STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465192	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Peak Rehabilitation	6084 South Summit Vista Boulevard Taylorsville, UT 84129

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility did not provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. Specifically, two residents' physicians orders for lidocaine lacked a dosage and did not match the administration record; and the facility staff were taping narcotic medications back into the medication cards. Resident identifiers: 49 and 84.Findings included:1. Resident 49 was admitted to the facility on [DATE] with diagnoses of nondisplaced fracture of shaft of right clavicle; spondylosis without myelopathy or radiculopathy cervical region; and multiple fractures of ribs, left side and left humerus.Resident 49's medical record was reviewed 5/5/26 through 5/11/26.A physician's order dated 4/7/26 at 2:48 PM indicated, Lidocaine External Patch (Lidocaine) Apply to affected area topically two times a day for pain.A Medication Administration Record (MAR) dated April 2026 indicated that a Lidocaine External Patch of an unknown dose was placed on resident 49 on 4/8/26 at 8:00 PM with no indication of when it was removed. It indicated a Lidocaine External Patch of an unknown dose was placed on resident 49 on 4/9/26 at 8:00 PM and removed on 4/10/26 at 8:00 PM. It indicated a Lidocaine External Patch of an unknown dose was placed on resident 49 on 4/11/26 at 8:00 AM and 8:00 PM and no indication of when it was removed for either application. It indicated a Lidocaine External Patch of an unknown dose was placed on resident 49 on 4/12/26 at 8:00 PM with no documentation of when it was removed and a new patch was placed on 4/13/26 at 8:00 AM. It indicated a Lidocaine External Patch of an unknown dose was placed on resident 49 on 4/22/26 with no indication of when it was removed.2. Resident 84 was admitted to the facility on [DATE] with diagnoses which included unstable burst fracture of first lumbar vertebra and thoracic vertebra T11-T12, fusion of spine thoracolumbar region, osteoarthritis, idiopathic peripheral autonomic neuropathy, ankylosing spondylitis lumbar region, and arthrodesis status.Resident 84's medical record was reviewed 5/5/26 through 5/11/26.A Physician Authorized Lidocaine Therapeutic Interchange of Medications document dated 4/28/26 indicated, LIDOCAINE 4% (percent) PATCHES.USE ONE PATCH ONCE DAILY (12 HRS [hours] ON/ 12 HRS OFF).A physician's order dated 4/28/26 at 4:17 PM indicated, Lidocaine External Patch (Lidocaine) Apply to affected area topically two times a day for pain.A MAR dated April 2026 indicated that on 4/28/26 at 8:00 PM, a Lidocaine External Patch of an unknown dose was placed on resident 84, with no indication of when it was removed On 4/29/26 and 4/30/26 at 8:00 AM, the MAR indicated a Lidocaine External Patch of an unknown dose was placed on resident 84 and taken off at 8:00 PM.A MAR dated May 2026 indicated a Lidocaine External Patch of an unknown dose was placed on resident 84 at 8:00 AM and was taken off at 8:00 PM on 5/1/26-5/5/26.On 5/11/26 at 1:15 PM, an interview was conducted with Registered Nurse (RN) 1 while she reviewed resident 84's electronic medical record. RN 1 stated the lidocaine order was incomplete because it lacked a specific dosage, a 12-hour on/off schedule, and a designated application and removal time.On 5/11/26 at 2:37 PM, an interview was conducted with the Director of Nursing (DON) and she stated that a second nurse should have reviewed all new orders for accuracy, noting that the lidocaine orders for residents (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49 and 84 were incomplete because they lacked a dosage, a 12-hour on/off schedule, and documentation of the patch placement location.3. On 5/7/26 at 8:50 AM, during morning medication administration an observation was made of the facility North East medication cart with Registered Nurse (RN) 2. The following medications were observed in the medication cart: a. Two multi dose medication cards which held Clonazepam 0.5 mg were observed. The first multi dose medication card had the back of pocket numbers 1, 7 and 11 that were opened with tape now closing the pocket. There were no medications observed in pocket numbers 7 and 11, pocket number 1 had a white tablet taped back into the pocket. The second multi dose medication card of Clonazepam 0.5 mg had pocket number 27 taped with a white tablet taped back into the pocket.On 5/7/26 at 9:15 AM, during morning medication administration an observation was made of the facility SouthEast medication cart with Registered Nurse (RN) 3. The following medications were observed in the medication cart:b. A multi dose medication card which held Oxycodone 10 mg had the back of pocket numbers 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 20, 21, 22, 23, 24, 25, 26, 