STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thalia Gardens Rehabilitation and Nursing	4142 Bonney Road Virginia Beach, VA 23452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, clinical record review, and facility document review, it was determined that facility staff failed to maintain a safe, clean, comfortable, and homelike environment for residents across 3 of the facility's 3 units, constituting substandard quality of care (SQC).The findings include:On 4/22/26 at 11:00 AM, a Resident Council meeting was held with the President and four other residents who regularly attend the group meeting. All attendees agreed that the facility was not a safe, clean, comfortable, and homelike environment. 1. Resident #22 was admitted to the facility on [DATE]. The residents' diagnoses included high blood pressure and asthma. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 3/20/2026, was coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 15 out of 15. This indicated that Resident # 22's cognitive abilities for daily decision-making were intact. On 4/22/26 at approximately 11:17 AM, an interview was conducted with Resident #22. Resident #22 stated that there are large flying roaches in the facility, and the shower room is unclean. She stated that she thought they at times landed on her bed and questioned whether she should avoid showering. 2. Resident #27 was admitted to the facility on [DATE]. The residents' diagnoses included diabetes and depression. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 3/7/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 0 out of 15. This indicated that Resident # 27's cognitive abilities for daily decision-making were severely impaired. Although Resident #27's BIMS score is low, staff interviews and resident statements validated that she is alert and oriented times 4. On 4/22/26 at approximately 11:22 AM, an interview was conducted with Resident #27. Resident #27 stated that there are flying roaches in the facility during the day and at night, and that they have worsened since construction began. 3. Resident #34 was admitted to the facility on [DATE]. The residents' diagnosis included cirrhosis of the liver and hepatic encephalopathy. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 2/7/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 15 out of 15. This indicated that Resident #34's cognitive abilities for daily decision-making were intact. On 4/22/26 at approximately 11:27 AM, an interview was conducted with Resident #34. Resident #34 reported that the shower room is very unclean, with poor drainage resulting in standing water, necessitating the use of shoes in the shower. The resident also stated that there is little to no privacy (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	in the shower room because the curtain at the door does not obstruct those passing by from viewing the person showering. 4. Resident #43 was admitted to the facility on [DATE]. The residents' diagnoses included protein-calorie malnutrition and COPD. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 3/12/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 15 out of 15. This indicated that Resident #43's cognitive abilities for daily decision-making were intact. On 4/22/26 at approximately 11:32 AM, an interview was conducted with Resident #43. Resident #43 stated that the roaches crawl on the ceilings and walls, making it difficult to sleep. The resident also stated that they had not seen pest control treat their room for the roaches. 5. Resident #108 was admitted to the facility on [DATE]. The residents' diagnosis included a non-pressure chronic ulcer, left calf, and osteoarthritis. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 4/17/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 15 out of 15. This indicated that Resident #108's cognitive abilities for daily decision-making were intact. On 4/22/26 at approximately 11:37 AM, an interview was conducted with Resident #108. Resident #108 stated that roaches are seen throughout the facility and that sightings have not improved. On 4/28/26 at approximately 4:45 pm, a final interview was conducted with the Interim Administrator, the Regional [NAME] President of Operations, the Director of Nursing, the Assistant Director of Nursing, and the Corporate Nurse Consultant. The above findings were conveyed to the administrative team, who made no comments and voiced no concerns. 6. For several Residents on the Fine Unit, the facility staff failed to ensure a clean, comfortable, homelike environment. During the initial tour on 04/21/2026, there were several observations of the issues regarding the lack of a clean, comfortable, home-like environment. Subsequent rounds during the survey revealed more observations of issues affecting several residents. Observations included but were not limited to the following: There was a gap in the threshold from the hall to the courtyard. It was observed that the semi-private rooms appeared to be small. The A beds by the doors in the semiprivate rooms were abutted against the walls. The bed in room [ROOM NUMBER] was abutted against the wall but there was only one resident in that room. The semiprivate rooms of concern were Rooms-301, 302, 303, 304, 305, 306, 307, 310, 311, 319 and 308- with only one resident in the room. Further review revealed a list of concerns: There were issues with the environment on the Fine Unit, including but not limited to the following: -There was a gap in the threshold from the hall to the courtyard. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During daily rounds on the Fine Unit, housekeeping staff members were observed cleaning rooms. Housekeeping staff were noted mopping floors and cleaning around beds. On several dates during the survey, a housekeeping staff member was observed pushing beds away from the wall to sweep around the bed. The resident was not in the room. When interviewed, the housekeeping staff member stated that it was difficult to squeeze behind the beds to clean the areas around the beds that were against the wall. Interviews were conducted with housekeeping staff members who stated they had difficulty cleaning around beds abutting the wall. 10. On 4/22/2026 at 11:10 a.m., Resident # 26 was observed sitting in the wheelchair next to the bed, which was abutted against the wall. There was very little space between the side of the bed and the wheelchair, and limited space between the wheelchair and the privacy curtain between Resident # 26 and the roommate. Resident # 26 was admitted to the facility on [DATE]. The most recent Minimum Data Set (MDS) was a comprehensive assessment with an Assessment Reference Date (ARD) of 03/24/2026. Resident # 26's BIMS (Brief Interview for Mental Status) Score was 08 out of 15, indicating severe cognitive impairment. 