STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465165	A. Building B. Wing	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Msm Brigham City LLC	1010 South Medical Drive Brigham City, UT 84302

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	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 interview and record review it was determined, for 2 out 25 sampled residents, that the facility did not ensure that the resident who was incontinent of bladder received the appropriate treatment and services to prevent urinary tract infections (UTI). Specifically, a resident developed a UTI following the use of a PureWick, which had been implemented without a physician's order or usage instructions. In addition, a resident had no follow-up after a urine culture was contaminated. This resulted in harm for resident 56. Resident identifiers: 3 and 56.Findings included: 1. Resident 56 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, fracture of left femur, fracture of right femur, repeated falls, and overactive bladder.Resident 56's medical record was reviewed on 12/9/25 through 12/15/25.A review of resident 56's progress notes revealed: a. On 9/8/25 at 12:30 PM, a nurse's note documented, Resident reviewed in IDT [interdisciplinary team] meeting. Resident states tried getting out of bed and couldn't stand and fell. Providers and family were notified. Intervention: Staff report they increased checks on residents after fall and put purewick on to help resident feel like they didn't have to get up until staff arrived to assist her. b. On 9/11/25 at 5:42 PM, a nurse's note documented, .family has purewick [sic] brought from home and purewick [sic] was placed upon arrival. resident's urine is dark at this time. c. On 9/15/25 at 4:46 PM, a nurse's note documented, CNA [Certified Nursing Assistant] reported to nurse that the family was continually wanting pure wick [sic] on resident, due to it starting to cause redness in peri [perineal] area. Nurse talked with family about not putting pure wick [sic] on resident 24 hours a day to allow area to heal. Cream is being applied to area. Family agreed to not put it on for the full day. d. On 9/17/25 at 10:33 PM, a nurse's note documented, .Redness to groin and labia. Continuing to monitor and apply barrier cream with brief changes. e. On 9/23/25 at 5:09 PM, a communication note documented, Resident was c/o [complaining of] pain this morning gave tylenol and Ibprophen [sic] and the pain went away. This evening she was c/o pain and said there was a smell. Collected a urine sample and did a urnie [sic] dip, sent to providers. Providers got back to the nurses and said send over for culture and sensitivity f. On 9/26/25 at 8.27 PM, a nurse's note documented, N.O. [new order] for UA [urinalysis] results. 1. Cipro 500 mg [milligram] po [by mouth] BID [two times a day] x [times] 5 days for UTI [urinary tract infection] 2. Septra DS 1 PO Qday [every day] x 5 days for UTI Both pulled from the stat safe and given this shift. Order faxed to pharmacy. g. On 10/2/25 at 11:55 PM, an orders administration note documented, May use purewick [sic] every shift Wet changing. [It should be noted that the resident had been using a PureWick for 8 days until a doctor order was received.]An order dated 9/16/25 revealed that resident 56 may use purewick [sic] every shift. [It should be noted that there were no treatment orders located in resident 56's medical record related to instructions for use and monitoring of PureWick.]A review of the facility's Specialized Medical Equipment Policy documented the following: PURPOSE: To ensure staff training and competency regarding identification and use of specialized medical equipment.POLICY: Maple Springs will ensure that all specialized medical equipment is identified and assessed for safety and necessity. Staff members will receive education on the use of specialized equipment and demonstrate (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	competency.PROCEDURES:1. Facility charge nurse will identify specialized resident equipment.2. Specialized equipment will be assessed for safety/necessity prior to use.3. Resident and/or POA [Power of Attorney] will be notified of assessment findings.4. If deemed safe for use, a provider order for use will be obtained.5. Nurse educator will develop an education module and competency checklist specific to the identified equipment.6. Staff will receive necessary education and demonstrate competency prior to use of identified specialized equipment.On 12/10/25 at 9:17 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that before a PureWick was used, it required an order from the provider. RN 1 stated that the facility did not supply PureWicks and if a resident requested to use one they had to pay for it. RN 1 stated that he had not received any training from the facility on how to use a PureWick. RN 1 stated that he would not want a CNA to change a PureWick because they would not know how to use them. RN 1 stated that a PureWick could cause irritation and redness to the peri area if it was applied incorrectly.On 12/10/25 at 9:40 AM, an interview was conducted with CNA 1. CNA 1 stated that she had worked at the facility for about 3 months. CNA 1 stated that she had never heard of a PureWick and had not received training for the use of one. On 12/10/25 at 10:26 AM, a telephone interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that a resident would require a physician's order to use a PureWick. LPN 1 stated that she had not received training on how to use or care for a PureWick at the facility. LPN 1 stated that resident 56 had some irritation and redness in her peri area after continued use of the PureWick. LPN 1 stated that resident 56's family wanted resident 56 to use the PureWick all the time because they did not want her sitting in a wet brief. LPN 1 stated that resident 56's family brought in the PureWick and that the facility did not provide supplies. LPN 1 stated she was unsure how often a Purewick needed to be changed but thought probably at least once a shift. LPN 1 stated that using a PureWick could cause urinary tract infections and skin breakdown. LPN 1 stated that resident 56 could verbalize when she needed to use the bathroom and could use a call light when she needed assistance.On 12/10/25 at 10:53 AM, an interview was conducted with CNA 2. CNA 2 stated that PureWicks weren't used and the facility did not supply them. CNA 2 stated she did not know how long PureWicks were good for or how often they should be changed. On 12/10/25 at 11:07 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the facility did use PureWicks if the family supplied them. The DON stated that a resident would need a physician's order before a PureWick could be used. The DON stated that she believed that most nurses knew how to use a PureWick and then they would teach the CNAs. On 12/11/25 at 9:19 AM, a follow-up interview was conducted with the DON. The DON stated that resident 56 had an order for the use of the PureWick on 9/16/25. The DON stated that resident 56 had the PureWick placed on 9/8/25. The DON stated that the facility had not provided any training for staff on how to use a PureWick. The DON stated that the risks of using a PureWick included skin breakdown and urinary tract infections.On 12/11/25 at 12:32 PM, a follow-up interview was conducted with the DON. The DON stated that nursing staff should have training on how to apply a PureWick and how often a PureWick needed to be changed. The DON stated that she was not sure if nurses or CNAs were provided education on how to properly use a PureWick. The DON stated that resident 56 did have a couple of urinary tract infections while at the facility. The DON stated that education for the use of a PureWick was not provided to staff because she did not think about it.2. Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hypo-osmolality and hyponatremia, type 2 diabetes mellitus, hypertensive heart and chronic kidney disease with heart failure. Resident 3's medical record was reviewed on 12/8/25 through 12/11/25.A quarterly Minimum Data Set (MDS) dated [DATE] revealed resident 3 was frequently incontinent of bladder. A nursing progress note dated 12/4/25 at 7:00 PM revealed a new order for Keflex 500 milligrams (mg) four times per day for 7 days for increased edema and redness to bilateral lower extremities (BLE).A physician's order dated 12/4/25 revealed Keflex Oral Capsule (Cephalexin), Give 500 mg by mouth four times a day for Possible cellulitis to BLE related to CHRONIC KIDNEY DISEASE, STAGE 4 until 12/11/25. A nursing (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	progress note dated 12/5/25 at 12:59 AM revealed, resident reported pain with urination and increased frequency. Resident 3 had increased lethargy with elevated temperature. UA (urinalysis) obtained per physician's orders. Urine was white with gel-like consistency, cloudy with strong odor. Positive dip stick for nitrites, leukocytes, glucose and blood.A physician's order dated 12/5/25 at 1:00 AM revealed UA with culture and sensitivity (C&S) one time only for Possible UTI. Pain with urination, increased frequency and lethargy with elevated temperature. Cloudy urine with a strong odor. Positive dip stick for nitrites, leukocytes, glucose and blood. A nursing progress note dated 12/6/25 at 6:15 AM revealed, refused cares last night during last rounds. Resident 3 requested as needed medication. On 12/7/25 at 10:58 AM, Received UA results back from [name of lab] notified providers.The results of the UA and C&S on 12/5/25 were not located in the medical record. On 12/11/25, the surveyor requested the UA and C&S results. The Corporate Quality Assurance Nurse provided the laboratory results on 12/11/25 and the sample had mixed flora present, probably contamination and the C&S was not completed. The laboratory form was printed on 12/11/25. On 12/11/25 at 3:30 PM, an interview was conducted with the Corporate Quality Assurance Nurse. The Corporate Quality Assurance Nurse stated that the nurse was notified over the weekend that the urine sample was contaminated and the C&S was not done. The Corporate Quality Assurance Nurse stated the nurse told her that the physician was contacted and the physician did not want to do another UA because resident 3 was already on Keflex. The Corporate Quality Assurance Nurse stated the nurse told him the doctor was planning to see resident 3 on 12/12/25. The Corporate Quality Assurance Nurse stated there was no note in the progress note regarding what happened so the nurse put one in on 12/11/25.