27, 28 and 29 that was opened with tape now closing the pocket. There was a white tablet observed to be in pockets 9 and 26.On 5/7/26 at 9:30 AM, an observation was made of the facility South [NAME] medication cart with Licensed Practical Nurse (LPN) 2. The following medication was observed in the medication cart:c. A multi dose medication card which held Hydrocodone - Acetaminophen 5/325 mg had the back of pocket numbers 23, 24 and 26 that was opened with tape now closing the pocket. There was a white tablet observed in pocket 24. On 5/7/26 at 9:45 AM, an interview was conducted with RN 2 who stated the nurses were supposed to do a narcotic count with the oncoming shift. RN 2 stated medications were not supposed to be taped back into the medication cards and that they were supposed to be wasted with another nurse. On 5/7/26 at 9:15 AM, an interview was conducted with RN 3 who stated that the staff taped the back of the narcotic cards when the medication was reduced and they only needed half of the pill. RN 2 stated she would have no way of knowing whether the correct medication was placed back into the card or if the medication had been touched by the previous nurse. On 5/7/26 at 9:30 AM, an interview was conducted with LPN 2 who stated they did not tape narcotics back into the medication cards, they wasted them with another nurse. On 5/7/26 at 9:45 AM, an interview was conducted with RN 4 who stated narcotics or any medication should not be taped back into the medication card. RN 4 stated that the medication should be wasted because there was no way of knowing if the medication was clean or if the correct medication had been put back into the card. On 5/7/26 at 10:15 AM, an interview was conducted with the Director of Nursing (DON) who stated it was not appropriate to tape medications back into the medication cards. The DON stated the staff should be wasting them with another nurse.

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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 that the facility did not ensure that each resident received and that the facility provided food and drink that was palatable, attractive, and at a safe and appetizing temperature. Specifically, there were numerous resident complaints about the food served at the facility, there were resident council concerns about the food served at the facility, and the test tray that surveyors sampled was not palatable.Findings included:1. On 5/6/26 at 9:43 AM, an interview was conducted with resident 2, who stated that the food served at the facility was sometimes good, sometimes marginal. 2. On 5/5/26 at 1:23 PM, an interview was conducted with resident 4, who expressed concerns about the taste of the food served at the facility.3. On 5/6/26 at 8:29 AM, an interview was conducted with resident 5, who stated that the flavor of the food served at the facility could be better. Resident 5 stated that dinner tended to be worse than other meals. 4. On 5/6/26 at 9:37 AM, an interview was conducted with resident 9 who stated the food was horrible. Resident 9 stated that she had verbally told them that the food was not good. Resident 9 stated she was on a feeding tube before this and it was better than the actual food served at the facility. 5. On 5/6/26 at 8:18 AM, an interview was conducted with resident 41 who stated the food really was not good and that it lacked flavor, had inconsistent portions, and was often unidentifiable. Resident 41 believed she was not receiving enough protein and relied on outside food that she purchased. Resident 41 reported these concerns to nursing and dietary staff, but felt the dietary department's response was dismissive.6. On 5/6/26 at 8:46 AM, an interview was conducted with resident 53 who stated the presentation of the food was poor and it just did not taste good. Resident 53 stated the facility administration had told them it would be better starting last week but it had not changed and was still awful. 7. On 5/5/26 at 11:13 AM, an interview was conducted with resident 56 who stated the food had no flavor and was cold. The food just did not taste very good. The desserts were not very good and residents only had pie. Resident 56 stated that the other day they only had cut up red beets with onions on top of it, Who wants to eat that?! Resident 56 stated the drinks had black specks in them. 8. On 5/5/26 at 12:09 PM, an interview was conducted with resident 67 who stated that the food was just awful. 