ADON 1. ADON 1 stated that the Director of Nursing usually handled the residents with wounds, but since she was out on leave it was handed to him last week. ADON 1 stated that the facility used wound vacs and facility staff were trained on how to use them. ADON 1 stated that facility staff had a mandatory nurse meeting last week where they were trained on how to properly use a wound vac. ADON 1 stated that he would try and locate the sign in sheet that nursing staff were required to sign for the wound vac training. It should be noted that wound vac training sign in sheet was not provided by the facility. On 6/25/26 at 10:16 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that she was not sure that there was proof that wound vac training had occurred last week.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that the resident right to self-administer medications was clinically appropriate and safe. Specifically for 4 out of 40 sampled residents, residents were observed to have medications in their rooms and were not evaluated to determine if they were safe to self-administer medications. Resident identifiers: 8, 22, 35, and 78. Findings included: 1. Resident 8 was admitted to the facility on [DATE] with diagnoses which included fracture of left femur, difficulty in walking, and muscle weakness. On 6/22/26 at 9:21 AM, a concurrent observation and interview were conducted with resident 8. On resident 8's bedside table there was a bottle of turmeric tablets and one white tablet. Resident 8 stated that the facility gave him a bunch of pills and he was unsure what the white tablet was. Resident 8 stated that he better take the white pill. A self administration evaluation or an order to self administer medications was not located. On 6/24/26 at 7:32 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that residents could not self-administer medications without an order and an evaluation. RN 1 stated that resident 8 was unable to self-administer medications. On 6/24/26 at 10:44 AM, an interview was conducted with Assistant Director of Nursing (ADON) 1. ADON 1 stated that he was unable to locate an assessment or an order for resident 8 to self-administer medications and it was not careplanned. 2. Resident 35 was admitted to the facility on [DATE] with diagnoses which included, type 2 diabetes mellitus without complications. On 6/22/26 at 12:49 PM, an observation was conducted of resident 35's room. Prescription medication was observed in resident 35's room. A self administration evaluation was not located. A physician's order dated 11/13/25, documented Triamcinolone Acetonide External Cream 0.1 % (Triamcinolone Acetonide (Topical)) Apply to arms topically three times a day related to PSORIASIS, UNSPECIFIED . unsupervised self-administration. On 6/25/26 at 12:58 PM, an interview was conducted with ADON 1. ADON 1 stated he was unable to locate a self administration evaluation in resident 35's medical record. 3. Resident 78 was admitted to the facility on [DATE] with diagnoses which included spinal stenosis, type 2 diabetes mellitus with diabetic neuropathy, personal history of urinary tract infections, polyosteoarthritis, and asthma. On 6/22/26 at 10:17 AM, an observation was made of resident 78 while she was seated in bed with her bedside table within reach. The following medications were observed on resident 78's bedside table: two tablets on top of a napkin, six tablets in a medication cup, and an inhaler. An interview was conducted with resident 78, who stated that she needed to swallow her medications slowly, otherwise her stomach would become upset. Resident 78 was unable to state what medications were at her bedside. A self administration evaluation or a current order to self administer medications was not located. A physician's order dated 5/12/25, documented Resident prefers to administer own medications independently. Nurse will prepare and monitor at bedside for safety. every shift. The order was discontinued on 10/23/25. On 5/9/26, a Brief Interview for Mental Status (BIMS) was conducted and resident 78 received a BIMS score of 12, which indicated moderate cognitive impairment. On 6/20/26 at 7:56 AM, a progress note documented that resident 78 had several medicine cups with her name written on them one which had a pill in it. Pt [patient] educated that medications can not be left at bedside. Nurse could not identify what pill was. Pt educated as to medication safety. She states that she takes one pillat [sic] a time and requires nurse to leave medications at bedside. On 6/25/26 at 12:31 PM, an interview was conducted with RN 2, who stated that a resident could not self-administer medications without an order and an evaluation. RN 2 stated that she received education about the requirements for residents to self-administer medications that (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure each resident who entered the facility with an indwelling catheter or subsequently received one was assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization was necessary. Specifically, for 3 out of 40 sampled residents, the facility did not discontinue residents' Foley catheters when there were no indications for use. Additionally, facility staff were not trained on the use of a PureWick for a resident and the PureWick tubing was observed draped over the head of the bed and not able to down drain. Resident identifiers: 3, 46, and 98. Findings included: 1. Resident 3 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included encephalopathy, altered mental status, type 2 diabetes, and dysphagia oropharyngeal phase. On 6/22/26 at 8:50 AM, an observation was made of resident 3. Resident 3 had a urinary catheter hanging on the right side of the bed. A review of resident 3's physician orders revealed: a. An order with a start date of 5/20/26, documented, CATHETER: Change catheter securement device q [every] week and PRN [as needed] as needed for CATHETER: Change catheter securement device q week and PRN. b. An order with a start date of 5/20/26, documented, Change Drainage bag monthly and PRN as needed for Infection, leakage, obstructions. c. An order with a start date of 5/20/26, documented, CATHETER: Change urinary catheter PRN as needed for Obstruction, Leaking, or infection. d. An order with a start date of 5/25/26, documented, CATHETER: Change catheter securement device q week and PRN one time a day every Mon [Monday] for catheter care. A review of resident 3's progress notes revealed: a. On 5/20/26 at 5:41 PM, an admission evaluation nursing note documented, . NURSING EVALUATION: EBP [Enhanced Barrier Precautions] qualifiers; Urinary Catheter Feeding Tube. BOWEL INCONTINENCE; No. NA [not applicable] due to catheter. Catheter present: Yes. Type if applicable: Foley Catheter. b. On 5/25/26 at 5:02 PM, an alert note documented, pt [patient] had labs and urine sample sent to central lab for assessment this date. Urine sample collected and sent for processing. c. On 5/26/26 at 1:00 AM, a physician encounter note documented, . her recent UA [urinalysis] came back positive. I am going to restart her on Levaquin and await culture results. d. On 5/28/26 at 4:58 PM, an infection note documented, Urine culture grew 50,000 enterococcus faecalis. Pt is currently taking levofloxacin for wound infection. wound culture is still pending. Levofloxacin is on sensitivity list for urine cx [culture]. Pt is also being treated prophylactic for UTI [urinary tract infection] since pt didn't meet mcgeer's [sic] criteria for UTI. On 6/24/26 at 9:01 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 that she was unaware of a urinary catheter for resident 3. On 6/24/26 at 9:08 AM, a follow-up interview was conducted with RN 1. RN 1 stated that resident 3 did have a urinary catheter and she was unsure of the reason resident 3 had one. On 6/24/26 at 9:14 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that resident 3 had to have her brief changed every 2 hours. CNA 1 stated that resident 3 came back from the hospital with a urinary catheter and she did not know why resident 3 needed one because she had frequent brief changes. On 6/24/26 at 9:30 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that she thought resident 3 had a urinary catheter in place because she had a sacral wound, but would look for documentation as to the reason why. It should be noted that the facility did not provide any additional information or documentation for the indication of the use of a urinary catheter. 