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, the dishmachine was not at the required temperature for sanitation, there were soiled areas in the kitchen, and domes over food were tarnished with a white substance. Findings included: A. On 12/8/25 at 10:16 AM, an initial tour of the kitchen was conducted. The following was observed: 1. There was a substance on the floor in the freezer. 2. The ice machine had dust on the vent in the front. The Cleaning Schedule revealed Tuesday night the ice machine was to be cleaned inside and out. There was no signature on the schedule. 3. There were food particles and dried substances under the shelf that was above the steam table. 4. The warming drawer was soiled on the outside and the wall by the grill had a dried white substance on it.B. On 12/8/25 at 10:39 AM, an observation was made of the refrigerator in the activities room. The following was observed: 1. A container labeled Boost glucose control had a use by date of 10/30/25. 2. There was an unlabeled container with a white substance in it with no date. 3. A McDonalds bag open to air with date of 12/7 with room [ROOM NUMBER] written on it. 4. There were 4 plastic grocery bags with food and no dates.C. On 12/11/25 at 1:40 PM, a follow-up kitchen tour was conducted. The following was observed: 1. Dietary Aide (DA) 1 was observed in the dishmachine area. DA 1 was observed to place a dishmachine basket full of dishes into the dishmachine 4 times. The following temperatures were observed: [Note: All temperatures were in degrees Fahrenheit.] a. Washing temp was at 140 and rinsing temp was 140. DA 1 was observed to replace plates without dipping them in a sanitizer solution. b. Washing temp was 135 and rinsing temp was 140. DA 1 was observed to replace plate lids without dipping them in a sanitizer solution. c. Washing temp was 138 and rinsing temp was 140. DA 1 replaced meal trays without dipping them in a sanitizer solution. d. Washing temp was 138 and rinsing temp was 140. DA 1 replaced bases and plates without dipping them in a sanitizer solution. DA 1 was immediately interviewed. DA 1 stated the dishmachine needed to have a washing temperature of 155 and rinsing temperature of 180. DA 1 stated the dishmachine repair company had been to the facility because the temperatures were low on the dishmachine. DA 1 stated the dishes needed to be dipped in a sanitizer solution after going through the dishmachine. DA 1 was observed to point to a 3 compartment sink with 1 basin full of a clear liquid. DA 1 stated there was sanitizer in that sink. There was a cart in front of the sink, thus creating a barrier to put dishes in the sink to sanitize. DA 1 stated the temperatures had been low for a month or 2. DA 1 stated there was a high limit warning on the machine because it was getting too hot.The Dishmachine Temperature Log for December 2025 was reviewed. On 12/4/25 for lunch the wash temp was 155 and rinse temp was 174. On 12/9/25 for dinner, there were no temperatures documented. On 12/10/25 for breakfast, the wash temp was 145 and rinse temp was 140. There was a hand written note that the dishmachine repair company was notified and coming on 12/10/25. On 12/11/25 for breakfast, the wash temp was 149 and rinse temp was 170. On 12/11/25 for lunch, the wash temp was 148 and rinse temp was 172 with 20 PPM (parts per million) and 350 for the INT (initials) column. DA 1 stated that the PPM column was plates per minute that were washed and he was able to wash 20 per minute. DA 1 stated he timed himself washing plates. DA 1 stated the INT column was for the sanitizer in the 3 compartment sink. DA 1 stated he used Quats strips to test the sanitizer and it was 350. 2. There was a substance on the floor in the freezer 3. The ice machine had dust on the vent in the front. The Cleaning Schedule revealed Tuesday night the ice machine was to be cleaned inside and out. There was no signature on the schedule. 4. There was dust on the ceiling around a vent. There was a table for food preparation under the vent. There were pots and pans hanging from the ceiling under the vent. There was dust on the pots and pans and on the rack they were hanging from. The table had a shelf under it for storage. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	There was debris and white splatter on it. 5. There was a white substance on the wall by the grill. 6. There were food particles and dried substances under the shelf that was above the steam table. 7. Inside the microwave the top of it was soiled with dried food. 8. There were 2 plastic drawers with utensils in it. The drawers were dirty on the outside and one was broken. 9. There was a dried brown liquid substance on the ceiling and walls by the soda boxes. On 12/11/25 at 2:22 PM, a phone interview was conducted with the Dietary Manager (DM). The DM stated she was in the facility when they needed help. The DM stated the facility was without a Dietary Manager for a few weeks. The DM stated she had helped out for approximately 36 hours total in the last 3 weeks. The DM stated there was a work order put in for the dishmachine because the soap was not going through correctly. The DM stated she was not aware of any temperature issues. The DM stated the dishmachine repair company was there the first week of November and were waiting for a part. The DM stated the dishmachine was a high temperature so the washing cycle needed to reach 155 and the rinsing cycle needed to reach 175-180. The DM stated if the dishmachine was not reaching the required temperatures, then staff needed to wash dishes in the 3 compartment sink. The DM stated the 3 compartment sinks required a wash compartment, rinse compartment and a sanitizer compartment. The DM stated the washing water needed to be hot so the staff needed to boil water to put into the sink. The DM stated she would not recommend the staff to put the dishes through the dish machine and then dip into the sanitizer compartment of the sink. On 12/11/25 at 2:12 PM, an interview was conducted with the Administrator. The Administrator stated the dishmachine was so hot it was melting the dishes, so they called the dishmachine repair company. The Administrator stated the dishes should be dipped in the sanitizer in the 3 compartment sink after going through the dishmachine. The Administrator stated the facility was between DM's and a DM from another facility was overseeing the kitchen.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined for 3 of 25 sampled residents, the facility did not ensure that all drugs and biologicals were stored and labeled in accordance with accepted professional principles and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Specifically, insulin pens were not dated with an open date or had expired past 28 days. Resident identifiers: 1, 3, and 15.Findings included: On [DATE] at 8:40 AM, an observation of medication cart 2 was conducted. Inside the cart resident 1 had an opened Lispro insulin pen that did not have an opened date. Resident 3 had a Lispro insulin pen with an opened date of [DATE].On [DATE] at 8:50 AM, an observation of medication cart 1 was conducted. Inside the cart resident 15 had a Lispro insulin pen with an opened date of [DATE].On [DATE] at 8:45 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that opened insulin pens were good for 28 days once opened and then should be discarded. On [DATE] at 8:53 AM, an interview was conducted with Certified Medication Technician (CMT) 1. CMT 1 stated that insulin was good for 28 days once opened. CMT 1 stated that it was the nursing staff that inspected the dates on insulin and should send the expired pens back to the pharmacy and order new pens.On [DATE] at 9:49 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that insulin was good for 28 days once it had been opened. The DON stated that unit clerks and nurses should check the medications weekly through an audit to ensure they were not expired.