9. Resident council notes were reviewed from 2025 and 2026. a. During the January 2025 resident council meeting, residents complained that the portions served at the facility were too large and that their eggs were frequently served cold. b. During the July 2025 resident council meeting, residents complained about food being served cold and juices from vegetables causing the bread served with meals to be soggy.c. During the August 2025 resident council meeting, residents complained about juices from vegetables causing the bread served with meals to be soggy.d. During the October 2025 resident council meeting, residents expressed concerns about wanting fresh fruit rather than canned fruit. e. During the November 2025 resident council meeting, residents expressed concerns about food being served cold and late.f. During the January 2026 resident council meeting, residents expressed concerns about food being served cold and late.g. During the April 2026 resident council meeting, residents expressed concerns about food being served cold and late. 8. On 5/7/26 at 12:09 PM, surveyors sampled a test tray from the lunch time meal service. The meal was chicken alfredo pasta with green beans. The green beans were overcooked, mushy, and were not seasoned. The alfredo sauce did not have any flavor. The chicken was gristly and difficult to chew. On 5/7/26 at 11:27 AM, an interview was conducted with the Dietary Manager (DM). The DM stated that if residents had complaints about food served at the facility they could tell the aides, nurses, or come to her directly with concerns. The DM stated that food concerns were discussed at the resident council and the dining committee meetings. The DM stated that the facility recently switched to a new menu.On 5/11/26 at 1:37 PM, an interview was conducted with the Registered Dietitian (RD). The RD stated that if a resident complained about the food to her during an assessment, she would pass the concern on to the dietary manager.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined for 1 out of 33 sampled residents, that the facility failed to ensure each resident had the right to be informed of, and participate in, his or her treatment, including the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred. Specifically, one resident's representative was not notified in advance of the risks and benefits or alternatives before starting or when changes were made for psychotropic medications. Resident identifier: 91.Findings included:Resident 91 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, depression, and anxiety disorder.Resident 91's medical record was reviewed 5/5/26 through 5/11/26.A physician's order dated 4/29/26 at 8:05 AM indicated, busPIRone HCl [hydrochloride] Tablet 10 MG [milligrams] .Give 10 mg by mouth three times a day related to ANXIETY DISORDER.On 5/11/26 at 2:37 PM, an interview was conducted with the Director of Nursing and she was unable to provide information that resident 91's representative was notified of the risks and benefits or alternatives before starting buspirone for anxiety.No documentation was provided to indicate resident 91's representative was notified of the risks and benefits or alternatives before starting buspirone for anxiety.

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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, for 1 of 33 sampled residents, that the facility did not ensure that a transfer or discharge was documented in the resident's medical record and appropriate information was communicated to the receiving health care institution or provider. Specifically, the facility did not document what documentation was sent with a resident that was discharged to a hospital after a change in condition. Resident identifier: 80.Findings included:Resident 80 was admitted on [DATE], and discharged on 4/5/26, with diagnoses including, but not limited to parkinson's disease without dyskinesia without mention of fluctuations and personal history of transient ischemic attack and cerebral infarction without residual deficits.Resident 80's medical record was reviewed from 5/5/26 through 5/11/26.On 4/5/26 at 6:26 AM, a nursing progress note stated, Approx [approximately] 5:25am resident vomited coffee ground colored emesis, Obtained [sic] VS [vital signs] BP [blood pressure] 102/69, P [pulse] 92, R [respirations] 18, Sats [oxygen saturation] 75% RA [room air], temp [temperature] 97.9. Verbally responded to name and touch. O2 [oxygen] applied and sats 92% on 5 liters with no active vomiting observed. [Name of provider company] on call provider notified and received verbal order to send to hospital for further evaluation of condition. Patient agreed to be sent to hospital. [Ambulance service] called and transported to [Name of hospital]. Nurse management and family also notified.On 4/6/26 at 2:42 PM, a nursing progress note stated, Admissions coordinator verified that [Resident 80] was admitted to [Name of hospital].There was not a progress note, assessment, discharge summary, or uploaded document that stated what documentation was sent with the resident when they were transferred to the hospital. On 5/11/26 at 12:11 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that when a resident was discharged to the hospital she sent their profile page, order summary, medication list, and