2. Resident 98 was admitted to the facility on [DATE] with diagnoses which (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included malignant neoplasm of endometrium, secondary malignant neoplasm of bone, and pathological fracture. On 6/22/26 at 9:57 AM, an interview was conducted with resident 98. Resident 98 stated that she did not know why she had a urinary catheter. A review of resident 98's physician orders revealed: a. An order with a start date of 6/18/26, documented, CATHETER: Change catheter securement device q week and PRN as needed for CATHETER: Change catheter securement device q week and PRN. b. An order with a start date of 6/18/26, documented, CATHETER: Change urinary catheter 14FR [french] /10ml [milliliter] PRN as needed for Obstruction, Leaking, or infection. A review of resident 98's progress notes revealed: a. On 6/17/26 at 12:47 AM, an admission evaluation nursing note documented, .NURSING EVALUATION: EBP qualifiers; Urinary Catheter. LOC Urinary Catheter. BOWEL INCONTINENCE; No. BLADDER INCONTINENCE; No. No. Catheter present: No. Type if applicable: b. On 6/21/26 at 8:39 AM, a daily skilled evaluation note documented, .Nursing Evaluation: Complete. CATHETER use. Type: Foley catheter in place. urinary catheter 14 fr 10 mL with dignity bag and drain intact, securement device in place DME [durable medical equipment] used by pt includes: c [cervical] collar and bedside commode pt requires assist from surface to surface with nurse assisting and perineal cares completion prior to morning medication pass this date. Pt requires guidance and minimal [sic] support. Encouragement for completion of task. Education provided for safe transfer techniques. Pt requires perineal cares as provided by staff at this time post bowel movement. On 6/24/26 at 1:34 PM, an interview was conducted with CNA 1. CNA 1 stated that resident 98 was a stand by assist but could get up by herself. CNA 1 stated that resident 98 used a bedside commode in her room. CNA 1 stated that resident 98 came to the facility with a urinary catheter and she was unsure why resident 98 needed one because she was able to get up and use the bedside commode, use a call light to call for assistance, and could transfer herself. On 6/24/26 at 2:11 PM, an interview was conducted with RN 4. RN 4 stated that resident 98 was admitted to the facility after experiencing a ground level fall at home and fracturing her cervical vertebrae. RN 4 stated that resident 98 was continent and did not know if she had a urinary catheter. On 6/24/26 at 2:16 PM, an interview was conducted with the RNC. The RNC stated that resident 98 had an admitting diagnosis of pathological fracture. The RNC stated that she thought that resident 98 might have the urinary catheter because of malignant neoplasm of the endometrium but she would find out why resident 98 had a urinary catheter. On 6/25/26 at 10:13 AM, a follow-up interview was conducted with the RNC. The RNC stated that she called resident 98's daughter to see why she had the urinary catheter as there was no diagnosis for the use of the urinary catheter. The RNC stated the facility Nurse Practitioner wanted to follow-up with resident 98 before they took out the catheter. 3. Resident 46 was admitted to the facility on [DATE] with diagnoses which included fibromyalgia, alcoholic cirrhosis, hepatic failure, generalized anxiety disorder, major depressive disorder, and chronic pain syndrome. On 6/13/24, resident 46 had a physician order for Pure wick catheter to be in place at all times while in bed. Change purewick catheter q 12 hours or if soiled every day and night shift for purewick. On 6/13/24, resident 46 had a physician order for Ensure privacy cover is over purewick urine canister every day and night shift for purewick. On 6/13/24, resident 46 had a physician order for Ensure purewick urine canister is emptied q shift every day and night shift for purewick. On 4/23/24, resident 46 had a Care Plan initiated for PureWick catheter in place related to urinary (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incontinence. Interventions identified were that resident 46 would be free of any untreated discomfort related to the PureWick catheter; patient was able to maintain suction to catheter as desired; and PureWick catheter in place while in bed. On 6/23/26 at 3:02 PM, an interview was conducted with CNA 7. CNA 7 stated that resident 46 was fully dependent on staff for toileting assistance and was bed bound. CNA 7 stated that resident 7 had a PureWick device in place. CNA 7 stated that they emptied the urine canister, they changed the PureWick device every 2 hours, and the change of the device was patient guided. CNA 7 stated that resident 46 told staff when to change the device and how to place it. CNA 7 stated that resident 46 would let staff know if the PureWick was positioned correctly or if it was too high or too low. CNA 7 stated that resident 46 had different PureWick sizes that were used at different times of the day. CNA 7 stated that the placement of the PureWick was based on how comfortable the resident was. CNA 7 stated that the PureWick tubing was placed over the top of the mattress and depended on resident 46's liking. On 6/23/26 at 3:35 PM, an interview was conducted with RN 3. RN 3 stated that the CNAs have been trained on how to replace the PureWick device and the nurses were trained this month on how to use the device. RN 3 stated that the device should be positioned in between the labia with the white weaved part positioned against the urethral opening and then the suction was turned on. RN 3 stated that there was not a suction setting for use. RN 3 stated that the tubing should be over the leg and positioned like a down drain. RN 3 stated that she was not sure if there was a potential for a back flow if the tubing was not positioned off the side of the bed. RN 3 stated that resident 46 had a history of urinary tract infections and the last infection was a couple of months ago. RN 3 stated that she had been working at the facility for 2 years and resident 46 had always had the device. On 6/24/26 at 3:46 PM, an interview was conducted with the RNC. The RNC stated that they identified an issue with the PureWick staff education, implemented training on 6/1/26, and required staff complete the training by 6/30/26. The RNC stated that the staff training included a video demonstration on how to place the device. The RNC stated that the video training included placement of the device with the pubic bone, how to remove the device safely to prevent injury, replacing the device every 8-12 hours, how to empty the urinary canister, and to empty the canister before 1800 milliliters of urine were collected. The RNC stated that the video was provided by the PureWick manufacturer and did not contain information on prevention of potential complications. On 6/25/26 at 10:18 AM, an interview was conducted with the CNA Coordinator. The CNA Coordinator stated that if resident 46 did not like a CNA she would refuse care from that CNA. The CNA Coordinator stated that resident 46 did not want CNA 2, CNA 3, CNA 4, CNA 5, and any male CNAs providing incontinence care to her. The CNA Coordinator stated that if resident 46 believed that the CNA did not know how to assist her she would wait until the next shift for incontinence care. The CNA Coordinator stated that all incontinence care refusals from resident 46 were related to staff not knowing how to place the brief and staff not knowing how to use a PureWick device. The CNA Coordinator stated that prior to the beginning of this month there was no CNA training on how to use the PureWick device. The CNA Coordinator stated that staff positioned the PureWick device with the white mesh over the urethral opening. The CNA Coordinator stated that the tubing exited the top of the device and was positioned under the resident's left arm. The CNA Coordinator stated that they positioned the tubing the way the resident preferred it and the device was changed when resident 46 informed them to change it.		