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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, it was determined for 5 out of 25 sampled residents that the facility did not file in the resident's clinical record laboratory reports. Specifically, urine culture and blood laboratory results were missing from the medical records for three residents, and the result for one resident's clotted laboratory sample was not located from the medical record. Resident identifiers: 3, 7, 8, 33, and 56.Findings included:1. Resident 56 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, fracture of left femur, fracture of right femur, repeated falls, and overactive bladder.Resident 56's medical record was reviewed 12/9/25 through 12/15/25.On 9/5/25 at 4:28 PM, an infection prevention/control note documented, Urine dipped, MD [medical doctor] notified for possible UTI [urinary tract infection] , MD ordered Septra and urine C&S [culture and sensitivity].An order for resident 56 dated 9/5/25 documented, Send urine for c &s one time only for Possible UTI for 1 Day.It should be noted that urine culture results could not be located in resident 56's medical record.On 12/11/25 at 9:19 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that she was unable to locate the urine culture results for resident 56. The DON stated that Medical Records uploaded records to resident's medical charts and she expected results to be there within one business day. 2. Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hypo-osmolality and hyponatremia and chronic kidney disease with heart failure. Resident 3's medical record was reviewed on 12/8/25 through 12/11/25. A physician's order dated 12/5/25 at 1:00 AM revealed UA with culture and sensitivity one time only for possible UTI. Pain with urination, increased frequency and lethargy with elevated temperature. Cloudy urine with a strong odor. Positive dip stick for nitrites, leukocytes, glucose and blood. On 12/7/25 at 10:58 AM, Received UA results back from [name of lab] notified providers.On 12/11/25, the surveyor requested the UA and C&S results. The Corporate Quality Assurance Nurse provided the laboratory results on 12/11/25 and the sample had mixed flora present, probably contamination and the C&S was not completed. The laboratory form was printed on 12/11/25. On 12/11/25 at 3:30 PM, an interview was conducted with the Corporate Quality Assurance Nurse. The Corporate Quality Assurance Nurse stated she obtained the UA and C&S from the laboratory website and that it was not in resident 3's medical record. 3. Resident 33 was admitted to the facility on [DATE] with diagnoses which included myopathy, sepsis, pneumonitis due to inhalation of food and vomit, Alzheimer's disease. Resident 33's medical record was reviewed 12/8/25 through 12/15/25. A physician's order dated 5/31/25 revealed to complete a CBC (complete blood count) and CMP (Comprehensive Metabolic Panel). A nursing progress note dated 5/31/25 at 1:29 PM revealed CMP and CBC drawn per nurse. Sent to the local hospital lab on STAT order for suspected pneumonia. The CBC was not located in resident 33's medical record. There was a CMP that was located. There were no nursing progress notes regarding the CBC results and physician notification. On 12/10/25, the surveyor requested the CBC. The Corporate Quality Assurance Nurse provided a copy of the CBC results which were run on 12/10/25 and revealed it was cancelled Sample was Clotted. On 12/10/25 at 3:08 PM, an interview was conducted with the Corporate Quality Assurance Nurse. The Corporate Quality Assurance Nurse stated that the CBC on 5/31/25 did not have results because it was clotted. The Corporate Quality Assurance Nurse stated she called the lab to get the results and the run date was when she printed the laboratory results. The Corporate Quality Assurance Nurse stated there were no nurses' notes about the sample being clotted and cancelled. The Corporate Nurse stated she would expect nurses to have contacted the physician and document if the physician wanted a new lab drawn or not. 4. Resident 7 was admitted to the facility on [DATE] with diagnoses which included an encounter for attention to colostomy, atrial fibrillation, schizophrenia, epilepsy, and neuromuscular dysfunction of bladder. Resident 7's medical record was reviewed on 12/8/25 through 12/15/25. A physician's order dated 11/26/25 revealed the following (continued on next page)

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	labs one time for one day only: CBC, Basic Metabolic Panel (BMP), and Vitamin D (VIT D).The results for a CBC, BMP, and VIT D collected on 11/26/25 could not be located on resident 7's medical record. On 12/10/25 at approximately 3:40 PM the surveyor requested the CBC, BMP, and VIT D results. On 12/11/25 at 10:18 AM, the DON stated that she called the laboratory and requested a copy of the labs ordered on 11/26/25. It should be noted that the laboratory forms were run on 12/10/25 at 4:22 PM.5. Resident 8 was admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which included cutaneous abscess of chest wall, cellulitis, osteomyelitis, dementia, chronic kidney disease, major depressive disorder, anxiety disorder, asthma, hypothyroidism, and insomnia.On 12/8/25 through 12/11/25 resident 8's medical records were reviewed.On 1/17/25, the physician ordered a CBC, CMP, Erythrocyte Sedimentation Rate (ESR), and a C-reactive protein (CRP). The results for the CBC, CMP, ESR, and CRP could not be located in resident 8's medical records. On 12/11/25 at 10:18 AM, the DON stated that she called the laboratory and requested a copy of the labs ordered on 1/17/25. It should be noted that the copy of the results for the labs ordered on 1/17/25 was dated 12/10/25 at 4:21 PM. On 12/10/25 at 3:45 PM, an interview was conducted with the DON. The DON stated the lab process was for staff to obtain an order from the physician, determine if it was routine or state, fill out a lab form the day before the lab was to be drawn, and then the hospital lab faxed results to the facility. The DON stated the nurse notified the physician of the results and the results were uploaded into the residents medical record The DON stated if the staff did not get the results, then staff called the lab for the results. The DON stated the nurse was to enter a progress note that the physician was notified of the results.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review it was determined the facility did not employ a full-time, designated person to serve as the director of food and nutrition services. Specifically, the facility did not have a qualified food service director. Findings included: On 12/8/25 at 10:16 AM, an interview was conducted with the Dietary Manager (DM). The DM stated she worked at a sister facility and helped in the kitchen since there was no full-time DM. The DM stated she was a Certified Food Manager (CFM). An observation was made of the CFM which expired on 8/1/26. On 12/11/25 at 2:14 PM, an interview was conducted with the Administrator (ADM). The ADM stated that the previous DM had been terminated and they had hired a new DM. The ADM stated the new DM was unable to start till 12/18/25, so the facility did not have a full-time DM but a DM from another facility was helping in the kitchen along with the Maintenance Director. The ADM stated the Maintenance Director was off this week. On 12/11/25 at 2:22 PM, a follow-up phone interview was conducted with the DM. The DM stated the facility had been without a DM since before Thanksgiving. The DM stated she stopped by in the mornings before going to her facility. The DM stated she had worked approximately 36 hours total in the last 3 weeks at the facility. (Cross Refer to F804 and F812)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review it was determined, for 4 of 25 sampled residents, each resident did not receive food that was palatable, attractive, and at a safe and appetizing temperature. Specifically, residents complained about the food temperatures and palatability, the test tray was not palatable, and resident council minutes revealed concerns regarding food. Resident identifiers: 11, 21, 35 and 39. Findings included: On 12/8/25 at 10:16 AM, an interview was conducted with resident 39. Resident 39 stated that the food was sometimes cold. On 12/8/25 at 10:37 AM, an interview was conducted with resident 21, who stated that the taste of the food had good days and bad days. Additionally, resident 21 stated that the food was often cold and doesn't look appetizing.On 12/8/25 at 1:50 PM, an interview was conducted with