11. For Resident # 6 in room [ROOM NUMBER], the facility staff failed to keep the room clean. Resident # 6 was admitted to the facility on [DATE]. Diagnoses included but were not limited to hypertension, non-Alzheimer's dementia, seizure disorder, bipolar disorder, schizophrenia, and psychotic disorder. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 02/02/2026. Resident # 6's BIMS (Brief Interview for Mental Status) Score was a 00 out of 15, indicating severe cognitive impairment. Resident # 6 required assistance with Activities of Daily Living. During the initial rounds on 04/21/2026 at 12:50 p.m., Resident # 6 was observed sitting in the wheelchair in the room. The room was barren and the floor appeared to be very dirty. There was trash debris on the floor. The bed against the wall, floor was filthy, trash debris. The outlet near the HVAC (heating, ventilation and air conditioning) unit was exposed with noted sharp edges. On 04/21/2026 at 2:50 p.m., Resident # 6 was observed propelling himself in the wheelchair in his room. There was a reddish colored substance observed in middle of the floor. The substance looked like reddish vomit. Staff members were in the hallway. Two Certified Nursing Assistant came into the room and stated they would get housekeeping staff. A housekeeping staff member came into the room and started cleaning the substance from the floor. She stated that everyone needed to make sure to put on shoe covers because of stuff on the floor. There was a sign posted on the door about Enhanced Barrier precautions and one about wearing shoe covers. On 04/22/2026 at 10:30 a.m., a substance was noted on the floor. The floor looked filthy. There was debris in the room. Registered Nurse #1 came into the room and stated that Resident # 6 would often spit on the floor. Several observations were made on different days during the survey. The floor consistently looked (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(ARD) of 2/24/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 4 out of 15. This indicated that Resident # 11's cognitive abilities for daily decision-making were severely impaired. On 4/21/26 at approximately 2:40 PM, the resident was observed asleep in a low bed. On the floor was a fall mat between the two residents' beds. On the fall mat was debris and footprints. The trash can was observed near the bed, and a soiled glove was noted on the floor. The floor was noticeably dirty and needed mopping. On 4/28/26 at 3:30 PM, a final interview was conducted with the Administrator, Assistant Administrator, Director of Nursing (DON), Regional Nurse Consultant, and Regional Minimum Data Set Consultant. The DON stated. 20. The [NAME] Unit Shower Room: On 4/21/26 at approximately 2:50 PM, an observation was made of the shower room on the [NAME] unit. The shower room was full of clutter, including many shower chairs with items sitting in them, such as bags of soiled clothing. The bathtub in the shower room was full of incontinence products, towels, shirts, dust, and sheets. The shower area had water constantly dripping from the head, and water could be heard draining. At the sight of the shower drain, a used dressing was observed saturated and with pink and yellow secretions. From corner to corner, the shower room was soiled and dusty, with the tiles looking muted as if they were not clean, and the floor appeared unclean. The water closet in the shower room was extremely cluttered with shower chairs and over-the-toilet hoppers. The toilet seat was sealed with plastic and tape. A note read out of order. 21. The Laundry Room: On 4/23/26 at approximately 12:40 PM, an observation was made of the laundry room. The laundry room had washed clothing waiting in the washers, the dryers had stopped, and clothing was sitting in all three waiting to be folded. All tables in the laundry were piled halfway to the ceiling with unfolded clothing. Two shelves were also observed to contain many plastic bags of clothing items, which the laundry aide stated were personal belongings to be donated. The laundry room floors were grossly soiled, and a large bin of soiled laundry was identified with soiled pillows that had a yellowish-brown substance on the ends. The pillows were mixed in with soiled bed linens. On 4/28/26 at 3:30 PM, a final interview was conducted with the Administrator, Assistant Administrator, Regional [NAME] President of Operations, Director of Nursing, Regional Nurse Consultant, and Regional Minimum Data Set Consultant. The facility's team made no comments and offered no additional information. 22. The facility staff failed to maintain a clean and homelike environment for Resident #59, replace missing floor tiles in the kitchen, and replace a damaged dining room entry door. Resident #59 was originally admitted to the facility 11/25/2020 after an acute care hospital stay. The admission diagnoses included; traumatic hemorrhage of cerebrum, chronic obstructive pulmonary (continued on next page)

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Thalia Gardens Rehabilitation and Nursing	4142 Bonney Road Virginia Beach, VA 23452

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	disease, type 2 diabetes mellitus, and morbid obesity. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/5/26 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 06 out of a possible 15. This indicated Resident #59's cognitive abilities for daily decision making were severely impaired. On 4/21/26 at 3:30 PM, during an observation tour of room [ROOM NUMBER], it was observed that the wall under the window was dirty and needed painting. Also, crusty material was on the floor, on the wall, and on the baseboard behind the bed. An interview was conducted with Resident #59 on 4/21/26 at 3:40 PM. Resident #59 stated that the staff never cleans her room. Resident #59 also stated that she has to look out the window and see the nasty mess and wall. On 4/23/26 at 2:45 PM, during an observation tour of room [ROOM NUMBER] with the Director of Maintenance, copious amounts of accumulated brown substance were observed on the walls, floor, and cove base. A member of the housekeeping staff was in the room using a flat mop to clean the floor. The housekeeping staff stated that each time she comes back, she cleans the floor where the resident has been spitting. The housekeeping staff also stated that most of the encrusted brown substances on the floor and cove base cannot be removed. The Housekeeping Director stated that she would explore cleaning substances that could soak the areas to remove the encrusted spit. On 4/24/26 at 1:05 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the room should have been a high focus area for cleaning. The DON also stated that the room is a concern, and the staff is going to make it a high focus area for cleaning moving forward. 23. On 4/21/26 at 11:30 AM, during an observation tour of the kitchen, it was observed that floor tiles were missing on the floor when entering through the kitchen door. It was also observed that the missing tiles were placed on a pellet warmer next to the missing tiles. On 4/23/26 at 4:00 PM, an interview was conducted with the Director of Maintenance. The Director of Maintenance stated that the floor tiles in the kitchen were removed a couple of months ago. The Director of Maintenance also stated that due to the floor in the kitchen having missing tiles, this could be an area where the staff could trip and fall. The Direc