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not file in the resident's clinical record the laboratory reports that were dated and contained the name and address of the testing laboratory. Specifically, for 3 out of 40 sampled residents, laboratory results were not located in the medical record. Resident identifiers: 4, 46, and 99. Findings included: 1. Resident 4 was admitted to the facility on [DATE] with diagnoses which included dependence on renal dialysis, type 2 diabetes, and anemia in chronic kidney disease. Resident 4's physician's orders revealed the following: a. On 5/15/26, Admit labs: CBC [complete blood count], CMP [comprehensive metabolic panel], prealbumin, Hga1c [hemoglobin A1C], TSH [thyroid stimulating hormone] one time only for 1 Day. b. On 5/18/26, repeat CBC one time only for 1 day. c. On 5/19/26, Repeat CBC one time only for 1 day. It should be noted that no laboratory results could be located in the medical record. 2. Resident 99 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included unspecified kidney failure, thrombocytopenia, and chronic myelomonocytic leukemia. Resident 99's physician's order revealed the following: a. On 5/12/26,, Admit labs: CBC, CMP, Prealbumin, HgA1c, Lipid panel one time only for 1 Day. b. On 5/14/26, Lab draw: CBC & [and] BMP [Basic metabolic panel] one time only for 1 day. c. On 6/15/26, CBC, CMP one time a day for 1 day. It should be noted that no laboratory results could be located in the medical record. On 6/24/26 at 10:51 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that they had to get the lab results from the hospital and they were not in the resident's medical record. 3. Resident 46 was admitted to the facility on [DATE] with diagnoses which included fibromyalgia, alcoholic cirrhosis, hepatic failure, generalized anxiety disorder, major depressive disorder, and chronic pain syndrome. Resident 46's physician's order revealed the following: a. On 1/2/26, a Liver Function Panel (LFP), urine potassium, and urine sodium. b. On 1/9/26, a BMP. c. On 1/7/26, a LFP. d. On 3/2/26, a CBC, BMP, International Ratio/Prothrombin Time (INR/PT), and prealbumin. e. On 3/5/26, a Urinalysis with a Culture and Sensitivity. f. On 4/6/26, a LFP, urine potassium, and urine sodium. g. On 4/15/26, a CBC, BMP, INR/PT, prealbumin. h. On 5/21/26, a LFP, urine potassium, and urine sodium. i. On 5/25/26, a LFP, urine potassium, and urine sodium. j. On 5/26/26, urine potassium and urine sodium. The laboratory results for all listed laboratory orders were not located in resident 46's medical record. On 6/23/26 at 4:19 PM, an interview was conducted with the RNC. The RNC stated that all laboratory reports were printed from the laboratory portal today and were not contained within resident 46's medical record.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, food items in the refrigerator and freezer were undated and opened to air. Additionally, food items in resident refrigerators were undated and/or expired. Findings included: 1. On 6/22/26 at 7:41 AM, the initial tour of the kitchen was conducted. The following were observed: a. In the freezer was an opened bag of chicken breasts that were undated. b. In the freezer was a bag of raisin swirl bread that was opened and undated. c. In the refrigerator was an expired small carton of milk with the use by date of 5/9/26. 2. On 6/22/26 at 10:25 AM, the resident refrigerators were observed. The following were observed: a. In the 100 hall resident refrigerator there was an expired yogurt container with a use by date of 6/14/26. b. In the 100 hall resident refrigerator there were four expired yogurt containers with a use by date of 5/22/26. c. In the 300/400 hall resident refrigerator there was an expired yogurt container with a use by date of 6/14/26. d. In the 200 hall resident freezer there were open chimichangas with no use by date. 3. On 6/24/26 at 11:45 AM, a follow-up tour was conducted of the kitchen. The following were observed: a. In the freezer was a box with a bag that was open to air that contained garlic toast that did not have an opened date. b. In the freezer was an opened box with a bag of meat patties that were open to air and undated. c. In the freezer was an opened box with a bag of [NAME] fillets that were open to air and undated. 4. On 6/24/26 at 12:06 PM, lunch tray line was observed. During the tray line there were multiple observations of kitchen staff touching multiple surfaces without changing gloves. At 12:18 PM, an observation was made of the cook touching a hamburger bun with gloved hands. The cook then picked up gluten free bread with the same gloved hands to serve a gluten free resident. On 6/22/26 at 7:58 AM, an interview was conducted with the Dietary Manager (DM). The DM stated that all foods in the refrigerator and freezer should be dated with an opened date. On 6/22/26 at 10:31 AM, an interview was conducted with Registered Nurse (RN) 5. RN 5 stated that the nursing staff were in charge of monitoring resident refrigerators and that all items should be dated. RN 5 stated that items in the refrigerators were good for 4 days or the expiration date. On 6/25/26 at 10:04 AM, a follow-up interview was conducted with the DM. The DM stated that kitchen staff were supposed to use utensils for everything and to not touch the food. The DM stated that kitchen staff should not cross-contaminate foods. On 6/25/26 at 11:26 AM, an interview was conducted with the Registered Dietitian (RD). The RD stated that kitchen staff should be wearing gloves or washing hands often when they were in contact with food. The RD stated that kitchen staff should put a date when items were received or opened. The RD stated that items should not be open to air and should be wrapped or sealed. The RD stated that facility nursing staff were responsible for maintaining resident refrigerators.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that each resident who was given a psychotropic drug had adequate monitoring of that drug. Specifically, for 1 out of 40 sampled residents, a resident receiving an antidepressant did not receive a gradual dose reduction (GDR) in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. Resident identifier: 35. Findings included: Resident 35 was admitted to the facility on [DATE] with a diagnosis which included major depressive disorder. A physician's order dated 9/12/25, documented DULoxetine HCL [hydrochloride] Capsule Delayed Release Particles 30 MG [milligrams]. Give 1 tablet by mouth one time a day related to MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE . for 7 Days THEN Give 2 tablet by mouth one time a day related to MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE . The physician's order was discontinued on 9/24/25. A physician's order dated 9/24/25, documented DULoxetine HCL Capsule Delayed Release Particles 30 MG Give 2 tablet by mouth one time a day for Phantom leg pain. On 6/25/26 at 12:58 PM, an interview was conducted with Assistant Director of Nursing (ADON) 1. ADON 1 stated that he remembered doing a GDR in April 2026, but he could not find the documentation. ADON 1 stated a GDR would depend on what the resident was using the medication for. ADON 1 stated if the medication was used for phantom leg pain or off label they would request that the Medical Director document a contraindication. ADON 1 stated if the medication was used for depression they would reduce the medication and if the resident failed the reduction they would request that the Medical Director document a contraindication.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not implement written policies and procedures on prohibiting and preventing abuse and investigating any such allegations. Specifically, for 1 out of 40 sampled residents, staff were aware of allegations of roughness during care but did not escalate the allegation up the chain of command to be investigated as a possible allegation of abuse. Resident identifier: 46. Findings included: Resident 46 was admitted to the facility on [DATE] with diagnoses which included fibromyalgia, alcoholic cirrhosis, hepatic failure, generalized anxiety disorder, major depressive disorder, and chronic pain syndrome. On 6/22/26 at 9:55 AM, an interview was conducted with resident 46. Resident 46 stated that a staff member previously provided rough care during a brief change and persisted despite resident 46's request to stop. Resident 46 stated that this staff member was no longer allowed to work with her. Resident 46 stated that she did not want to disclose the staff member's name. Resident 46 stated that the facility said they spoke with the staff member and instructed them on resident 46's care. Additionally, Resident 46 stated that certain staff were not allowed to work with her due to issues with their treatment and things that they had said to her. Resident 46 would not elaborate on the issues, but said the staff yelled at her and screamed inappropriate comments. Resident 46 stated that she felt like the Certified Nursing Assistants (CNAs) were immature and retaliated towards her by not providing care. Resident 46 stated that staff rushed with her bed bath and it felt like they were rough with cleaning her. Resident 46 stated that she stopped filling out the grievance forms because facility leadership were no longer providing her with the facility resolution to her concerns. Resident 46 began crying and stated that she struggled with getting her incontinence care and bed baths. On 6/25/26 at 10:18 AM, an interview was conducted with the CNA Coordinator with the Regional Nurse Consultant (RNC) present. The CNA Coordinator stated that if resident 46 did not like the CNA she would refuse care from that CNA. The CNA Coordinator stated that resident 46 did not want CNA 2, CNA 3, CNA 4, CNA 5, or any male CNAs providing incontinence care or bathing assistance to her. The CNA Coordinator stated that she was aware of reports from resident 46 that staff were rough with providing her care. The CNA Coordinator stated that resident 46 reported that the staff were rough when wiping during incontinence care and bathing. The CNA Coordinator stated if a resident had a concern related to staff being rough she provided that resident a grievance form and then she talked to the staff member about the concern. The RNC stated that she identified last week that the staff were not aware of abuse reporting and the difference between abuse and a grievance. The facility documentation on allegations of abuse were reviewed. No documentation could be found that resident 46's allegations of rough care were reported to the state agencies or thoroughly investigated. Review of the facility policy on Resident Rights/Dignity: Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating documented that any suspicion of resident abuse must be reported immediately to the administrator and to other officials according to state law, and all allegations were thoroughly investigated. The policy was last revised on February 1, 2024.