a copy of the resident's provider order for life sustaining treatment (POLST). RN 1 stated that she also entered a progress note that documented what happened.On 5/11/26 at 12:22 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that when a resident was discharged to the hospital, they sent the resident's face sheet, the resident's medication list, a list of treatments that the resident received, a copy of the resident's POLST form, and a copy of the resident's face sheet. LPN 1 stated that they made two copies, one for the hospital and one for the ambulance. LPN 1 stated that they usually documented the discharge in a progress note.On 5/11/26 at 3:06 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that when a resident is discharged to the hospital, facility staff should send a face sheet, a POLST, a medication list, and send all of this information with the patient. The DON stated that this should be documented in the medical record.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined for 1 of 33 sampled residents, that the facility did not ensure that the resident environment remained as free of accident hazards as was possible; and that each resident received adequate supervision and assistance devices to prevent accidents. Specifically, a dependent resident was transferred using a Hoyer lift by only one staff member on two separate occasions. Resident identifier: 30.Findings included:Resident 30 was admitted to the facility on [DATE] with diagnoses which included malignant neoplasm of parietal lobe, major depressive disorder, repeated falls, dependence on supplemental oxygen, age related osteoporosis, altered mental status and encephalopathy. Resident 30 was admitted to hospice services on 11/13/25. On 5/4/26 at 8:23 AM, resident 30 was observed to be lying in bed. A staff member was observed to take a Hoyer lift into resident 30's room and close the door. There was no other staff observed to be in resident 30's room prior to the door closing. Approximately 10 minutes later the staff member opened the door and exited the room with the Hoyer lift. No other staff members were observed to enter the room while the door was closed. Resident 30 was then observed to be sitting in her wheelchair and the bed was made. An immediate interview was conducted with the staff member who identified herself as a hospice aide. The hospice aide (HA) stated that she saw resident 30 in the mornings to get her ready for the day. HA stated that she was the only hospice aide that comes in to see resident 30, so she would usually get her out of bed on her own. On 5/7/26 at 8:32 AM, an observation was made of the HA taking the Hoyer lift into resident 30's room, there were no other staff present. Resident 30 was observed to be in bed. The HA closed the door and reopened the door 10 minutes later and resident 30 was sitting in her wheelchair. The HA stated she had gotten resident 30 into her wheelchair and ready for the day. A Minimum Data Set (MDS) dated [DATE] documented resident 30 was dependent for toileting hygiene and required substantial/maximum assistance with bathing and dressing. Resident 30's medical record dashboard documented, Hospice aide for ADLs (Activities of Daily Living) every morning, including weekends . MUST BE A HOYER LIFT FOR TRANSFERS.A care plan entry dated 10/18/25 had a goal of ADL self-care performance deficit r/t (related to) brain tumor and impaired mobility. With interventions dated 11/24/25 that included resident 30 was usually dependent with transfers and required dependent assistance with personal hygiene.On 5/7/26 at 2:04 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1 who stated that resident 30 used a Hoyer for transfers. CNA 1 stated that there should always be two people to assist with a Hoyer lift. CNA 1 stated that they should always have 2 people to assist so the resident was safe no matter if it was regular staff, agency or home health/hospice. On 5/11/26 at 10:00 AM, an interview was conducted with CNA 2 who stated resident 30 was a 2-person assist and that a Hoyer lift was needed to transfer her. CNA 2 stated there should always be 2 people when using a Hoyer lift and the hospice aides could ask the regular staff for help if needed.On 5/11/26 at 2:34 PM, an interview was conducted with the Director of Nursing (DON) and the Administrator (ADM). The DON stated that resident 30 was a 2-person assist with transfers and the Hoyer was used with those transfers. The ADM stated it was best practice to have 2 people when using a Hoyer lift. The DON stated that all staff should have a second staff member with them if they were using the Hoyer lift, this included contracted staff or those who work for outside agencies which included hospice services. The DON stated the hospice aides were expected to ask another staff member for assistance if they had a resident who required a Hoyer lift for transfers.