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and review of facility documents, the facility staff failed to provide a drug regimen review that was reviewed monthly by a licensed pharmacist for 6 of 63 residents (Resident #2, #10, #11, #23, #6, and #107), in the survey sample.The findings included:1. Resident #2 was admitted to the facility on [DATE] after a hospital stay. The resident's diagnoses included fracture of unspecified part of neck of right femur, alcoholic cirrhosis of liver without ascites, essential hypertension, and depression. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/14/26 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 09 out of a possible 15. This indicated Resident #2's cognitive abilities for daily decision making were moderately impaired. Review of the clinical record was conducted 04/21/2026 to 04/28/2026. Review of the progress notes revealed no documentation of the facility responding to irregularities identified by the Pharmacist during Monthly Drug Regimen Reviews. On 4/28/2026 at 11:40 AM an interview was conducted with the Director of Nursing (DON). The DON stated that she does not know where the monthly resident drug regimen reviews are located and she does not have them. On 04/28/2026 at 2:15 PM the DON stated that the facility has no other information regarding the location of the monthly resident drug regimen reviews and is unable to provide this information at this time. On 4/28/26 at 3:30 p.m., a final interview was conducted with the Administrator, Assistant Administrator, Director of Nursing, Regional Nurse Consultant, and Regional Minimum Data Set Consultant. They had no further comments and voiced no concerns regarding the above information. No further information was provided prior to the end of the survey. 2. Resident #10 was admitted to the facility on [DATE] after a hospital stay. The resident's diagnoses included type 2 diabetes mellitus, chronic kidney disease, muscle weakness, and essential hypertension. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/21/26 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 06 out of a possible 15. This indicated Resident #10's cognitive abilities for daily decision making were severely impaired. Review of the clinical record was conducted 04/21/2026 to 04/28/2026. Review of the progress notes revealed no documentation of the facility responding to irregularities identified by the Pharmacist during Monthly Drug Regimen Reviews. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/28/2026 at 11:40 AM an interview was conducted with the Director of Nursing (DON). The DON stated that she does not know where the monthly resident drug regimen reviews are located and she does not have them. On 04/28/2026 at 2:15 PM the DON stated that the facility has no other information regarding the location of the monthly resident drug regimen reviews and is unable to provide this information at this time. On 4/28/26 at 3:30 p.m., a final interview was conducted with the Administrator, Assistant Administrator, Director of Nursing, Regional Nurse Consultant, and Regional Minimum Data Set Consultant. They had no further comments and voiced no concerns regarding the above information. No further information was provided prior to the end of the survey. 3. The facility's staff failed to ensure that Resident #11's drug regimen was reviewed at least once each month by a licensed pharmacist. Resident #11 was admitted to the facility on [DATE]. The residents' current diagnoses included a stroke with aphasia and anxiety. The Significant Change Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 2/24/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 4 out of 15. This indicated that Resident # 11's cognitive abilities for daily decision-making were severely impaired. A review of the resident's physician order summary revealed an order dated 4/06/2026 for Lorazepam Tablet 0.5 MG; give 0.5 mg via G-Tube every 4 hours as needed for anxiety. Another order was for Morphine PF 20mg/ml. Give 0.25 ml sublingually every 1 hour as needed for mild pain/distress dissolve 0.25 ml under tongue (PSR 1-3) (5mg); Give 0.5 ml sublingually every 1 hour as needed for moderate pain/distress by mouth or sublingually (PSR 4-6) (10mg) and Give 1 ml sublingually every 1 hours as needed for severe pain or distress PSR (7-10) (20mg). This medication was frequently administered without pharmacy reviews or recommendations. An appraisal of pharmacy reviews revealed that, over the past 12 months (April 2025 through March 2026), no monthly pharmacy reviews were documented in the resident's clinical record. The last review identified in the clinical record was dated 3/30/2025, and the last recommendation was dated 9/25/2025. On 4/24/26 at 2:10 PM, an interview was conducted with the Director of Nursing (DON) concerning the monthly pharmacist reviews. The DON stated that she had started a pharmacy review and recommendation binder, but it was still in its early stages. The DON further stated she would attempt to obtain more information to present. On 4/28/26 at 3:30 PM, a final interview was conducted with the Administrator, Assistant Administrator, DON, Regional Nurse Consultant, and Regional Minimum Data Set Consultant. The DON stated there was no further information to give. 4. The facility's staff failed to ensure that Resident #23's drug regimen was reviewed at least once each month by a licensed pharmacist. Resident #23 was admitted to the facility on [DATE]. The residents' current diagnoses included cataracts and anxiety. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 4/6/2026, coded that the resident completed the Brief Interview for Mental (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Status (BIMS) and scored 9 out of 15. This indicated that Resident #23's cognitive abilities for daily decision-making were moderately impaired. An appraisal of pharmacy reviews revealed that, over the past 12 months (April 2025 through March 2026), no monthly pharmacy reviews were documented in the resident's clinical record. The last review identified in the clinical record was dated 3/28/2025, and the last recommendation was dated 11/18/2025. On 4/24/26 at 2:10 PM, an interview was conducted with the Director of Nursing (DON) concerning the monthly pharmacist reviews. The DON stated that she had started a pharmacy review and recommendation binder, but it was still in its early stages. The DON further stated she would attempt to obtain more information to present. On 4/28/26 at 3:30 PM, a final interview was conducted with the Administrator, Assistant Administrator, DON, Regional Nurse Consultant, and Regional Minimum Data Set Consultant. The DON stated there was no further information to give. 5. For Resident # 6, the facility staff failed to implement policies and procedures which address steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Resident # 6 was admitted to the facility on [DATE]. Diagnoses included but were not limited to hypertension, non-Alzheimer's dementia, seizure disorder, bipolar disorder, schizophrenia, and psychotic disorder. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 02/02/2026. Resident # 6's BIMS (Brief Interview for Mental Status) Score was a 00 out of 15, indicating severe cognitive impairment. Resident # 6 required assistance with Activities of Daily Living. Review of the clinical record was conducted 04/21/2026 to 04/28/2026. Review of the progress notes revealed no documentation of the facility responding to irregularities identified by the Pharmacist during Monthly Drug Regimen Reviews. On 04/28/2026 at 11:40 a.m., an interview was conducted with the Director of Nursing who stated that she did not have a process for responding to the irregularities identified by the Pharmacist. The Director of Nursing stated that she had been employed at the facility since March 2026 and had not developed a system for responding to the irregularities identified. On 04/28/2026 at 2:15 p.m., the Director of Nursing stated that the facility had no other information regarding the location of the monthly resident drug regimen reviews and was unable to provide the information. During the end of day debriefing on 04/28/2026, the Administrator, Assistant Administrator, Director of Nursing, Regional Nurse Consultant, and Regional Minimum Data Set Consultant were informed of the findings. No further information was provided . 6. For Resident # 107, the facility staff failed to implement policies and procedures which address (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Resident # 107 was admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included but were not limited to: chronic respiratory failure with hypoxia, diabetes with diabetic autonomic poly neuropathy, lymphedema, gastroesophageal reflux disease, cirrhosis of the liver ,nonalcoholic steatohepatitis (NASH), hepatic fibrosis, advanced fibrosis, chronic obstructive pulmonary disease, body mass index 60.0-69.9, ventral hernia with obstruction, gastroparesis, panic disorder, chronic kidney disease Stage 3B, major depressive disorder, and anxiety disorder. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 04/22/2026. Resident # 107's BIMS (Brief Interview for Mental Status) Score was a 15 out of 15, indicating no cognitive impairment. Resident # 107 required assistance with Activities of Daily Living. Review of the clinical record was conducted 04/21/2026 to 04/28/2026. Review of the progress notes revealed no documentation of the facility responding to irregularities identified by the Pharmacist. On 04/28/2026 at 11:40 a.m., an interview was conducted with the Director of Nursing who stated that she did not have a process for responding to the irregularities identified by the Pharmacist. The Director of Nursing stated that she had been employed at the facility since March 2026 and had not developed a system for responding to the irregularities identified. On 04/28/2026 at 2:15 p.m., the Director of Nursing stated that the facility had no other information regarding the location of the monthly resident drug regimen reviews and was unable to provide the information. During the end of day debriefing on 04/28/2026, the Administrator, Assistant Administrator, Director of Nursing, Regional Nurse Consultant, and Regional Minimum Data Set Consultant were informed of the findings. No further information was provided . During the end of day debriefing on 04/28/2026, During the end of day debriefing on 04/28/2026, the Administrator, Assistant Administrator, Director of Nursing, Regional Nurse Consultant, and Regional Minimum Data Set Consultant were informed of the findings. No further information was provided prior to the end of the survey.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on staff interview and facility documentation review, the facility failed to ensure the implementation of policies regarding the management and operations of the facility potentially affecting all residents in the facility.The findings included:For all residents in the facility, the governing body failed to ensure that the facility had an effective QAPI Quality Assurance Performance Improvement program. The facility had multiple areas in which deficient practices were identified, including environmental services, sanitary, clean-and-safe building, infection control practices, medication storage, and administration. These issues affected the residents' quality of life in the facility.During the survey, investigations revealed the facility had issues involving multiple systems. There had been recent changes in administration and key personnel. There were several new employees in management positions who had been employed for a month or less. The Director of Nursing had been employed for approximately one month at the time of the survey. The Social Services Director had been employed for one week. The Human Resources Director was newly hired. The Maintenance Director was new in his role. Long-term residents complained about the facility and some of the issues going on. There were issues with environmental services, including laundry. Residents were complaining about not having adequate linens and not getting their personal clothing washed and returned in a timely manner. Staff members were observed while performing duties and providing care. Surveyors interviewed staff members who stated there had been issues with the laundry for a while. Inspection of the laundry department revealed unsatisfactory conditions, including mounds of clean and dry laundry waiting to be folded, and other issues were identified. The facility failed to maintain an effective QAPI (Quality