resident 35. Resident 35 stated that the food items were not served at the correct temperature and sometimes the food was cold. Resident 35 stated the taste of the food and the way it was cooked was not appealing. Resident 35 stated the food could be improved. Resident 35 stated the oatmeal was served without milk. On 12/8/25 at 2:43 PM, an interview was conducted with resident 11. Resident 11 stated that sometimes the flavor of the food was bland. On 12/10/25 at 12:05 PM, an observation was made of the posted meal. The meal was Cranberry Glazed Turkey Roast, Fresh Cooked Yams, [NAME] Bean Casserole, Baked Roll and Pumpkin Cheesecake Bars.On 12/10/25 at 12:13 PM, the food was taken to the hallway in a cart to be served to residents. A test tray was obtained. The plate of food was covered with a stainless steel cover that was tarnished with a white substance. There was no warmer under the plate. The Last meal served was at 12:29 PM, the temperatures were obtained from the test tray. [Note: All temperatures were in degrees Fahrenheit.] a. A white meat with a light brown gravy with carrots and celery was 122.7. b. Yellowish orange cubed vegetables were 110.1. c. [NAME] Bean Casserole was 116.7 d. An individual container of vanilla ice cream was runny and 29.7. The meat was lukewarm to the taste and did not have cranberry glaze. The vegetables were squash which were lukewarm to the taste. The green bean casserole had green beans with a crispy texture and was not palatable. The vanilla ice cream was warm to the taste and was melted to a liquid consistency. On 12/10/25 at 1:29 PM, [NAME] 1 brought a slice of pie to the surveyors and stated pie was the dessert but not everyone liked pie so it was not served with the food. [NAME] 1 stated pie was never served with the food trays but was offered later. [NAME] 1 stated she offered the residents in the dining room pie and was planning to go room to room and ask who wanted pie. An observation was immediately conducted of the dining room. There were 3 residents in the dining room. The pie temperature was 22 and the middle of the pumpkin pie was frozen. On 12/15/25 at 10:07 AM, an interview was conducted with [NAME] 2. [NAME] 2 stated pie was served with the meal when it was on the menu. [NAME] 2 stated pie was not served 2 hours later by going room to room to see who wanted pie. Resident Council Minutes were reviewed and revealed the following: a. On 2/13/25, Some of the residents stated that some of the meals are not great and that some of the meals are not hot or they do not receive what they have ordered. b. On 6/19/25, Meals are not always hot when delivered and cold meals are delivered on hot plates. c. On 8/13/25, Salads needed to be larger when it was the main meal, condiments were not being sent out, residents liked more mashed potatoes and less rice, and they stated fries have not been fully cooked and sent out cold. d. On 10/15/25, breakfast was served cold, residents were playing What is this during meal times trying to figure out what they were eating, some items on the residents plates were not what was written on the menu, no one knew what the pot pie was because there was no crust or roll, there was no sauce on the beef stroganoff and fries were not being cooked/raw/cold. On 12/15/25 at 10:12 AM, an interview was conducted with the Administrator (ADM). The ADM stated food had been discussed in the Quality Assurance and Performance Improvement (QAPI). The ADM stated the DM was recently terminated because of lack of response to residents regarding food. The ADM stated there were concerns about updating resident dietary profiles for preferences and that the DM was trying to help update those and the DM had altered the menu to accommodate preferences.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review it was determined for 3 out of 25 sampled residents, that the facility did not maintain medical records on each resident that were complete and accurately documented. Specifically, a resident had conflicting Metoprolol Tartrate and Metoprolol Succinate documentation, a resident had conflicting International Normal Ratio (INR) laboratory orders, and a resident had a diagnosis of diabetes mellitus for the use of intravenous antibiotics. Resident identifiers: 6, 14, and 34.Findings included: 1. Resident 14 was admitted to the facility on [DATE] with diagnoses which included paroxysmal atrial fibrillation, repeated falls, and unspecified tremor.Resident 14's medical record was reviewed 12/9/25 through 12/15/25.A review of resident 14's orders revealed: a. On 8/13/25 an order to Check PT(Prothrombin Time)/INR in the morning every Tue [Tuesday] b. On 8/15/25 an order for INR-notify provider of results every day shift for INR for 2 days c. On 8/15/25 and order for INR one time only for INR for 1 Day Check INR notify providers if INR outside of 2.0-3.0 range d. On 8/16/25 an order for INR-notify provider of results every day shift for INR for 1 DayA review of the facility's incident report dated 8/16/25 revealed that INRs were not checked on 8/16/25 and 8/17/25 as ordered. The immediate action was to notify the providers that an INR was not drawn. A review of resident 14's progress notes revealed: a. On 8/19/25 at 7:39 AM, a nurse's note documented, Late Entry: INR 7.4 this morning. Coumadin has been held since 8/16 per orders from providers. Providers notified of the above. Providers ordered the following labs to be drawn tomorrow: CBC [complete blood count], CMP [comprehensive metabolic panel], PTT [partial thromboplastin time], PT [prothrombin time], INR, vitamin k and factor 7 clotting factors. Continuing withhold order and daily INR checks. b. On 8/19/25 at 9:59 AM, a plan of care note documented, Reviewed in weekly therapy meeting. Resident has had several falls since she admitted . INR elevated, checking INR daily and holding coumadin indefinitely.On 12/10/25 at 1:47 PM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that if a resident's INR was above 6 then she would be concerned and notify the medical provider for orders. RN 2 stated if there were multiple lab orders then she would contact the medical provider for clarification. On 12/11/25 at 8:22 AM, an interview was conducted with the Medical Doctor (MD) via text message. The MD texted that he had ordered resident 14's Coumadin to be held for two days and to be redrawn on 8/18/25.On 12/11/25 at 9:06 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the MD should be notified of all INR results and that a normal range for INR was between 2-3. The DON stated that on 8/15/25 resident 14's INR was 6.5. The DON stated that the provider was notified of the results and gave the order to hold Coumadin for two days and to draw INR for two days. The DON stated that on 8/18/25 the INR was obtained and the first level was greater than 8 and the INR was redrawn and came back at 7. The DON stated the provider ordered to hold warfarin and to check the INR daily. The DON stated that the INR on 8/16/25 and 8/17/25 were missed and not drawn.On 12/11/25 at 10:17 AM, an interview was conducted with the Administrator (ADM). The ADM stated the INR was checked on 8/15/25 and it was 6.4. The ADM stated that the normal range for INR was 2-3. The ADM stated that one progress note was to hold Coumadin for two days and recheck daily for two days. The ADM stated the other progress note was to hold Coumadin and then recheck the INR in hopes that the level would come down. The ADM stated that she had talked with the MD this morning and he stated that the facility was to hold the Coumadin and to recheck the INR in two days. The ADM stated that the unit clerk and the nurse had put in two orders that conflicted with each other. The ADM stated that a progress note should have been entered with the correct physician order information. The ADM stated that the lack of accuracy with the orders actually was the correct order and that resident 14 had not needed her INR checked on 8/16/25 and 8/17/25. The ADM stated that she completed an incident report because she was confused about the INR order and thought that (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff had not completed the INR on 8/16/25 and 8/17/25 in error. 