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F 0690 Level of Harm - Minimal harm or potential for 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 record review and interview, it was determined that for 1 out of 33 sampled residents, the facility failed to ensure that each resident who was incontinent of bladder received appropriate treatment and services to restore continence to the extent possible and who was incontinent of bowel received appropriate treatment and services to restore as much normal bowel function as possible. Specifically, one resident who was incontinent of bowel and bladder did not receive services to restore function to the extent possible. Resident identifier: 47.Findings included:Resident 47 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side.Resident 47's medical record was reviewed 5/5/26 through 5/11/26.A Minimum Data Set assessment dated [DATE] indicated resident 47 was always incontinent of bowel and bladder continence and had not had an attempted trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) on admission/entry or reentry or since urinary incontinence was noted in this facility and was not currently on a toileting program to manage the resident's bowel continence.A Care Plan Report indicated a Focus initiated on 9/6/24 of [Resident 47] has bladder/bowel incontinence r/t [related to] Impaired Mobility. It indicated a Goal of [Resident 47] will remain free from skin breakdown due to incontinence and brief use through the review date. It further indicated Interventions of, INCONTINENT: Check Q2 [every 2] hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN [as needed] after incontinence episodes.A Care Plan Report indicated a Focus initiated on 6/2/24 of [Resident 47] has an ADL [activities of daily living] self-care performance deficit r/t/ hx [history] of CVA [cerebrovascular accident] with hemiplegia, weakness. She has functional limitation in ROM [range of motion] to both RUE [right upper extremity] and RLE [right lower extremity] on the right side. It indicated a Goal of [Resident 47] will maintain current level of function in [sic] through the review date. It further indicated interventions that included, TOILET USE: [Resident 47] is usually dependent with toileting; and, TRANSFER: [Resident 47] is usually dependent to transfer. Requires a 2 person assist.On 5/11/26 at 1:25 PM, an interview was conducted with Licensed Professional Nurse (LPN) 1. LPN 1 stated that resident 47 used to be able to get up to the wheelchair to use the bathroom but was now incontinent and dependent on 2 people to help her stand. LPN 1 stated resident 47 had no medical reason to be incontinent and that she was alert and oriented to person, place, time, and situation and could convey her needs.On 5/11/26 at 1:47 PM, an interview was conducted with Certified Nurse Assistant (CNA) 3. CNA 3 stated that resident 47 was incontinent but was able to communicate her needs. CNA 3 stated resident 47 could alert staff both before needing to use the restroom and when she required a brief change.On 5/11/26 at 3:21 PM, an interview was conducted with the Director of Nursing (DON) and she stated that she was not sure if resident 47 had been on a bowel and bladder retraining program and that she would have to look into it.No documentation was provided that indicated that resident 47 received bowel and bladder retraining.

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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 record review and interview, it was determined that for 1 of 33 sampled residents, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice. Specifically, one resident did not have vital signs, weights, and assessments of their AV (arteriovenous) fistula documented before and after dialysis treatments and communication of the patient's status with the dialysis center was not complete. Resident identifier: 49.Findings included:Resident 49 was admitted to the facility on [DATE] with diagnoses of end stage renal disease and dependence on renal dialysis.Resident 49's medical record was reviewed 5/5/26 through 5/11/26.Renal Dialysis Communication Forms were reviewed and revealed the following: Form dated 4/10/26 was missing vital signs, weight, and assessment of the access site prior to leaving the facility. Form dated 4/13/26 was missing vital signs, weight, and assessment of the access site prior to leaving the facility. Form dated 4/20/26 was missing vital signs and weight prior to leaving the facility and a missing post dialysis weight. Form dated 4/29/26 was missing vital signs, weights, and assessments of the access site prior to leaving the facility and post dialysis. Form