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined that the facility did not document in the resident's medical record the information that was provided to the receiving provider which must include a minimum of the practitioner responsible for the care of the resident; the resident representative contact information; advanced directive information; comprehensive care plan; a copy of the resident discharge summary; and all necessary information to ensure a safe and effective transition of care. Specifically, for 2 out of 40 sampled residents, the facility did not document in the resident's medical record the information conveyed to the receiving provider when the resident was transferred to the Emergency Room. Resident identifiers: 18 and 54. Findings included: 1. Resident 54 was admitted to the facility on [DATE], and was readmitted on [DATE] with diagnoses which consisted of asthma, pneumonia, type 2 diabetes mellitus, congestive heart failure, hypertension, and chronic kidney disease. On 6/22/26 at 11:48 AM, an interview was conducted with resident 54. Resident 54 stated that he went to the emergency room (ER) for a bowel issue and they also identified pneumonia at that time. Resident 54's medical records were reviewed. On 6/13/26 a 11:18 AM, a discharge summary note documented, Type: Hospital Transfer Resident transferred to a Short-term General Hospital/Acute Care Hospital. Resident transported via Non-Emergent Transport. Responsible Party was notified prior to transfer. Physician was notified prior to transfer. Director of Nursing or Designee was notified prior to transfer. Details: resident's results showed colonic ileus, was advised by oncall provider to be sent out during previous shift but declined to go, wanted to go this AM [morning]. On 6/13/26 at 11:18 AM, resident 54's Discharge Transfer summary was completed. The summary documented the reason for transfer and that the current reconciled medication list was provided to the resident. On 6/25/26 at 8:28 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that when they transferred a resident to the hospital they sent a copy of the facesheet, medication list, and documented the resident's change in condition. RN 1 stated that she documented this information in a progress note and evaluation form. RN 1 stated that she would document what information was sent to the receiving provider in the progress note. It should be noted that resident 54's progress notes did not contain the information that was sent to the receiving provider upon discharge/transfer. On 6/25/26 at 8:31 AM, an interview was conducted with RN 6. RN 6 stated that when she transferred a resident to the hospital she sent a copy of the orders and facesheet. RN 6 stated that this information was documented in the discharge paperwork. RN 6 stated she was not sure if the resident code status was contained on the facesheet. On 6/25/26 at 10:05 AM, an interview was conducted with Assistant Director of Nursing (ADON) 1. ADON 1 stated that the nurses send a copy of the resident facesheet, history and physical, labs, Physician Order for Life Sustaining Treatment (POLST), and medication list when a resident was transferred to the hospital, unless the Emergency Medical Technician (EMT) asked for other information. ADON 1 stated that the information sent to the receiving provider was not typically documented in a progress note and they never documented the actual forms that were sent to the receiving provider. 2. Resident 18 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included fracture of unspecified part of neck of left femur. On 6/13/26 at 7:04 AM, a Discharge Summary documented Hospital Transfer Resident transferred to a Short-term General Hospital/Acute Care Hospital. Resident transported via Ambulance. Responsible Party was notified prior to transfer. Physician was notified prior to transfer. Director of Nursing or Designee was notified prior to transfer. Administrator (continued on next page)		

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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.			
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was notified prior to transfer. The Discharge Transfer Leave of Absence Form dated 6/13/26, did not include all the required information that should have been sent to the receiving provider. The form did not include contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, Advance Directive information, and comprehensive care plan goals. On 6/25/26 at 12:56 PM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that she could not find anything other than what was already located in resident 18's medical record. The RNC stated that she would update the evaluation form with their home office team to include a more comprehensive check boxes addressing the order for life-sustaining treatment (OLST) form and the other missing documents.		

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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 40 sampled residents, a resident's tube feeding was labeled with an incorrect formula, an incorrect administration rate, and was not labeled with the initials of the nurse who initiated the infusion. Furthermore, additional tube feedings were missing required labeling information. Resident identifier: 3. Findings included: Resident 3 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included encephalopathy, altered mental status, type 2 diabetes, and dysphagia oropharyngeal phase. A review of resident 3's physician orders revealed: a. On 6/3/26, an order for Enteral Feed Order every 24 hours for enteral feed administer Jevity 1.5 at 60 ml [milliliters] continuously. b. On 6/9/26, an order for Enteral Feed Order every day and night shift Flush feeding tube with 100 cc [cubic centimeter] of water q [every] 4 hours and with 30 cc of water before and after medication administration. On 6/22/26 at 8:50 AM, an observation was made of resident 3. Resident 3 was receiving a tube feed via a nasogastric tube. The tube feed bag was labeled with resident 3's first name and last initial, Jevity 1.5, 60 mL/hr [milliliters an hour], and 6/21 2300 [11:00 PM]. The water bag next to the tube feed was unlabeled. On 6/23/26 at 7:49 AM, an observation was made of resident 3's tube feed that was infusing. The tube feed bag was labeled with the resident's first name and last initial, Jevity 1.5 @ [at] 60 mL/hr @ 2200 (10:00 PM). The water bag was unlabeled. On 6/24/26 at 7:19 AM, an observation was made of resident 3's tube feed that was infusing. The tube feed was labeled with the resident's first name and last initial, Jevity 1.2, 70 mL/hr, 6/23/26 2030 [8:30 PM]. The tube feed pump was administered at a rate of 60 mL/hr. The water bag was not labeled. It should be noted that a physician's order for Jevity 1.2 could not be located in resident 3's medical record. On 6/24/26 at 9:01 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 3 had a nasogastric tube that was used for tube feedings and medication administration. RN 1 stated that she was given in report that resident 3 had her tube feed order changed to Jevity 1.2 on 6/23/26, but she was unable to find the new order. On 6/24/26 at 9:08 AM, RN 1 was asked to observe the tube feed that was running. RN 1 stated that she did not know why there was a discrepancy of the tube feed that was written on the bag and what was ordered for the resident. RN 1 stated the night shift nurses changed out the tube feeds. RN 1 stated that the tube feed was incorrectly labeled because it did not contain the nurse's name that administered the tube feed and the water bag was not labeled. It should be noted that staff were unable to determine whether Jevity 1.2 or Jevity 1.5 was infusing. On 6/24/26 at 9:30 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that resident 3 was on a tube feed and received Jevity 1.5 at 60 mL/hr continuously and to flush with 100 mLs of water every 4 hours. The RNC stated that resident 3's tube feed order had not changed since 6/3/26. The RNC stated that she was unsure of a specific process for labeling tube feed bags. The RNC stated that water bags should be labeled to ensure they were changed out daily. On 6/25/26 at 11:26 AM, an interview was conducted with the Registered Dietitian (RD). The RD stated that she helped the facility with residents that required tube feeds and made the orders. The RD stated that she had not approved any recent changes to Resident 3's tube feed order, and stated that Jevity 1.2 was not the correct formula. The facility's tube feed policy was reviewed. T011-Gastrointestinal Conditions: Enteral Tube Feeding Via Continuous Pump. General Guidelines. 3. Check the enteral nutrition label against the order before administration. Check the following information: a. Resident name, ID [identification] and room number; b. Type of (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	formula;c. Date and time formula was prepared;d. Route of delivery;e. Access site;f. Method (pump, gravity, syringe); and g. Rate of administration (mL/hour) .The facility policy was in effect 2/1/24.