Assurance Performance Improvement) program. There was no documentation of a Performance Improvement Plan and no QAPT meeting for three of four quarters.From 04/21/2026 to 04/28/2026, the survey team reviewed the facility's systems and processes to correct previously cited deficiencies and address resident care concerns. It was noted that the facility had failures and remained out of compliance in areas previously cited as deficient during abbreviated surveys. The Maintenance logs and Pest control logs were reviewed by the survey team. There were issues identified.A review of the Resident Council minutes and Grievance logs shows that the facility's administration was aware of the concerns raised by residents and families. The issues continued for several months without resolution.On 04/23/2026 at approximately 3:20 p.m., an interview was conducted with the Administrator, who stated that the facility was making improvements and renovations. He stated it was important for the facility to have a clean, comfortable, homelike environment for the residents.Substandard quality of care was identified at the facility during the survey resulting in an extended survey from 04/24/2026-04/28/2026.The facility staff also failed to notify the State survey and certification agency when fire watch commenced on 3/17/26. The Maintenance Director presented the Fire Watch Patrol Log Sheet to the survey team on 4/24/26 at approximately 5:00 pm. On 3/17/26 at 8:30 AM, there were two trouble alarms on the fire control panel; at that time, fire watch was initiated every 15 minutes on all three units, including the lobby, laundry, kitchen, and dining room. On 3/18/26, the monitoring company evaluated the system on-site, and the technician restored the system functionality, reprogrammed the panel, and confirmed the system was operational and actively transmitting alarm signals to the monitoring service. The monitoring company's service request confirmed that signals were properly being sent over phone lines on 3/18/26, and the fire watch was lifted. The Maintenance Director stated, I fully understand and have a clear message that I need to report this to the State as coming from the Life Safety Code inspector and you all. The Administrator also stated that it was his responsibility to ensure a report to the state was made whenever a firewatch is initiated, including an explanation, the plan, and when it is lifted.During the end-of-day debriefing on 04/24/2026, the Facility Administrator, the Regional (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	[NAME] President of Operations, the Assistant Administrator, the Regional Nurse Consultants, and the Director of Nursing were informed of the findings of the substandard quality of care that were identified by the survey team, resulting in an extended survey task to be completed by the survey team. During the extended survey and investigation, it was determined that the facility lacked an effective training program. The facility failed to maintain an effective training program for employees on required topics, including, but not limited to, QAPI, effective communication, and behavioral health.During the end-of-day debriefings on 04/27/2026 and 04/28/2026, the Facility's Administrator, Assistant Administrator, Regional Nurse Consultant, and Director of Nursing were informed of the findings. The governing body should have been made aware of the issues identified by the survey team. The Administrator stated that he would address all identified issues.No further information was provided.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on observation, staff interview and facility documentation review, the facility staff failed to implement and maintain an effective Quality Assurance Performance Improvement (QAPI) Program/Plan for three of four quarters reviewed, affecting all residents in the facilityThe Findings included: During the survey, investigations revealed the facility had issues involving multiple systems. There was no documentation of the issues being discussed during QAPI meetings. These issues affected the quality of life of the residents in the facility.The facility failed to maintain an effective QAPI (Quality Assurance Performance Improvement) program. There was no documentation of a Performance Improvement Plan and no QAPT meeting for three of four quarters.Throughout the survey conducted 04/21/2026 - 04/28/2026, the survey team inspected and investigated the facility's systems and processes regarding correcting previously cited deficiencies and resident care concerns. It was noted the facility had failures and remained out of compliance in areas that had previously been cited as deficient during previous abbreviated surveys. The Maintenance logs and Pest control logs were reviewed by the survey team. There were issues identified.Review of the Resident Council minutes and Grievance logs revealed the facility's administration was aware of issues/concerns voiced by residents and families. The issues continued for several months without resolution.On 04/23/2026 at approximately 3:20 p.m., an interview was conducted with the Administrator who stated the facility was making improvements and renovations in the facility. He stated it was important for the facility to have a clean, comfortable homelike environment for the residents.Substandard quality of care was identified at the facility during the survey resulting in an extended survey from 04/24/2026-04/28/2026.During the end of day debriefing on 04/24/2026, the Facility Administrator, the Regional [NAME] President of Operations, Assistant Administrator, Regional Nurse Consultants and Director of Nursing were informed of the findings of the substandard quality of care that were identified by the survey team resulting in an extended survey task to be completed by the survey team. On 04/27/2026 at 4:01 p.m., an interview was conducted with the Assistant Administrator who stated she did not have any information about QAPI prior to January 2026. She stated the current administrative staff could not find documentation of any QAPI activities from the previous administrator. The Assistant Administrator stated the facility was expected to meet monthly to discuss Quality Assurance and quarterly for the QAPI meetings. She stated there was no current Performance Improvement Project being conducted.During the extended survey, investigations, it was determined that the facility did not have an effective training program. The facility failed to maintain an effective training program regarding required training for employees regarding topics including but not limited to: QAPI, effective communication and behavioral health.During the end of day debriefings on 04/27/2026 and 04/28/2026, the Facility's Administrator, Assistant Administrator, Regional Nurse Consultant and Director of Nursing were informed of the findings. The Administrator stated he would address the issues identified.No further information was provided.