dated 5/4/26 was missing vital signs, weight, and assessment of the access site prior to leaving the facility.An APP (Advanced Practice Provider) Admit Visit Note dated 4/12/26 at 5:28 PM indicated, END STAGE RENAL DISEASE Continue scheduled hemodialysis (M/W/F) [Monday/Wednesday/Friday]. Monitor for complications (electrolytes, volume status, access issues) . ARTERIOVENOUS FISTULA, ACQUIRED Monitor for patency, signs of infection or dysfunction.Review of the medical record indicated that there was no documentation of AV fistula assessment prior to leaving the facility for dialysis on 4/10/26.Review of the medical record indicated that there was no documentation of AV fistula assessment when resident the returned from dialysis on 4/8/26, 4/10/26, 4/13/26, 4/15/26, 4/20/26, 4/22/26, 4/24/26, 4/26/26, 4/29/26, 5/1/26, 5/4/26, and 5/6/26.Review of the medical record indicated that there were no vital signs obtained when the resident returned from dialysis on 4/20/26, 4/22/26, 4/24/26, 4/26/26, 4/29/26, 5/1/26, and 5/4/26. The Care Plan Report indicated a Focus initiated on 4/8/26 of The resident needs dialysis (hemo) r/t [related to] renal failure. It indicated the Goal The resident will have no s/sx [signs or symptoms] of complications from dialysis through the review date. It further indicated interventions which included, Coordinate care with Dialysis center using communication form; Monitor VITAL SIGNS as indicated. Notify MD [medical doctor] of significant abnormalities; Monitor/document/report PRN [as needed] any s/sx of infection to access site: Redness, Swelling, warmth or drainage; and Monitor/document/report PRN for s/sx of the following: Bleeding, Hemorrhage, Bacteremia, septic shock.On 5/7/26 at 2:36 PM, an interview was conducted with Licensed Practical Nurse (LPN) 2 and she stated that the dialysis communication form needed to be filled out prior to sending the resident to dialysis and reviewed when they returned from dialysis. LPN 2 stated they reviewed the note to see if there were any notes from the dialysis center and to ensure the vital signs were okay. LPN 2 stated they did not need to do an assessment of the resident when they returned from dialysis as long as that form was okay.On 5/7/26 at 2:59 PM, an interview was conducted with Registered Nurse (RN) 4 and he stated when a resident came back from dialysis, they should assess the access site for bleeding, check the bruit and thrill to ensure proper function, and obtain a blood pressure to monitor for fluid-shift fluctuations.On 5/11/26 at 3:25 PM, an interview was conducted with the Director of Nursing (DON) and she stated that post-dialysis nursing assessments must include monitoring vital signs, skin color, and the fistula site for bleeding, infection, and a positive bruit and thrill.The facility Policy/Procedure Dialysis Services dated 10/2017 indicated, It is the policy of this facility that staff will coordinate with the dialysis center, in individual cares for residents receiving dialysis services and will complete duties and obligations as agreed upon by the facility and the dialysis center. PURPOSE: To establish protocol which will facilitate coordination with the dialysis center to ensure proper care for dialysis residents.11. Nursing staff will (continued on next page)

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	465192	A. Building B. Wing	05/11/2026

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitor port site for signs of bleeding and infection. 12. Nursing staff will monitor for bruits and thrills at port site.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and interview, it was determined that the facility failed to post the nurse staff posting data in a prominent place readily accessible to residents, staff, and visitors and failed to post the resident census on a daily basis. Specifically, the nurse staff posting did not include the resident census and was not in an area that residents and visitors would readily find. Findings included:On 5/7/26 at 3:25 PM, an observation was made from the entrance of the facility throughout all of the main hallways of the resident rooms and nursing stations. No nurse staff posting was observed. The Director of Nursing (DON) was then found and she walked the surveyor down the south east rehabilitation hallway down to a cubby on the left side of the hallway next to staff offices to view the nurse staff posting. There was no resident census included on the posting.On 5/7/26 at 3:25 PM, a concurrent interview was conducted with the DON and she stated that family and residents go to the office next to the nurse staff posting for meetings with staff so they knew where it was found.