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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that a resident who was unable to carry out activities of daily living (ADLs) received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Specifically, for 1 out of 40 sampled residents, a resident did not receive bathing assistance per their schedule. Resident identifier 46. Findings included: Resident 46 was admitted to the facility on [DATE] with diagnoses which included fibromyalgia, alcoholic cirrhosis, hepatic failure, generalized anxiety disorder, major depressive disorder, and chronic pain syndrome. On 6/22/26 at 9:58 AM, an interview was conducted with resident 46. Resident 46 stated she had not had a bed bath in a week. Resident 46 stated that she required 2 staff to assist with bathing cares and the staff had reported not having enough time to complete the task. Resident 46 stated she was supposed to have bed baths 3 times a week and she had been provided one bed bath in the last 2 weeks. Resident 46 stated she has had to beg to get her hair washed. Resident 46 stated that the Certified Nursing Assistants (CNAs) tell her that they have to hurry through her bed bath, and they can only take 20 minutes to complete the task and her bed bath required a bit more time. Resident 46 stated that the CNAs would say that she refused the care and attempt to have her sign a refusal sheet. Resident 46 stated that they did not have enough staff to provide the care. Resident 46 stated that when she signed the refusal sheet she also documented on that sheet that the reason for the refusal was due to not enough staff available to provide the care. Resident 46 stated that sometimes they did not provide the refusal sheet because they did not want her documenting this as the reason. On 7/1/25, the Annual Minimum Data Set Assessment documented that resident 46 was dependent for shower/bathing assistance. On 10/9/25, resident 46 had an order initiated for Resident to be offered a bed bath on Tuesdays, Thursday, and Saturdays at around 4pm or 8pm per resident's request. If resident refuses, please document. The CNA task for bathing for the last 30 days documented that bed baths were provided on 6/13/26 at 2:00 PM. It should be noted that this was the only bed bath documented for resident 46 during the 30 day time period. The task documented that the bath was refused on 5/26/26, 5/28/26, 5/30/26, 6/2/26, 6/4/26, 6/6/26, 6/9/26, 6/11/26, 6/16/26, 6/18/26, and 6/20/26. The task documented the schedule was Tuesday, Thursday, and Saturday PM and as needed. No documentation of shower refusal sheets could be found in resident 46's medical record. Resident 46 had a care plan for ADL self-care performance deficit initiated on 4/3/24. Interventions identified on the care plan included Bathing/Showering: [Resident 46] needs substantial assist with bathing. She is able to wash her hands/face. She prefers bed baths. On 3/26/26, resident 46 had a grievance concern for bathing initiated. The form documented, -Accountability for After Hour Care-Need for bed Bath To Be By Someone /w [with] Experience.-Retrieving individuals Sometimes Are Inconvenienced and Says 'I Don't Have Time'. -Only Asking For 2 People One With Experience 1630 [4:30 PM] After Pain Med At 1600 [4:00 PM] Need Consistency-Also Exploring Chance For AM Instead For Flexibility. The investigation findings were Spoke with the resident and her husband regarding the plan that will be implemented, including the individual education to be provided to the staff involved. Both the resident and her husband verbalized understanding and agreed with the plan. On 6/24/26 at 7:57 AM, an interview was conducted with Registered Nurse (RN) 7. RN 7 stated that typically residents had a set shower day but they could have showers as needed. RN 7 stated that the process for shower refusals was that they would ask the resident a second time if they would like a shower and if they continued to refuse they would have the resident sign a shower sheet. RN 7 stated that for residents who refused a lot they had an (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order from the provider to ask 3 times or encourage the resident to have a shower. On 6/24/26 at 11:00 AM, an interview was conducted with Assistant Director of Nursing (ADON) 1. ADON 1 stated that he was not sure if the signed shower refusal sheets were scanned into the resident medical record. On 6/24/26 at 11:01 AM, an interview was conducted with the Medical Records staff. The Medical Records staff stated that she did not scan shower refusal sheets into the resident's medical record, and the CNA Coordinator was responsible for the shower sheets. The Medical Records staff stated that she was the only person who scanned documents into the resident's medical record. On 6/24/26 at 11:09 AM, an interview was conducted with CNA 6. CNA 6 stated that resident 46 was dependent and a 2 person total assist for care. CNA 6 stated that resident 46 was scheduled for bathing in the afternoon shift, 3 times a week. CNA 6 stated that if a resident refused a shower she offered the resident 3 times a shower, then informed the nurse of the refusal. CNA 6 stated that the process was the CNA, nurse, and the resident signed the shower refusal sheet. On 6/24/26 at 3:23 PM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that the CNA Coordinator reported that they did away with the shower sheets a few months ago and the new process was to document the bathing in the tasks. The RNC stated that she was not sure if the process change had been implemented yet. The RNC stated that she preferred that they run a task report to determine who was refusing a lot so they could figure out why they were refusing.		

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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 interview and record review, for 2 out of 40 sampled residents, the facility did not ensure each resident received adequate supervision and assistance devices to prevent accidents. Specifically, a resident left the facility and called his daughter to report he was lost and a week later another resident, who needed to be supervised during a Leave of Absence, left the facility. Resident identifiers: 29 and 110. Findings included: 1. Resident 110 was admitted to the facility on [DATE] and discharged on 3/27/26 and readmitted on [DATE] and discharged on 6/2/26 with diagnoses which included depression, alcohol dependence, and history of transient ischemic attack. The facility reported to the State Survey Agency (SSA) on 5/22/26 at 11:32 AM, that resident 110 took an uber to get a haircut and called his daughter because he did not know how to get back on 5/14/26 at 11:35 AM. The daughter called the facility and they went and picked him up. It should be noted the incident happened on 5/21/26, not 5/14/26 as reported. An elopement risk evaluation completed on 3/19/26, documented that resident 110 scored a 2. There was no information regarding what a score of 2 meant and if he was an elopement risk. It should be noted this was from his previous admission and he did not have a current elopement assessment. An admission Minimum Data Set assessment dated [DATE], revealed resident 110 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. An admission Nursing assessment dated [DATE], revealed resident 110 had altered mental status and was alert and oriented to person and place. There were no care plans regarding a possible wander risk or elopement. A nursing progress note dated 5/21/26 at 12:59 PM, revealed Resident left in an Uber to get a haircut and his nails done, notified his daughter when he was finished with the hair cut that he did not know how to get back. Resident [sic] daughter is concerned with his confusion as it is not baseline, notified NP [Nurse Practitioner], to obtain UA [urine analysis]. Resident is being retrieved from salon and back to the facility. Will place wander guard on resident to promote safety, daughter consent. A care plan focus area stating I utilize a wander guard devices to promote safety r/t [related to] potential or history of wandering/exit seeking was initiated on 5/26/26, along with the intervention wanderguard placed on 5/26/26. It should be noted the care plan was initiated 5 days after the incident. Resident 110 was found to have a urinary tract infection and was treated with antibiotics. The investigation the facility conducted into the incident was reviewed. There was a timeline that was created which revealed resident 110 left the building on 5/14/26 at 11:35 AM, unaccompanied in an Uber for a haircut. Shortly after resident 110 called his daughter stating he did not know how to get back. Resident 110's daughter called the facility and About 11:35 AM - 12:xx [sic] facility staff [name removed] went and picked him up. Resident was assessed upon return with no injuries. The facility determined the root cause was a: process gap - lack of a prominent, consistently utilized LOA [Leave of Absence] tracking mechanism at the main exit/front desk combined with momentary lapse in exit monitoring/verification for a resident with cognitive/mobility risk. The departure was not detected in real time because the sign-out step was not followed or verified. The Determination was This was an isolated event. There was no evidence of systemic neglect, willful failure to supervise, or violation of the resident's rights. Documented precautions were in place. The identified gap was procedural and had been immediately addressed through process improvement. No substantiated finding of neglect was warranted. Corrective Action Implemented was improvement dedicated LOA sign-out book/process at front desk/main exit, updated care plan and elopement-risk interventions, staff education on elopement (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	protocols and new LOA process, reinforce special instructions and exit monitoring, and Quality Assurance and Performance Improvement initiated a review. 