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on staff interview and facility documentation review, the facility staff failed to ensure implementation of a comprehensive QAPI (Quality Assurance Performance Improvement) Program/Plan included performance improvement projects potentially for three of four quarters affecting all residents in the facility The Findings included:Substandard quality of care was identified at the facility during the survey resulting in an extended survey from 04/24/2026-04/28/2026.During the end of day debriefing on 04/24/2026, the Facility Administrator, the Regional [NAME] President of Operations, Assistant Administrator, Regional Nurse Consultants and Director of Nursing were informed of the findings of the substandard quality of care that were identified by the survey team resulting in an extended survey task to be completed by the survey team. On 04/27/2026 at 4:01 p.m., an interview was conducted with the Assistant Administrator who stated she did not have any information about QAPI prior to January 2026. She stated the current administrative staff could not find documentation of any QAPI activities from the previous administrator. The Assistant Administrator stated the facility was expected to meet monthly to discuss Quality Assurance and quarterly for the QAPI meetings. She stated there was no current Performance Improvement Project being conducted. Four quarters were reviewed. Three quarters had no informationDuring the end of day debriefings on 04/27/2026 and 04/28/2026, the Facility's Administrator, Assistant Administrator, Regional Nurse Consultant and Director of Nursing were informed of the findings. The Administrator stated he would address the issues identified.No further information was provided.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 information obtained during the Infection Control task, the facility staff failed to document each staff member's COVID-19 information. The findings included: On 4/23/26 at approximately 1:05 PM, the Infection Control information for the facility's staff was requested. The Infection Preventionist (IP) stated at 3:38 PM that she was not directed to maintain staff's COVID-19 vaccination status. The IP also stated that she had no documentation indicating that any staff had been provided with education regarding the benefits and potential risks associated with the COVID-19 vaccine, nor that staff were offered the COVID-19 vaccine or any information on obtaining it, because she was not directed to do so.On 4/28/26 at 3:30 PM, a final interview was conducted with the Administrator, Assistant Administrator, Director of Nursing, Regional Nurse Consultant, and Regional Minimum Data Set Consultant. The facility's team made no comments and offered no additional information regarding staff COVID-19 data.

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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 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on staff interview and facility documentation review, the facility staff failed to develop, implement, and maintain an effective training program for all staff, including training on QAPI (Qualiity Assurance Performance improvement) for 5 (RN #2, RN # 3, LPN # 7, CNA # 6, CNA #7) of 5 staff records reviewed. Registered Nurse (RN), Licensed Practical Nurses (LPN) and Certified Nursing Assistant (CNA) The Findings included: Substandard Quality of Care was identified by the survey team on resulting in extended survey from 04/24/2026-04/28/2026.During the end of day debriefing on 04/24/2026, the Facility Administrator, the Regional [NAME] President of Operations, Assistant Administrator, Regional Nurse Consultants and Director of Nursing were informed of the findings of the substandard quality of care that were identified by the survey team resulting in an extended survey task to be completed by the survey team. During the extended survey, investigations, it was determined that the facility did not have an effective training program. The facility failed to maintain an effective training program regarding required training for employees regarding topics including but not limited to QAPI.On 04/28/2026 at 10:12 a.m., an interview was conducted with the Staff Development Coordinator in her office. The Staff Development Coordinator was asked about the training schedules and to provide documentation of the staff training. The Staff Development Coordinator stated she did not have any evidence of training being provided to all staff on QAPI. She stated that she did not do training on QAPI and that she thought it was done by the Human Resources department when staff was hired. She stated some of the staff members received different types of training on the computer. The Staff Development Coordinator presented a copy of the educational calendar she used for education annually. The Staff Development Coordinator was asked for a list of employees to include Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nursing Assistants (CNAs) and other disciplines.On 04/28/2026 at 10:32 a.m., an interview was conducted with the Human Resources Director who stated she did not provide QAPI education with new hires. A copy of the topics discussed during Orientation was reviewed. Those topics were: Employee Benefits, Health and Safety, Customer Service and Admissions, Resident Rights, Life Enrichment (Activities), Environmental Services, Fire Safety, Food Service, Therapy Department, Infection Control, (Name of Electronic Health Record System redacted) Navigation , Risk Management (Nurses/CNAs-Certified Nursing Assistants), Competencies (Nurses), Competencies (Aides). There was no mention of QAPI on the list for orientation. Review of the annual calendar presented by the Staff Development Coordinator revealed the calendar was a 2017 Annual Education Calendar and did not have QAPI listed as a topic. Review of the educational records of 5 nursing staff members (RN #2, RN # 3, LPN # 7, CNA # 6, CNA #7) revealed no documentation of training on QAPI. Staff members were asked during the survey if they had received training on QAPI. All responded they could not remember any training on QAPI. They stated that sometimes training was done in person and some were on the computer.The training sample of 5 employees included Registered Nurse (RN), Licensed Practical Nurses (LPN) and Certified Nursing Assistants (CNA).The training records for RN #2, RN # 3, LPN # 7, CNA # 6, CNA #7 were reviewed. None of the records had documentation of education on QAPI.On 04/28/2026 at 3:15 p.m., the Staff Development Coordinator stated that she found some documentation on QAPI. She submitted copies of computer-based training on QAPI. When asked it the list included all employees, the Staff Development Coordinator stated that she was not sure. Review of the documentation revealed a list of 14 employees in different disciplines who received QAPI in-service education in March 2026. There were 117 employees who completed QAPI training that was assigned on 07/01/2025. Employees from all disciplines completed that training. However, not all employees were listed and there was no evidence of training after new goals with QAPI.On 04/28/2026 during the end of day debriefing, the Administrator, Assistant Administrator and Director of Nursing were made aware of the findings. They stated there were no more education documents for those staff on record. No further information was provided.