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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, it was determined that the facility did not ensure residents were free of any significant medication errors. Specifically, for 1 out of 33 sampled residents, a resident received more seizure medication than was prescribed on eight different occasions. Resident identifier: 9.Findings included:Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease, anxiety disorder, bipolar disorder, mood disorder and tremors. During record review on 5/11/26 at 12:38 PM, an incident report was reviewed and revealed that resident 9 had been administered 2000 mg (milligrams) of Depakote three times a day (TID) when only 500 mg of Depakote should have been administered.The initial physician order dated 9/22/25 at 4:33 PM revealed the following order, Depakote Oral Tablet Delayed Release 500 mg (Divalproex Sodium). Give 3 tablet by mouth three times a day related to BIPOLAR DISORDER, UNSPECIFIED. This order was discontinued on 9/22/25 at 7:39 PM.A follow up order dated 9/22/25 at 7:39 PM revealed the order was changed to the following, Depakote Oral Tablet Delayed Release 500 MG (Devalproex Sodium). Give 4 tablet by mouth three times a day related to BIPOLAR DISORDER, UNSPECIFIED.The September 2025 Medication Administration Record (MAR) was reviewed and documented resident 9 had received 2000 mg of Depakote one time on 9/22/25 and 6000 mg of Depakote on 9/23/25 and 9/24/25. It should be noted that resident 9 should have only received 500 mg of Depakote on 9/22/25 and 1500 mg of Depakote on 9/23/25 and 9/24/25. A nursing progress note dated 9/22/25 at 4:38 PM documented, The order you have entered Depakote Oral Tablet Delayed Release 500 MG (Divaloproex Sodium) Give 3 tablet by mouth three times a day related to BIPOLAR DISORDER, UNSPECIFIED - The dosing regimen of 3 tablets 3 times a day exceeds the usual dosing regimen of 0.5 tablet 2 times per day to 2.33 tablets 3 times per day. It should be noted that the medication dosage was not adjusted after this computer generated warning. A nursing progress note dated 9/22/25 at 7:40 PM documented, The order you have entered Depakote Oral Tablet Delayed Release 500 MG (Divaloproex Sodium) Give 3 tablet by mouth three times a day related to BIPOLAR DISORDER, UNSPECIFIED - The dosing regimen of 3 tablets 3 times a day exceeds the usual dosing regimen of 0.5 tablet 2 times per day to 2.33 tablets 3 times per day. - The single dose of 4 tables exceeds the maximum single dose of 3.4096 tablets. The usual dosing regimen is 0.5 tablet 2 times per day to 2.33 tablets 3 times a day.It should be noted that the medication dosage was not adjusted after this computer generated warning. A nursing progress note dated 9/25/25 at 8:00 AM documented, This nurse noted that [resident 9's] previous Depakote order was 500 mg TID (4 sprinkle capsules of 125 mg form) and that it had recently been changed to 2000 mg TID (4 tabs of 500 mg ER [extended release] form). Double checked dosing with provider and he stated that it was input incorrectly and should still be 500 mg TID. Notified resident and family, stated gratitude for update. Notified administration. Corrected order form [sic] 4 tabs of 500 mg Depakote TID to 1 tab 500 mg TID. Provider gave order to hold AM [morning] dose and draw STAT [immediate] valproic acid level. VSS [vital signs stable], cont [continue] O2 [oxygen] via NC [nasal cannula], no noted drowsiness or other ASE [adverse side effect]. Added order to monitor for ASE and VS [vital signs] q [every] shift x [times] 3 days. Valproic acid level returned, 61.2. Notified provider, order to resume Depakote administration.A nursing progress note dated 9/26/25 at 12:50 PM documented, [Resident 9] did sleep this morning and c/o [complained of] drowsiness but currently awake and eating lunch.A nursing progress note dated 9/26/25 at 3:34 PM, Patient reviewed in psychotropic meeting with [provider], pharmacist, DON [Director of Nursing] and ADON [Assistant Director of Nursing]. Next review in 30 days. No changes to medications at this time .On 5/11/26 at 2:36 PM, an interview was conducted with the DON and the Administrator (ADM). The DON stated the provider would give a verbal order to the floor nurse, the DON, or the ADON. The DON stated that whoever was currently working could put the order into the medical records system. The DON stated that herself, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and both ADONs reviewed any new orders daily. The DON stated the order then goes to the pharmacy for review. The DON stated that with this incident the nurse put the order in wrong and it wasn't caught until a few days later. The DON stated resident 9 got a few doses because the medication was ordered four times a day. The ADM stated that they added medication error to the facility in-services and to their daily rounding. The DON stated the computer generated warning always comes up when any order is entered, it's a red warning to make them aware that the medication interacted with other medications. The DON and ADM stated they had educated the nurses who were directly affected by the incident but not every nurse in the facility. The DON stated that they wished that it hadn't happened and that they made a mistake.