2. Resident 29 was admitted to the facility on [DATE] and discharged on 6/4/26 with diagnoses which included chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, convulsions, dementia, heart failure and cannabis use. The facility reported to the SSA on 5/31/26 at 6:50 PM, resident 29 required supervised LOA when leaving the facility. Left the building at approximately 6:50 PM. Staff identified that the resident was missing and contacted police for assistance in locating him. The resident returned to the facility on his own at approximately 7:10 PM. The resident stated that he was going to the gas station. Resident's care status requires supervision for any leave of absence; he was not authorized to leave the facility unaccompanied. Planned/initiated actions: Reassess resident on return and monitor respiratory status; review and update care plan and elopement-risk interventions; review supervision/staffing and exit-monitoring for the affected area; reinforce supervised-LOA status with staff; confirm smoking materials remain secured; provide staff education on monitoring and elopement protocols; notify physician. Investigation initiated. An elopement risk evaluation was completed on 3/15/26 at 7:48 PM. Resident 29 scored a 12 which indicated he was at risk for elopements. Resident 29 had a prior elopement or near-elopement and other behaviors that put him at risk for elopements marked on the evaluation. There was no care plan located in resident 29's medical record regarding his elopement risk. There were no nursing progress notes in resident 29's medical record about the incident on 5/31/26. The facility investigation was reviewed and revealed, The incident was classified as an isolated event with an identified process gap that has been promptly corrected. The timeline was on 5/31/26 at 6:50 PM, resident left the facility unaccompanied. Between 6:55 PM until 7:05 PM, staff identified resident 29 was missing. Local police were contacted for assistance in locating him. At 7:10 PM, resident 29 returned to the facility independently. Resident 29 stated he went to the gas station. There were no signs of distress or injury and the resident assessed. Notified police of resident return. The facility conducted a root cause analysis and determination which revealed there was a process gap - lack of a prominent, consistently utilized LOA tracking book/log at the main exit/front desk combined with a momentary lapse in exit monitoring/verification of supervision status for a high-risk resident. The resident's departure was not detected in real time because the sign-out step was not followed or verified. The determination was that This was an isolated event. There is no evidence of systemic neglect, willful failure to supervise, or violation of resident's rights. Documented precautions (supervised LOA designated and special instructions) were in place. The identified gap was procedural and has been immediately addressed through process improvement. No substantiated findings of neglect is warranted. The corrective action was Resident reassessment [plus] respiratory monitoring on return. The facility Implemented a dedicated LOA sign-out book at the front desk/main exit. The resident's care plan was updated, staff education on elopement and new LOA book process. It should be noted that resident 29's care plan was not updated. It should also be noted this was not an isolated event. Resident 29 eloped from the facility after he was evaluated as unsafe to leave the facility without supervision on 5/31/26, despite the root cause analysis performed and corrective action taken after Resident 110 had left the facility on 5/21/26. On 6/25/26 at 10:35 AM, an interview was conducted with the Administrator (ADM). The ADM stated he must have put the wrong date on the initial reporting of resident 110's elopement. The ADM stated that previously there was an LOA binder for residents to sign out at each nurses station, but there was no check in or sign out at the front door. The ADM stated the process was updated to require the receptionist to check out residents for LOA after resident 110 left. The ADM stated if a resident scored a 14 or higher on the elopement evaluation then the resident was at risk. The ADM stated nurses completed the elopement (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the person-centered care plan and the residents' goals and preferences. Specifically, for 1 out of 40 sampled residents, a resident reported that his Tramadol dose was frequently administered late and it impacted his pain control. Resident identifier: 54. Findings included: Resident 54 was admitted to the facility on [DATE], and was readmitted on [DATE] with diagnoses which included asthma, pneumonia, type 2 diabetes mellitus, congestive heart failure, hypertension, chronic kidney disease, and low back pain. On 6/22/26 at 11:51 AM, an interview was conducted with resident 54. Resident 54 stated that he had pain in his lower back, bilateral knee pain, and coccyx related to a pressure ulcer. Resident 54 stated he took Tramadol and Tylenol for pain. Resident 54 stated that the dose of Tramadol was frequently administered late and it impacted his pain control. On 1/3/26, resident 54 had a physician order initiated for Tramadol Hydrochloride Oral Tablet 50 milligrams (mg), Give 2 tablet by mouth one time a day for pain AND Give 1 tablet by mouth one time a day for Pain AND Give 2 tablet by mouth one time a day for Pain. Resident 54's June 2026 Medication Administration Record (MAR) documented that 2 tablets of Tramadol were scheduled for administration at 8:00 AM, one tablet was scheduled for administration at 12:00 PM, and 2 tablets were scheduled for administration at 8:00 PM. Resident 54's June 2026 MAR documented that the Tramadol was administered greater than one hour after the scheduled administration time on 6/1/26 at 1:34 PM, on 6/3/26 at 3:01 PM, on 6/8/26 at 9:14 AM, on 6/11/26 at 2:02 PM, on 6/20/26 at 9:25 PM, and on 6/22/26 at 9:35 PM. On 6/25/26 at 11:41 AM, an interview was conducted with Registered Nurse (RN) 6. RN 6 stated that resident 54's Tramadol had scheduled administration times and staff could administer the medication one hour before and one hour after the scheduled time. On 6/25/26 at 1:01 PM, an interview was conducted with Assistant Director of Nursing (ADON) 1. ADON 1 stated staff should administer medications as ordered during the timeframe it was ordered. ADON 1 stated that if a medication was ordered at a specific time staff had one hour before and one hour after to administer the medication. ADON 1 stated that resident 54 slept a lot and it impacted his medication administration. ADON 1 stated that staff should document that it was administered late because resident 54 was sleeping and they should notify the provider if it was not given as ordered. ADON 1 stated that if it was documented it would be in a progress note or medication administration note. It should be noted that no documentation was located for the late administration of the Tramadol.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility must ensure that residents who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Specifically, for 1 out of 40 sampled residents, a resident receiving dialysis had incomplete communication notes. Resident identifier: 4. Findings included: Resident 4 was admitted to the facility on [DATE] with diagnoses which included dependence on renal dialysis, type 2 diabetes, and anemia in chronic kidney disease. A review of resident 4's physician orders revealed: a. An order with a start date of 5/18/26, documented, COMPLETE the Dialysis Post Assessment Form after resident returns from dialysis. Ensure resident returns from dialysis with the Pre-Dialysis Assessment and Communication Form. Review and follow up as indicated. Call Dialysis center if not returned with resident. every day shift every Mon [Monday], Wed [Wednesday], Fri [Friday]. b. An order with a start date of 6/19/26, documented, COMPLETE and PRINT the Pre-Dialysis Assessment and Communication Form and ensure it is sent to dialysis with the resident. in the morning every Mon, Wed, Fri for Assessment and vitals for dialysis COMPLETE and PRINT the Pre-Dialysis Assessment and Communication Form and ensure it is sent to dialysis with the resident. The facility's pre and post dialysis assessment evaluation was reviewed. The pre evaluation documented resident's vital signs, cognition, mood, skin condition, presence of edema, abnormal lung sounds, gastrointestinal status, cardiac condition, type of dialysis access, presence of a bruit and thrill, access condition, pain level and location, and any additional comments. The post evaluation documented whether the resident had dialysis, the resident's vital signs, cognition, mood, skin condition, presence of edema, abnormal lung sounds, gastrointestinal status, cardiac condition, type of dialysis access, presence of a bruit and thrill, access condition, pain level and location, and any additional comments. A review of resident 4's pre and post dialysis assessment evaluations revealed: a. On 5/20/26, resident 4's post assessment evaluation was blank. b. On 5/29/26, resident 4's post assessment evaluation was blank. c. On 5/31/26, resident 4's post assessment evaluation was blank. d. On 6/3/26, resident 4's pre assessment did not have vital signs documented. e. On 6/12/26, resident 4's pre assessment did not document the type of dialysis access, an assessment on resident 4's lungs, gastrointestinal and cardiac systems, and pain level. The post assessment only documented that resident 4 had dialysis. The rest of the form was blank. f. On 6/22/26, resident 4's post assessment evaluation was blank. On 6/23/26 at 3:03 PM, an interview was conducted with Registered Nurse (RN) 5. RN 5 stated that for dialysis residents, nurses had to complete a pre and post evaluations. RN 5 stated there was an evaluation in the computer and nurses had to check for a thrill and bruit before and after dialysis and chart this. RN 5 stated that the evaluation included resident vital signs, dressing check, and a pain scale. On 6/23/26 at 3:16 PM, an interview was conducted with Assistant Director of Nursing (ADON) 1. ADON 1 stated that there was one resident in the facility that was on dialysis. ADON 1 stated that he expected nursing staff to complete the pre and post evaluation for dialysis. ADON 1 stated that staff should be completing vital signs when resident 4 returns from dialysis. ADON 1 stated that the pre and post evaluation form should be filled out in its entirety.		