2. Resident 34 was admitted to the facility on [DATE] with diagnoses which included brief psychotic disorder, unspecified atrial fibrillation, and age-related physical debility.Resident 34's medical record was reviewed 12/9/25 through 12/15/25.A review of resident 34's orders revealed the order dated 11/19/25 for Metoprolol Tartrate Oral Tablet 50 MG (milligram) Give one tablet by mouth in the morning for hypertension.On 12/9/25 at 8:21 AM, during facility medication pass an observation was made of resident 34's morning medications. Resident 34 was administered one tablet of Metoprolol Succinate ER 50 mg by Certified Medication Technician (CMT) 1.On 12/9/25 at 9:32 AM, an interview was conducted with CMT 1. CMT 1 stated that resident 34 was administered Metoprolol Succinate because that was what the pharmacy sent to the facility. CMT 1 stated that she did not know the difference between Metoprolol Tartrate and Metoprolol Succinate. On 12/11/25 at 12:39 PM, an interview was conducted with the DON. The DON stated that when a resident was admitted to the facility either the unit clerk or nurse would enter the medications for residents and that a second person double checked the orders for accuracy. The DON stated that the pharmacy received a fax copy of the medication list when a resident was admitted to the facility. The DON stated that resident 34's hospital discharge orders were for Metoprolol Succinate which was the extended version of the medication and it was incorrectly entered as an order. The DON stated that resident 34 had been given the correct medication and it was just the order that was an error. 3. Resident 6 was admitted to the facility on [DATE] with diagnoses which include hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia following cerebral infarction, dysphagia, type 2 diabetes mellitus and vascular dementia. Resident 6's medical record was reviewed 12/8/25 through 12/15/25. A physician's order dated 10/29/25 revealed Vancomycin HCl Intravenous Solution Reconstituted 1 GM (gram) (Vancomycin HCl) Use 1 dose intravenously two times a day related to type 2 diabetes mellitus without complications for 6 Weeks. Another physician's order dated 10/28/25 revealed cefTRIAXone Sodium Intravenous Solution Reconstituted 2 GM (Ceftriaxone Sodium) Use 1 dose intravenously two times a day related to type 2 diabetes mellitus without complications for 6 Weeks. A nursing progress note dated 10/29/25 at 10:12 AM, revealed resident 6 had osteomyelitis and Vancomycin was ordered. On 12/10/25 at 3:36 PM, an interview was conducted with the DON. The DON stated Vancomycin and Ceftriaxone were antibiotics and would not be used for type 2 diabetes mellitus. The DON stated the diagnoses for the antibiotics should have been osteomyelitis. The DON stated nurses or unit clerks entered the orders into the residents medical record. The DON stated the unit clerks were medication technicians. The DON stated usually the unit clerk put the order in and the nurse double checked the order for accuracy.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 of 25 sampled residents, that the facility did not immediately consult with the resident's physician when there was a need to alter treatment. Specifically, the physician was not notified when a resident's Donepezil and Levothyroxine was held for multiple days due to unavailability. Resident identifier: 8.Findings included:Resident 8 was admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which included dementia and hypothyroidism.On 12/8/25 through 12/11/25 resident 8's medical records were reviewed.On 9/23/25, resident 8's physician ordered Levothyroxine Sodium Tablet 25 micrograms, give 1 tablet by mouth one time a day for Hypothyroidism.On 10/16/25, resident 8's physician ordered Donepezil Hydrochloride Tablet 5 milligrams, give one tablet by mouth in the evening. Resident 8's November 2025 Medication Administration Record (MAR) revealed the following: a. On 11/3/25 and 11/4/25 the Levothyroxine was documented with a code 9 (see progress note). The progress note documented that the medication was not in the facility and they would reorder from the pharmacy. b. On 11/9/25 and 11/11/25 the Levothyroxine was not documented as administered. c. On 11/17/25 through 11/19/25 the Donepezil was documented as not available. No documentation could be found that resident 8's physician was notified that the medications were not administered as ordered. On 12/11/25 at 8:44 AM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated that if medications were unavailable for administration she would notify the resident, the resident representative, and the physician. RN 3 stated that she would document in the progress note that linked to the MAR that these notifications were made. On 12/11/25 at 10:18 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that when a medication was not available for administration staff should find out why it was not there and then notify the pharmacy and notify the physician. The DON stated that staff should document the notification to the physician in a progress note.

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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, for 1 of 25 sampled residents, that the facility did not ensure that when a resident was transferred that the transfer was documented in the resident's medical record and appropriate information was communicated to the receiving health care institution or provider, and a copy of the notice of transfer was sent to the Office of the State Long-Term Care Ombudsman. Specifically, the resident's medical records did not have documentation of what information was provided to the receiving health care provider when they were transferred to the emergency room (ER) and no documentation could be found to indicate that the Ombudsman was notified of the transfer. Resident identifier: 8.Findings included: Resident 8 was admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which included cutaneous abscess of chest wall, cellulitis, osteomyelitis, dementia, chronic kidney disease, major depressive disorder, anxiety disorder, asthma, hypothyroidism, and insomnia.On 12/8/25 through 12/11/25 resident 8's medical records were reviewed.Resident 8's progress notes documented the following: a. On 8/20/25 at 5:29 PM, the Nurse's Note documented, Resident's blood pressure increased 30 minutes post fall to 171/115, Pulse 101. Reports she is having chest pain. 911 called and non-emergent transfer to hospital requested. Family and medical provider and nursing administration notified. b. On 8/21/25 at 10:25 AM, the Nurse's Note documented, ER diagnosed resident with UTI [urinary tract infection] and started PO [by mouth] cephalexin.On 8/20/25, the hospital discharge summary documented that the resident was seen for a urinary tract infection, fall, and confusion. No documentation could be found in resident 8's medical records of a transfer/discharge assessment or what information was sent to the receiving provider. Additionally, no documentation could be found of the notice provided to the Ombudsman for the transfer on 8/20/25. It should be noted that the ER Transfer Assessment form contained a section for what transfer documentation was sent to the receiving provider, but the assessment was not completed for the 8/20/25 transfer. On 12/11/25 at 1:59 PM, an interview was conducted with the Resident Advocate (RA). The RA stated that when a resident was transferred or discharged they filled out a form for a Nursing Home Resident Discharge Notice. The RA stated that they started this process a couple of months ago and prior to that she was doing a monthly notification to the Ombudsman. The RA reviewed her documentation and confirmed that the Ombudsman was not notified of resident 8's transfer to the hospital on 8/20/25. On 12/11/25 2:11 PM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that when they transferred a resident to the hospital they documented a progress note of the resident's condition, who was notified, the time of the transfer, and what assessment and interventions were provided. RN 2 stated that the Med Techs gathered the information that was sent to the receiving provider and it should include a face sheet, medication orders, and resident history. RN 2 stated that she would then document the discharge note and do a transfer/discharge assessment. RN 2 reviewed resident 8's medical records and confirmed that the transfer/discharge assessment was not completed for the 8/20/25 transfer to the ER. On 12/11/25 at 2:19 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that when they transfer a resident to the ER, nursing staff should do an ER transfer assessment, send a face sheet, a medication list, the resident care plan, and a copy of the Physician Order for Life Sustaining Treatment (POLST). The DON stated that they have a checklist that tells the nurse what to send with the resident. The DON stated that the RA does the notification to the Ombudsman.