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on staff interview and facility documentation review, the facility staff failed to develop, implement, and maintain an effective training program for all staff, including training on behavioral health care and services for 5 (RN #2, RN # 3, LPN # 7, CNA # 6, CNA #7) of 5 staff records reviewed. Registered Nurse (RN), Licensed Practical Nurses (LPN) and Certified Nursing Assistant (CNA)The Findings included:Substandard Quality of Care was identified by the survey team on resulting in extended survey from 04/24/2026-04/28/2026.During the end of day debriefing on 04/24/2026, the Facility Administrator, the Regional [NAME] President of Operations, Assistant Administrator, Regional Nurse Consultants and Director of Nursing were informed of the findings of the substandard quality of care that were identified by the survey team resulting in an extended survey task to be completed by the survey team. On 04/28/2026 at 10:12 a.m., an interview was conducted with the Staff Development Coordinator in her office. The Staff Development Coordinator was asked about the training schedules and to provide documentation of the staff training. The Staff Development Coordinator stated she did not have any evidence of behavioral health training being provided to all staff. She stated some of the staff members received training on the computer. The Staff Development Coordinator was asked for a list of employees to include Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nursing Assistants (CNAs) and other disciplines.Review of the educational records of 5 nursing staff members (RN #2, RN # 3, LPN # 7, CNA # 6, CNA #7) revealed no documentation of training on behavioral health care. Staff members were asked during the survey if they had received training on behavioral health. All responded they could not remember any training. They were asked who provided training and they stated some were done in person and some were on the computer.The training sample of 5 employees included Registered Nurse (RN), Licensed Practical Nurses (LPN) and Certified Nursing Assistants (CNA).The training records for RN #2, RN # 3, LPN # 7, CNA # 6, CNA #7 were reviewed. None of the records had documentation of education on behavioral health.The Staff Development Coordinator stated she did not have documentation of any employees receiving training on behavioral health careDuring the extended survey investigations, it was determined that the facility did not have an effective training program. The facility failed to maintain an effective training program regarding required training for employees regarding topics including but not limited to behavioral health.On 04/28/2026 during the end of day debriefings, the Administrator., Assistant Administrator, Regional Nurse Consultant and Director of Nursing were made aware of the findings. They stated that all staff should receive required training including training on behavioral health. They stated the education/training documents were maintained by the Staff Development Coordinator.No further information was provided.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews and a review of clinical records, the facility staff failed to assist the resident to maintain personal belongings for 1 of 63 residents (Resident #101) in the survey sampleThe findings included:Resident #101 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses included cancer, hypertension, and hyperlipidemia. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 03/13/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 12 out of 15. This indicated Resident # 101's cognitive abilities for daily decision making were intact. On 4/21/26 at 3:27 pm, during an interview with resident #101. The resident stated, My stuff is stolen every week. The resident proceeded to list missing items: soaps, lotions, clothes, and a broken bottle of perfume. The resident stated that my daughter and I have reported it to the staff, prior administrators, and nursing many times, but nothing has been done. The resident and daughter reported the missing items again at the care plan meeting on 4/22/26. On 4/22/26 at 10:20 am, an interview was conducted with CNA #7 regarding the missing items for resident #101. CNA #7 was aware of the resident's allegation that her personal items have been missing periodically. CNA #7 stated that if a resident reports something missing to them, they would look for the items and or report it to the charge nurse or Director of Nursing. CNA #7 was not aware whether resident #101's items were reported as missing. On 4/22/26, at 10:28 am, an interview was conducted with CNA #3. CNA #3 stated that they remembered in the past that resident #101 alleged that she had missing items. CNA #3 was unsure whether this had been reported to anyone. On 4/23/26 at 11:30 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the expectation is that when a resident reports missing, lost, or stolen items, a grievance is completed. The only grievance provided by the DON was completed on 4/22/26. On 4/28/26 at approximately 4:45 pm, a final interview was conducted with the Interim Administrator, Director of Nursing, Assistant Director of Nursing, and the Corporate Nurse Consultant. The above findings were conveyed to the administrative team, who made no comments and voiced no concerns.