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NAME OF PROVIDER OR SUPPLIER Monument Healthcare Stonecreek		STREET ADDRESS, CITY, STATE, ZIP CODE 523 North Main Street Bountiful, UT 84010	
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents were free of any significant medication errors. Specifically, for 1 out of 40 sampled residents, a resident taking a phosphate binder was not administered the medication with meals. Resident identifier: 4. Findings included: Resident 4 was admitted to the facility on [DATE] with diagnoses which included dependence on renal dialysis, type 2 diabetes, and anemia in chronic kidney disease. On 6/23/26 at 8:38 AM, an interview was conducted with resident 4. Resident 4 stated that she had been receiving her phosphate binder before and after meals and not with meals as she should be taking them. Resident 4 stated the medication needed to bind the phosphates in her food so her body did not absorb them. Resident 4 stated that she ate her meals in her room. A review of resident 4's physician orders revealed: a. On 5/14/26, Sucroferic Oxyhydroxide 500 MG [milligram] Tablet Give 2 tablet by mouth three times a day for Phosphorus Binder With meals (08 [8:00 AM], 12 [12:00 PM], 17 [5:00 PM]) b. On 5/16/26, Renvela Oral Tablet (Sevelamer Carbonate) Give 400 mg by mouth before meals for phosphorus binder. On 5/19/26, Renvela Oral Tablet (Sevelamer Carbonate) Give 400 mg by mouth three times a day for phosphorus binder before meals. A review of the facility's posted meal times for the 200 hall revealed that breakfast was served at 8:10 AM, lunch was served at 12:40 PM, and dinner was served at 5:55 PM. A review of resident 4's Medication Administration Record revealed the following: a. On 5/15/26, sucroferic was administered at 9:07 AM and 1:39 PM. b. On 5/16/26, sucroferic was administered at 8:36 AM and 1:15 PM. c. On 5/17/26, Renvela was administered at 6:57 AM and 2:25 PM. d. On 5/18/26, Renvela was administered at 6:48 AM and 11:46 AM. e. On 5/19/26, Renvela was administered at 6:42 AM and 12:16 PM. f. On 5/20/26, Renvela was administered at 7:26 AM, 10:32 AM, and 4:21 PM. g. On 5/21/26, Renvela was administered at 7:18 AM, 10:55 AM, and 4:25 PM. h. On 5/22/26, Renvela was administered at 8:27 AM, 1:29 PM, and 5:16 PM. i. On 5/23/26, Renvela was administered at 9:07 AM, 12:05 PM, and 4:15 PM. j. On 5/24/26, Renvela was administered at 6:54 AM, 11:33 AM, and 4:42 PM. k. On 5/25/26, Renvela was administered at 6:32 AM, 10:07 AM, and 4:34 PM. l. On 5/26/26, Renvela was administered at 7:13 AM, 11:14 AM, and 4:16 PM. m. On 5/27/26, Renvela was administered at 8:02 AM, 10:47 AM, and 5:28 PM. n. On 5/28/26, Renvela was administered at 8:04 AM, 11:08 AM, and 4:37 PM. o. On 5/29/26, Renvela was administered at 8:40 AM, 10:34 AM, and 4:37 PM. p. On 5/30/26, Renvela was administered at 7:57 AM, 11:38 AM, and 4:59 PM. q. On 5/31/26, Renvela was administered at 7:31 AM, 11:25 AM, and 5:10 PM. r. On 6/1/26, Renvela was administered at 6:31 AM, 11:13 AM, and 7:02 PM. s. On 6/2/26, Renvela was administered at 6:58 AM, 10:54 AM, and 4:26 PM. t. On 6/3/26, Renvela was administered at 6:40 AM, 12:20 PM, and 4:34 PM. u. On 6/4/26, Renvela was administered at 7:22 AM, 10:59 AM, and 4:01 PM. v. On 6/5/26, Renvela was administered at 8:16 AM, 10:25 AM, and 5:14 PM. w. On 6/6/26, Renvela was administered at 7:55 AM, 11:08 AM, and 4:52 PM. x. On 6/7/26, Renvela was administered at 7:59 AM, 11:05 AM, and 4:04 PM. y. On 6/8/26, Renvela was administered at 7:11 AM, 12:21 PM, and 5:42 PM. z. On 6/9/26, Renvela was administered at 9:17 AM, 12:07 PM, and 4:06 PM. aa. On 6/10/26, Renvela was administered at 8:07 AM, 12:59 PM, and 4:33 PM. bb. On 6/11/26, Renvela was administered at 7:52 AM, 11:09 AM, and 4:49 PM. cc. On 6/12/26, Renvela was administered at 8:08 AM, 12:23 PM, and 5:20 PM. dd. On 6/13/26, Renvela was administered at 8:54 AM, 11:53 AM, and 4:09 PM. ee. On 6/14/26, Renvela was administered at 7:08 AM, 10:18 AM, and 4:09 PM. ff. On 6/15/26, Renvela was administered at 6:37 AM, 10:24 AM, and 4:59 PM. gg. On 6/16/26, Renvela was administered at 7:34 AM, 11:21 AM, and 4:13 PM. hh. On 6/17/26, Renvela was administered at 8:06 AM, 12:43 PM, and 4:01 PM. ii. On 6/18/26, Renvela was administered at 8:06 AM, 12:43 PM, and 4:01 PM. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered at 7:26 AM, 10:57 AM, and 4:27 PM.jj. On 6/19/26, Renvela was administered at 8:13 AM, 12:05 PM, and 4:01 PM.kk. On 6/20/26, Renvela was administered at 8:10 AM, 12:18 PM, and 4:02 PM.ll. On 6/21/26, Renvela was administered at 7:27 AM, 10:52 AM, and 4:29 PM.mm. On 6/22/26, Renvela was administered at 8:05 AM, 11:06 AM, and 4:00 PM.On 6/23/26 at 3:03 PM, an interview was conducted with Registered Nurse (RN) 5. RN 5 stated that Renvela was for dialysis patients and it was a binder that was supposed to be given with meals. RN 5 stated that the medication needed food to bind with in order to work. RN 5 stated that with Renvela, she would wait until she saw the resident receive their meal tray before administering the medication. On 6/23/26 at 3:16 PM, an interview was conducted with Assistant Director of Nursing (ADON) 1. ADON 1 stated that Renvela was a phosphate binder that needed to be taken with food. ADON 1 stated that Renvela binded with phosphate in food and helped to absorb it. ADON 1 stated that the order for resident 4 stated that Renvela was to be given three times a day before meals. ADON 1 stated that Renvela needed to be taken with meals in order to be effective. ADON 1 stated that he expected nursing staff to know that the phosphate binder needed to be given with food. ADON 1 stated that Renvela was time stamped to be administered at 6:00 AM, 10:00 AM, and 4:00 PM, and these times should be adjusted to when she received meals.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility did not ensure that all drugs and biologicals were stored in compartments under proper temperature controls. Specifically, observations were made of multiple medications stored in a refrigerator that had a registered temperature of 24 degrees Fahrenheit (F). Resident identifiers: 5, 41, 46, and 73. Findings included: On 6/24/26 at 9:27 AM, an observation was made of the medication refrigerator on 300/400 hallway with Registered Nurse (RN) 3. The internal temperature gauge read 24 degrees Fahrenheit (F). RN 3 stated that temperature was not in the safe zone as indicated on the thermometer which was between 34-40 degrees. RN 3 stated that at a temperature of 24 degrees F they risked having the medication freeze. RN 3 stated that she would adjust the temperature and check the thermometer again later. The following medications were observed inside the refrigerator on 6/24/26 at 9:27 AM. Resident 5's Insulin Lispro 100 unit /milliliter (ml) - 5 pens total Resident 5's Insulin Lispro 100 unit/ml - 3 vials Resident 73's Admelog solostar 100 unit/ ml - 4 pens Resident 73's Insulin Lispro 100 unit/ml - 1 pen Resident 46's Trulicity 4.5 milligram (mg)/0.5 ml - 1 pen Resident 41's Lorazepam 2 mg/ml liquid - approx 2.5 ml remaining in bottle On 6/24/26 at 10:24 AM, an interview was conducted with Assistant Director of Nursing (ADON) 1. ADON 1 stated the medication refrigerator temperatures were labeled on the fridge and should be within 36-46 degrees Fahrenheit. ADON 1 stated that a refrigerator temperature that was 24 degrees could cause the medication to freeze. ADON 1 stated that they would move the medication to another fridge until they could verify the accurate temperature of the refrigerator. It should be noted that ADON 1 did not seek to verify the integrity of the medication that was stored within the refrigerator. Review of the facility policy for Medications: Medication Labeling and Storage documented that the facility stored all drugs and biologicals in locked compartments under proper temperature, humidity, and light controls. The policy did not address what the proper temperature would be for a refrigerator that stored medication. The policy was last revised on February 1, 2024.		

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F 0779 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep signed and dated reports of x-rays and other diagnostic services in the residents record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not file in the resident's medical record signed and dated reports of radiological services. Specifically, for 1 out of 40 sample residents, a resident's Electrocardiogram (EKG) report was not located in the medical record. Resident identifier: 99. Findings included: Resident 99 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included unspecified kidney failure, thrombocytopenia, and chronic myelomonocytic leukemia. On 6/1/26 at 4:49 PM, an order note documented, STAT [immediate] order for EKG due to HR [heart rate] ranging from 37 to 54, she also has been having N [nausea] . It should be noted that an EKG report was not located in resident 99's medical record. On 6/24/26 at 3:53 PM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated the EKG was not in the resident's medical record and the facility had to call and get the results.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not keep confidential all information contained in the resident medical records and safeguard against unauthorized access. Specifically, observations were made of the licensed nurse leaving the computer unattended and open to resident medical records and leaving the report sheet with resident health information unattended and visible on the medication cart. Findings included: On 6/24/26 at 8:15 AM, an observation was made of Registered Nurse (RN) 8 during the morning medication administration. RN 8 was observed to leave her report sheet unattended and visible on the medication cart outside room [ROOM NUMBER]. A resident roster with health information was visible to passersby. At 8:34 AM, RN 8 walked away from the medication cart to obtain additional medication. RN 8's nurse report sheet and computer were left unattended, open and resident identifiable health information was visible to passersby. An immediate interview was conducted with RN 8 upon her return to the medication cart. RN 8 stated that she should lock the computer and turn over her nurse report sheet when she walked away from the medication cart. On 6/24/26 at 10:24 AM, an interview was conducted with Assistant Director of Nursing (ADON) 1. ADON 1 stated that the staff should lock the computer screen or close the lid to ensure no resident identifiable information was visible and anything with personal information should be covered or secured.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment. Specifically, for 2 out of 40 sampled residents, personal protective equipment (PPE) was not worn for high contact care for residents on Enhanced Barrier Precautions (EBP). Resident identifiers: 3 and 15. Findings included: 1. Resident 3 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included encephalopathy, altered mental status, type 2 diabetes, and dysphagia oropharyngeal phase. On 6/25/26 at 7:27 AM, an observation was made of Registered Nurse (RN) 1 administering medications to resident 3 through her Nasogastric tube and was not wearing a gown. On 6/25/26 at 8:22 AM, an interview was conducted with RN 1. RN 1 stated that EBP PPE included wearing gloves and a gown. RN 1 stated that EBP was used for any resident that had a urinary catheter, feeding tube, or wounds. RN 1 stated that a gown and gloves were to be worn when administering medications through a tube feed. RN 1 stated that she was not wearing a gown when she administered medications to resident 3 this morning. On 6/25/26 at 8:24 AM, an interview was conducted with the Infection Preventionist (IP). The IP stated that EBP would be required for any resident that had a urinary catheter, feeding tubes, and wounds. The IP stated that nursing staff should perform hand hygiene prior to donning gloves and a gown. The IP stated that administering medications through a feeding tube would require a gown and gloves to be worn. 2. Resident 15 was admitted to the facility on [DATE] with diagnoses which included nontraumatic intracranial hemorrhage, dysarthria, and encounter for gastrostomy tube. On 6/22/26 at 8:50 AM, an observation was made of resident 15's room. Resident 15 had a tube feed (TF) pole located inside the room. Gowns and gloves were located inside the room next to the door. An interview was conducted with resident 15. Resident 15 stated that the TF was for water only. Resident 15 replied yes when asked if he had a feeding tube in his stomach. Resident 15 had a physician order for EBP due to a feeding tube that was initiated on 3/16/26. On 6/22/26 at 12:34 PM, an observation was made of the Certified Nursing Assistant (CNA) Coordinator during lunch meal service. The CNA Coordinator provided dining assistance to resident 15. The CNA Coordinator donned gloves and assisted resident 15 in sitting up in his wheelchair. The CNA Coordinator reclined resident 15's wheelchair, positioned herself behind the head of the wheelchair, reached under resident 15's bilateral arms, and pulled the resident up in the chair. The CNA Coordinator's bilateral arms and torso came into direct contact with resident 15 and his wheelchair. The CNA Coordinator then adjusted the wheelchair to a high Fowler's position. The CNA Coordinator then sat down on a stool and proceeded to assist resident 15 with his lunch meal. The CNA Coordinator did not have a gown donned while assisting resident 15. On 6/23/26 at 3:15 PM, an interview was conducted with the IP. The IP stated that EBP was initiated for residents with urinary catheters, intravenous access, wounds, or tube feeds. The IP stated that staff should be wearing a gown and gloves for any high contact care activities. The IP stated that staff should wear a gown and gloves when repositioning a resident if they are making direct contact with the resident or their immediate environment.		