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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 it was determined, for 2 of 25 sampled residents, that the facility did not provide each resident adequate supervision to prevent accidents. Specifically, a resident sustained multiple injuries while operating his power wheelchair after therapy evaluated the resident as needing supervision while operating the wheelchair. In addition, another resident was not provided two person assistance during repositioning for a brief change and sustained a fall. Resident identifiers: 4 and 33. Findings included: 1. Resident 33 was admitted to the facility on [DATE] with diagnoses which included myopathy, sepsis, pneumonitis due to inhalation of food and vomit, Alzheimer's disease, type 2 diabetes mellitus, chronic kidney disease, and hereditary and idiopathic neuropathy. On 12/8/25 at 10:59 AM, an interview was conducted with resident 33. Resident 33 stated he had a power wheelchair that was taken away. Resident 33 stated he had some accidents with his power wheelchair, cut his leg wide open, and needed 19 stitches. Resident 33 stated he received a new bed after his leg was cut open.Resident 33's medical record was reviewed 12/8/25 through 12/15/25. A nursing progress note dated 3/25/25 at 4:49 AM revealed resident 33 stated that he ran into his bed while in his wheelchair. The nurse assessed his leg and noticed blood coming down his leg and skin torn. The nurse applied gauze and stopped the bleeding then wrapped it. The nurse called emergency medical services. At 7:30 PM, a nursing note revealed resident 33 was brought back to the facility. A nursing progress note dated 3/27/25 revealed resident 33 had 13 staples to his left lateral lower leg. The progress note further revealed a telephone order for Physical Therapy (PT) to complete a wheelchair safety evaluation was written. A power-mobility indoor driving assessment dated [DATE] revealed that resident 33 was not able to drive independently with no restrictions. There were comments that resident 33 had a diagnosis of Alzheimer's, resident also has a new diagnosis of pneumonia potentially affecting cognition. An Interdisciplinary (IDT) note dated 3/28/25 revealed PT completed an evaluation assessment and was working on wheelchair driving with resident 33. [It should be noted, the results of the power-mobility indoor driving assessment, which concluded resident 33 could not drive independently without restrictions, was not addressed.] A nursing progress note dated 4/4/25 at 6:52 PM revealed resident 33 had a laceration to his right lower leg, and that resident 33 stated to the nurse he had banged it against the bed. The nurse provided education to resident 33 on power chair safety. A physician's note dated 4/10/25 revealed that resident 33 had a new laceration to right lower leg from running into an object in his wheelchair. A Power-Mobility Indoor Driving Assessment form dated 4/16/25 revealed Pt [patient] demonstrates cognitive impairments & has a dx [diagnosis] of dementia. Pt demonstrates improvements in PWC [Power Wheelchair] driving when under observation, but pt observed to have poor safety awareness & bumps [sic] into objects often when driving IND [independently]. The form further revealed resident 33 had poor safety awareness, bumped into multiple things, and did not slow down. Resident 33's total score was 64%. The PT's opinion was resident 33 was unable . to drive independently with no restrictions. Resident 33 was in need of training because he was able to drive with some difficulty. An in-service was provided to the staff on 5/2/25, addressing the topic of accident hazards, with a focus on blunt force trauma from high-powered wheelchairs. A nurses progress note dated 5/2/25 at 8:05 PM revealed resident 33 had 2 large hematomas that were bleeding with skin tears to bilateral lower extremities. A nurses progress note dated 5/8/25 at 2:29 PM revealed staff reported multiple incidents where resident 33 had run into things or almost ran into staff when driving his electric wheelchair. Resident 33 has had two incidents where he ran into things and cut open his legs. Therapy has been working on patients ability to drive WC safely and wheelchair tests show he is not safe. The speed on his WC was turned down lower, but resident is still able to adjust the speed within the lower range. At this time IDT removed electric WC, and resident will be using a manual WC. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident was educated on this. Resident will be re-evaluated by therapy in the future to test residents capabilities to drive electric WC. A nurses note dated 5/21/25 at 11:14 AM, revealed that an IDT meeting was completed with family and patient regarding his electric wheelchair. Resident 33 was allowed to operate the electric wheelchair when supervised by family. A plan of care note dated 6/30/25 at 3:18 PM revealed resident 33's electric wheelchair usage was reviewed in an IDT meeting. Staff were able to get a different company to lower the wheelchair speed and lock the low speed so resident 33 was unable to adjust it. Resident 33 was educated that he could have his wheelchair back for a trial period since the speed was lowered. A nurses note dated 7/20/25 at 12:42 AM revealed that resident 33 came to the nurses station and the nurse noticed blood on the sock of right foot. Resident 33 stated he had hit a soda machine cabinet while in his wheelchair. A nurses note revealed on 7/21/25 at 10:18 AM the IDT met to discuss an abrasion to the top of resident 33's right foot from running into a soda machine. The intervention was to educate resident 33 to be careful when driving and therapy would do another wheelchair evaluation. A communication note dated 7/24/25 at 12:02 PM, revealed resident 33 had an x-ray of left foot due to increased pain. A nurses note dated 7/24/25 at 4:14 PM revealed, staff discussed a behavior contract with resident 33 and his daughter regarding power wheelchair safety. A nurses note dated 7/25/25 at 6:52 PM revealed resident 33 came to nurses station and told the nurse he had accidentally bumped into his bed. The nurse looked at resident 33's left leg and it was bleeding down the leg. There were 2 skin tears with blood pooling and bruising. The nurse asked resident's daughter to bring in shin guards. Resident 33 stated he had bumped into his bed and asked the nurse not to tell anyone. Resident 33 was concerned his power wheelchair would be taken away. Resident 33 was educated on being more careful with the power chair and his surroundings.A care plan dated 7/29/25 initiated the focus area: [Resident 33] uses an electric wheelchair for mobility. [Resident 33] has has [sic] incidents of running into furniture and walls when driving electric wheelchair. [Resident 33] will often not report injuries to the staff. The goal was resident 33 will drive his wheelchair safely through the review date. An intervention on 7/25/25 was for resident 33's daughter to get resident 33 shin guards. Interventions on 7/29/25 included therapy as ordered; wheelchair speed was turned down; and staff provide education as needed on wheelchair safety. On 7/31/25, an intervention was electric wheelchair to be taken away, therapy to do evaluation. A nurses note dated 7/29/25 at 10:18 AM revealed resident 33 asked staff to help him transfer to the toilet. Resident 33 was frantic and drove his chair into the bathroom walls which pinned his left foot between his foot board on the power wheelchair and the wall. Resident continued to yell I fucked up my foot, an x-ray was ordered and waiting for results. Resident 33 was provided a manual wheelchair. A nurses note dated 7/31/25 at 4:59 PM revealed resident 33 was reviewed in an IDT meeting related to driving his wheelchair into the bathroom. The power wheelchair had been taken away. A Power-Mobility Indoor Driving assessment dated [DATE] revealed resident 33 bumped into a bed at high speed and had small bumps into the dresser and closet. Resident 33 scored at 72% and continued to have poor safety awareness and had difficulty determining appropriate speeds when navigating small spaces. Resident 33 was showing improved safety when backing up but had difficulty with looking back over his shoulder. Resident 33 had a diagnosis of dementia which contributed to his safety awareness. A Power Wheelchair Contract was signed on 9/1/25 by the resident, family, and the facility. The contract revealed resident 33 would stay on the right side of the hallway; speed would be less than two miles per hour in the facility, reduce speed in congested areas; check over his shoulder and use his horn before backing up; use a seatbelt; not use pillows or cushions on the seat; be aware of people coming out of rooms and around corners; would not intentionally block or run into residents, staff or equipment; safely navigate crosswalks and intersections, sign himself out