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not label all drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include appropriate accessory instructions and the expiration date when applicable. Specifically, two insulin pens were not labeled with an open date and a resident was given an inhaler that was not labeled with a resident identifier or open date. Resident identifiers: 9. Findings included:On [DATE] at 8:10 AM, an observation was made of the North East medication cart during morning medication pass with Registered Nurse (RN) 2, the following medications were located in the medication cart: A prefilled insulin pen containing Novolog 100 unit/ml (milliliter) was open and available for use, no open date was observed on the insulin pen. A prefilled insulin pen containing Glargine 100 unit/ml was open and available for use, no open date was observed on the insulin pen. An immediate interview was conducted with RN 2 who stated the insulin pens were supposed to have the resident's name and an open date written on them so the staff knew when they expired. RN 2 stated the staff should date the insulin when they got it out of the medication room. On [DATE] at 8:42 AM, an observation was made of the North East medication cart during morning medication pass with RN 2. RN 2 was observed to obtain a Umeclidinium Bromide InhalationAerosol Powder 62.5 MCG/ACT (microgram/per actuation) inhaler from the bottom drawer in the medication cart after multiple attempts to locate the needed inhaler. There was no resident identification or open date observed on the inhaler. RN 2 was observed to give the inhaler to resident 9 who took 1 puff orally from the inhaler. An immediate interview was conducted with RN 2 who stated she was not sure if the inhaler belonged to resident 9 but it was with her other medications so she assumed it was resident 9's. RN 2 was then observed to write resident 9's name on the inhaler, no date was written. The inhaler was then returned to the bottom drawer of the medication cart, no box with the resident's prescription or identifier was observed. On [DATE] at 10:15 AM, an interview was conducted with the Director of Nursing (DON) who stated the staff were expected to write the date on the medication when it was pulled out of the storage room, and the medication should already have the prescription label on it. The DON stated a medication should not be given to a resident if there was not a prescription label on it and if the staff did not know who the medication belonged to. The DON stated if the medication was not labeled the staff would not know if the medication belonged to that resident and if the medication was the correct medication for that resident.

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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. Based on record review and interview, it was determined that the facility failed to conduct an annual review of its IPCP (infection prevention and control program) and update their program, as necessary. Specifically, there was no documentation indicating that the Infection Prevention and Control Policy was reviewed annually.Findings included:The Policy / Procedure - Infection Prevention and Control Section: Subject: Infection Prevention and Control Program Infection Prevention and Control Program Overview adopted 09/2017 indicated, UPDATING THE INFECTION PREVENTION AND CONTROL PLAN The Infection Prevention and Control Plan will be reviewed annually and updated as indicated by changes in services, changes in the population served, or other changes as appropriate.On 5/11/26 at 3:29 PM, an interview was conducted with the Director of Nursing (DON) and she stated that IPCP policy was reviewed annually with corporate. Documentation that indicated when it was reviewed last was requested but was not provided.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, it was determined that the facility failed to develop and implement policies and procedures to ensure all of the following: When COVID-19 vaccine was available to the facility, each staff member was offered the COVID-19 vaccine unless the immunization was medically contraindicated or the resident or staff member had already been immunized, and before offering COVID-19 vaccine, all staff members were provided with education regarding the benefits and risks and potential side effects associated with the vaccine. The facility also failed to maintain documentation related to staff COVID-19 vaccination that included at a minimum, the following: Staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and the COVID-19 vaccine status of staff and related information was indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). Specifically, there was no documentation that four staff members were offered the COVID-19 vaccine and no policy was found to address staff COVID-19 vaccine requirements.Findings included:COVID-19 vaccine documentation was requested for four staff members: Registered Nurse 4, Certified Nurse Assistant 4, Licensed Practical Nurse 2, and the Dietary Manager.On 5/11/26 at 3:29 PM, an interview was conducted with the Director of Nursing (DON) and she stated they held a flu and COVID-19 clinic every year and that it was open to staff. The DON stated every staff member was offered the COVID-19 vaccine but it was not documented. No documentation for any of the four requested staff members was provided that indicated they were offered or had accepted or declined the COVID-19 vaccine.No policy was provided that indicated the required elements for staff regarding the COVID-19 vaccine.