if he left the property; the facility could continually assess and modify wheelchair rights; use of the wheelchair could be limited or ceased if he was injured, others or property; and the speed capacity could be reduced. It should be noted that there were no additional nursing notes located in resident 33's medical record that documented his use of the power (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair after 7/31/25.On 12/11/25 at 11:00 AM, an interview was conducted with the Director of Nursing (DON) and Administrator (ADM). The DON stated resident 33 injured himself multiple times when using his power wheelchair. The DON stated on different occasions resident 33 had injured his foot and had required stitches on his shin when using his power wheelchair. The ADM stated the staff felt like he had a notable injury from running into a therapy desk. The ADM stated that was when management questioned resident 33's ability to use his power wheelchair. The ADM stated therapy was asked to do extra wheelchair training. The ADM stated she talked to the ombudsman about resident rights versus resident safety. The ADM stated the facility developed a power wheelchair safety assessment with goals that therapy staff were looking for to determine safety. The ADM stated resident 33 did the assessment and he was unsafe to drive it. The ADM stated resident 33 was reassessed because staff wanted him to be safe and able to use his power wheelchair. The ADM stated an IDT meeting was done since resident 33 was assessed as not being safe and they tried to allow resident 33 to have it as long as possible. The DON stated resident 33 had an accident on 7/14/25, 7/20/25, 7/21/25, 7/24/25 and 7/29/25. The ADM stated she could not remember when resident 33's power wheelchair was taken away. The DON stated that there were some incidents where resident 33 almost hit staff but had not hit any residents. The ADM stated therapy assessed the resident and felt that he was safe when he was being observed but when he was not he had more risky behaviors. The ADM stated family were allowed to supervise him while he was using the power wheelchair. The ADM stated there was no documentation of how staff supervised resident 33 when he was using his power wheelchair. The ADM stated resident 33 currently had a manual wheelchair and he was unable to propel himself very far. The ADM stated they had not thought of a power assist manual wheelchair for him to maintain his independence and be safe. On 12/15/25 at 10:47 AM, a follow-up interview was conducted with the ADM. The ADM stated that after resident 33 had an accident with the power wheelchair, staff did not immediately remove it because an infection was determined to be interfering with his cognition. The ADM stated that the Maintenance Director examined resident 33's bed and confirmed there were no sharp areas. The ADM stated they presume the date the bed was checked was around 3/26/25. The ADM stated after resident 33 injured himself on 3/25/25 by running into his bed, a power wheelchair assessment was done on 3/27/25. The ADM stated resident 33 hurt himself on 4/10/25 and education on operating the power wheelchair was provided and he was treated for pneumonia. The ADM stated that on 4/16/25 another power wheelchair assessment was completed. The ADM stated he hurt himself 5/2/25 and had a hematoma and an all staff education was provided on accident prevention. The ADM stated they removed his power wheelchair on 5/5/25. The ADM stated she did not know why there was a 3 day delay in removing his wheelchair but thought there were conversations with management on how to keep him as safe as possible. The ADM stated on 5/8/25 the wheelchair speed was lowered but resident 33 was able to adjust it back up and education was provided to the resident to keep his speed low. The ADM stated an IDT meeting was completed on 5/21/25 and the decision was to remove the power wheelchair again except when family were there to supervise him. On 5/30/25, the ADM stated that a different wheelchair company successfully lowered and locked the device's speed, allowing resident 33 to use his wheelchair on a trial. However, the ADM stated she was unsure what the 'trial' status specifically entailed and stated that no information was available regarding the specific monitoring or observations staff were performing for resident 33. The ADM stated resident 33 was treated for pneumonia on 6/6/25. The ADM stated resident 33 got lost when he left the faciity on 7/13/25 so the ombudsman was contacted on 7/13/25. The ADM stated there was another IDT meeting with family on 7/14/25, where they discussed resident 33's Brief Interview for Mental Status (BIMS) and reviewed incidents of him running into objects. The ADM stated the IDT discussed resident 33's power wheelchair being taken away if he continued to injure himself. The ADM stated staff were to supervise resident 33, if he went outside or he needed to use a manual wheelchair. The ADM stated that resident 33 injured himself on 7/20/25 and was provided education on 7/21/25, as he was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determined to be cognitively intact. The ADM stated therapy did another power wheelchair assessment. The ADM stated that on 7/25/25, resident 33's daughter was asked to bring shin guards for him. The ADM believed the daughter had brought them in, but was not sure when The ADM stated resident 33 injured his foot on 7/29/25. The ADM stated another IDT meeting was held on 7/31/25, after which resident 33's power wheelchair was taken away and it had not been returned to him. 2. Resident 4 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included dysphagia, streptococcal sepsis, depression, chronic pain, polyneuropathy, aphasia, generalized anxiety disorder, seizures, and adjustment disorder with depressed mood.On 12/8/25 through 12/11/25, resident 4's medical records were reviewed. On 7/2/25, state optional Minimum Data Set (MDS) assessment documented resident 4's functional status as 2 person extensive assist for bed mobility and toileting. The resident was assessed as total dependence with 2 persons for transfers.On 9/4/25 at 12:20 AM, the Nurse's Note documented, CNA's [Certified Nurse Assistant] were in resident room changing resident's brief. Resident was rolled onto her left side when she lifted her leg and rolled off of the bed. Resident was lowered to the floor by CNA's. CNA's immediately called nurse in to assess resident. Provider, family, DON, Administration notified. Resident has small scratch above right eye. Resident complaining of pain in right wrist. Pain medications administered, will continue to monitor resident.On 9/3/25 at 7:20 PM, the incident report documented that CNAs were providing incontinence care and the resident was rolled onto her left side and subsequently rolled off the bed. The resident was lowered to the floor. The report documented that resident 4 sustained an abrasion to the face. The report did not document the names of the CNA witnesses.On 11/24/24, resident 4's care plan for Activities of Daily Living self care performance deficit was initiated. The interventions documented that resident 4 was totally dependent on one staff for toilet use. It should be noted that this care plan intervention was not updated to reflect the MDS assessment on 7/2/25 that assessed the resident as requiring 2 person extensive assistance for toileting. On 10/5/22, resident 4's care plan for at risk for falls related to Cerebrovascular Accident, muscle weakness, and difficulty walking was initiated. The interventions identified on the care plan included that clinical staff were educated to use 2 staff when changing the resident's brief. It should be noted that this intervention was initiated on 9/4/25 after resident 4's fall. On 12/11/25 at 2:39 PM, an interview was conducted with CNA 3. CNA 3 stated that resident 4 was totally dependent on staff for everything. CNA 3 stated that resident 4 did not get out of bed for toileting and they changed her incontinence brief in bed. CNA 3 stated that resident 4 had always required 2 staff for incontinence care. On 12/11/25 at 2:50 PM, an interview was conducted with the DON and the Corporate Quality Assurance Nurse (CQAN). The DON stated that resident 4 required a Hoyer lift for transfers and was totally dependent on staff for all ADLs. The DON confirmed that the 7/2/25 MDS assessment documented that resident 4 was dependent and an extensive 2 person assistance for toileting. The DON stated that the aides involved in the fall on 9/4/25 during incontinence care were not specified on the incident report and she was not aware of who those individuals were. The DON was informed that the intervention on the care plan after the fall was to have 2 staff present during incontinence care. The CQAN stated that the incident report documented 2 aides were present but she was not sure why the intervention would be to have 2 aides if that was already done. The DON stated that the incident report documented 2 aides were present but did not recall if she followed up on the report and she did not recall why she implemented 2 staff for an intervention. The CQAN stated that resident 4 rolled off the bed and there should have been one staff present on either side of the bed to prevent the fall. On 12/11/25 at 3:37 PM, an interview was conducted with Registered Nurse (RN) 4. RN 4 confirmed that she was the nurse that documented resident 4's incident report for the fall on 9/3/25. RN 4 stated that CNA 4 and CNA 5 were present during resident 4's fall. RN 4 stated that CNA 5 had exited the resident room to obtain more supplies and when she walked back into the room she witnessed resident 4 falling. On 12/11/25 at 3:47 PM, an interview was conducted with CNA 5. CNA 5 stated that she was providing resident 4 with incontinence care on the night of the fall. CNA 5 stated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that she exited the room to obtain a chuck pad and the other aide, CNA 4, started to roll resident 4 by herself. CNA 5 stated that when she re-entered the room resident 4's leg was over the side of the bed. CNA 5 stated that she tried to grab resident 4's leg and push her back onto the bed but it was too much weight and she assisted her to the floor. CNA 5 stated that resident 4 was dead weight and she assisted her to the ground by herself. CNA 5 stated that CNA 4 was trying to help but she was on the other side of the bed, holding resident 4's arm. CNA 5 stated that at the time of the incident resident 4 was a one person extensive assist for toileting and she had been assisting her as a one person assist since she worked with her. CNA 5 stated that she had a second aide with her because she was training CNA 4. CNA 5 stated that after the incident they changed resident 4 to a two person assist for toileting and all ADLs.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 out of 25 sampled residents, that the facility did not provide routine and emergency drugs and biologicals to its residents. Specifically, the resident's Levothyroxine and Donepezil were not available from the pharmacy for administration. Resident identifier: 8.Findings included: Resident 8 was admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which included cutaneous abscess of chest wall, cellulitis, osteomyelitis, dementia, chronic kidney disease, major depressive disorder, anxiety disorder, asthma, hypothyroidism, and insomnia.On 12/8/25 through 12/11/25 resident 8's medical records were reviewed.On 9/23/25, resident 8's physician ordered Levothyroxine Sodium Tablet 25 micrograms, give 1 tablet by mouth one time a day for Hypothyroidism.On 10/16/25, resident 8's physician ordered Donepezil Hydrochloride Tablet 5 milligrams, give one tablet by mouth in the evening for Psychotropic.Resident 8's November 2025 Medication Administration Record (MAR) revealed the following: a. On 11/3/25 and 11/4/25 the Levothyroxine was documented with a code 9 (see progress note). The 11/3/25 progress note documented that the medication was not in the facility and they would reorder from the pharmacy. The 11/4/25 progress note documented that the medication did not come from the pharmacy and they would reorder the medication. b. On 11/9 and 11/11 the Levothyroxine was not documented as administered. c. On 11/17/25 through 11/19/25 the Donepezil was documented as not available. On 12/11/25 at 8:44 AM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated that the nurses were to reorder medications from the pharmacy when the medication blister pack got past the refill date indicated on the pack, and typically that was the last week that medications were available. RN 3 stated that everyone was responsible for reordering medications. RN 3 stated that the nurse who did the reordering should label the blister pack with the date it was reordered so that the other nurses could see that it had been done. RN 3 stated that the nurse should also check the medication cart to see if there were any other blister packs already available for use prior to ordering more medication. RN 3 stated that if medication was unavailable she would check the Pixus to see if the medication was available in the overstock, and then she would enter a stat order from the pharmacy for the medication. RN 3 stated that stat medication orders would be delivered by the pharmacy approximately 4 hours later. RN 3 stated that if a medication did not have documentation it was not easy to tell if it was given so she would check with the previous nurse to see if it was administered. On 12/11/25 at 10:18 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that if medication was not available then the nursing staff should find out why it was not at the facility. The DON stated that the nurse should notify the pharmacy of any needed medication, then check the stat safe and the Over the Counter (OTC) supply for any inventory availability. The DON stated that an empty spot on the MAR meant that it was not signed out, but that signature was the proof that the medication was administered.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 of 25, the facility did not promptly notify the ordering physician of laboratory results that fall outside of clinical reference ranges. Specifically, the physician was not notified after a laboratory specimen was clotted and not completed as ordered. Resident identifier: 33.Findings included: Resident 33 was admitted to the facility on [DATE] with diagnoses which included myopathy, sepsis, pneumonitis due to inhalation of food and vomit, Alzheimer's disease, type 2 diabetes mellitus, chronic kidney disease, and hereditary and idiopathic neuropathy. A physician's order dated 5/31/25 revealed to complete a CBC (complete blood count) and CMP (Comprehensive Metabolic Panel). A nursing progress note dated 5/31/25 at 1:29 PM revealed CBP and CMP drawn per nurse. Sent to the local hospital lab on STAT order for suspected pneumonia. The CBC was not located in resident 33's medical record. There was a CMP that was located. There were no nursing progress notes regarding the CBC results and physician notification. On 12/10/25, the surveyor requested the CBC. The Corporate Quality Assurance Nurse provided a copy of the CBC results which were run on 12/10/25 and revealed it was cancelled Sample was Clotted. On 12/10/25 at 3:08 PM, an interview was conducted with the Corporate Quality Assurance Nurse. The Corporate Quality Assurance Nurse stated that the CBC on 5/31/25 did not have results because it was clotted. The Corporate Quality Assurance Nurse stated she called the lab to get the results and the run date was when she printed the laboratory results. The Corporate Quality Assurance Nurse stated there were no nurses' notes about the sample being clotted and cancelled. The Corporate Nurse stated she would expect nurses to have contacted the physician and document if the physician wanted a new lab drawn or not. On 12/10/25 at 3:45 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the lab process was for staff to obtain an order from the physician, determine if it was routine or state, fill out a lab form the day before the lab was to be drawn, and then the hospital lab faxed results to the facility. The DON stated the nurse notified the physician of the results and the results were uploaded into the residents medical record The DON stated if the staff did not get the results, then staff called the lab for the results. The DON stated the nurse was to enter a progress note that the physician was notified of the results.

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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, it was determined for 1 out of 25 sampled residents the facility did not file in the resident's clinical record radiologic reports. Specifically, a resident's head Computed Tomography (CT) results were not in the medical record. Resident identifier: 14.Findings included:Resident 14 was admitted to the facility on [DATE] with diagnoses which included, paroxysmal atrial fibrillation, repeated falls, and unspecified tremor.Resident 14's medical record was reviewed 12/9/25 through 12/15/25.On 8/18/25 at 5:27 PM, a nurse's note documented, Provider ordered a head CT scan due to increased confusion and high INR [International Normal Ratio]. Resident transported to and from appointment at [local hospital] by staff around 1500 [3:00 PM]. Resident now in room with husband.It should be noted that resident 14's head CT results could not be located in the medical record.On 12/11/25 at 9:06 AM, an interview was conducted with the Director of Nursing. (DON). The DON stated that she had to request the head CT results from the hospital for resident 14 because they were not in the medical record. The DON stated that radiology results should be uploaded into the medical record under the miscellaneous tab.