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview and clinical record documentation review, the facility staff failed to ensure accommodation of needs for 4 residents (Resident # 97, # 21, #26 and # 5) in a survey sample of 63 residents.The Findings included:1. For Resident # 97, the facility staff failed to ensure the large clock on the bedroom wall was working. The room was shared with a roommate who also was not included in the sample.Resident # 97 was admitted to the facility with the diagnoses of but not limited to: anemia hypertension, anxiety and depression.The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 03/18/2026. Resident # 97's BIMS (Brief Interview for Mental Status) Score was 6 out of 15, indicating severe cognitive impairment.Review of the clinical record was conducted on 04/212026-04/28/2026.During the initial tour on 04/21/2026 at 12:15 p.m., the clock on the wall in Resident # 97's room was observed to have the time of 5:51. Resident # 97 was in the room, lying in the bed and watching television.On 04/21/2026 at 2:10 p.m., the clock had the time of 5:51. On 04/22/2026 at 9:40 a.m., the clock had the time of 5:51. The second hand was not moving. On 04/22/2026 at 3:00 p.m., the clock had the time of 5:51 Resident # 97 was sitting in the wheelchair. On 04/23/2026 at 8:45 a.m., the clock had the time of 5:51. Resident 97 was sitting in the wheelchair.On 04/23/2026 at 12:38 p.m., the clock had the time of 5:51. Resident 97 was not in the room.Staff members were observed in the room picking up food trays, delivering ice and water and providing care to during the survey. No staff person addressed the issue of the clock having the wrong time.On 04/23/2026 at 3:05 p.m., an interview was conducted with the Unit Manager who stated it was important for clocks to be accurate in the residents' rooms. The Unit Manager stated the clock in the room should have had the correct time because it was important for the orientation of the residents. The Unit Manager stated staff members should have observed the clock was wrong.During the end of day debriefing on 04/23/2026, the Facility Administrator, the Assistant Administrator, the Regional [NAME] President of Operations, and the Director of Nursing were informed of the issue. They all stated the clocks in residents' rooms should be accurate. The Director of Nursing stated it was important for clocks to be accurate because they would help with orientation of the residents. The Director of Nursing stated the staff members should have observed that the clocks were not working. No further information was provided. 2. For Resident # 21, the facility staff failed to ensure the large clock on the bedroom wall was working. The room was shared with a roommate who was also not included in the sample.Resident # 21 was admitted to the facility on [DATE] with the diagnoses of, but not limited to:The most recent Minimum Data Set (MDS) was a comprehensive assessment with an Assessment Reference Date (ARD) of 02/24/2026. Resident # 21's BIMS (Brief Interview for Mental Status) Score was00 out of 15, indicating severe cognitive impairment.Review of the clinical record was conducted on 04/212026-04/28/2026.During the initial tour on 04/21/2026 at 12:20 p.m., the clock on the wall in Resident # 21's room was observed to have the time of 4:20. Resident # 21 was in the room, lying in the bed and watching television.On 04/21/2026 at 2:10 p.m., the clock had the time of 4:20. Resident # 21 was lying in bed.On 04/22/2026 at 9:40 a.m., the clock had the time of 4:20. The hands were not moving. On 04/22/2026 at 3:00 p.m., the clock had the time of 4:20. Resident # 21 was sitting in the wheelchair. On 04/23/2026 at 8:45 a.m., the clock had the time of 4:20. Resident 21 was sitting in the wheelchair.On 04/23/2026 at 12:38 p.m., the clock had the time of 4:20. Resident 21 was sitting in the wheelchair.Staff members were observed in the room picking up food trays, delivering ice and water and providing care to during the survey. No staff person addressed the issue of the clock having the wrong time.On 04/23/2026 at 3:05 p.m., an interview was conducted with the Unit Manager who stated it was important for clocks to be accurate in the residents' rooms. The Unit Manager stated the clock in the rooms should have had the correct time because it was important for the orientation of the residents. The Unit Manager stated staff members should have observed the clock was (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wrong.During the end of day debriefing on 04/23/2026, the Facility Administrator, the Assistant Administrator, the Regional [NAME] President of Operations, and the Director of Nursing were informed of the issue. They all stated the clocks in residents' rooms should be accurate. The Director of Nursing stated it was important for clocks to be accurate because they would help with orientation of the residents. The Director of Nursing stated the staff members should have observed that the clocks were not working.No further information was provided. 3. For Resident # 26, the facility staff failed to ensure the large clock on the bedroom wall was working. The room was shared with a roommate who also was not included in the sample.Resident # 26 was admitted to the facility on [DATE] with the diagnoses of but not limited to:The most recent Minimum Data Set (MDS) was a comprehensive assessment with an Assessment Reference Date (ARD) of 03/24/2026. Resident # 26's BIMS (Brief Interview for Mental Status) Score was 08 out of 15, indicating severe cognitive impairment.Review of the clinical record was conducted on 04/212026-04/28/2026.During the initial tour on 04/21/2026 at 12:30 p.m., the clock on the wall in Resident # 26's room was observed to have the time of 10:50. Resident # 26 was in the room, sitting in the wheelchair and watching television.305 8:30 a.m. and 9:20 -time 10:50On 04/21/2026 at 2:10 p.m., the clock had the time of 4:20. Resident # 26 was lying in bed.On 04/22/2026 at 8:30 a.m. and 9:20 -time on the clock had 10:50.On 04/22/2026 at 12:10 p.m.- time on clock had the time of 1:38. An interview was conducted with Resident # 5. When asked what time lunch was being served, Resident # 26 looked at the clock and stated she did not know.On 04/22/2026 at 3:00 p.m., the clock had the time of 4:20. Resident # 26 was sitting in the wheelchair. On 4/23/2026 at-1015 a.m.th4 clock had the time of 11:34 Resident 26 was sitting in the wheelchair.On 04/23/2026 at 12:38 p.m., the clock had the time of 2:02. Resident 26 was sitting in the wheelchair beside the bed.Staff members were observed in the room picking up food trays, delivering ice and water and providing care to during the survey. No staff person addressed the issue of the clock having the wrong time.On 04/23/2026 at 3:05 p.m., an interview was conducted with the Unit Manager who stated it was important for clocks to be accurate in the residents' rooms. The Unit Manager stated the clock in the rooms should have had the correct time because it was important for the orientation of the residents. The Unit Manager stated staff members should have observed the clock was wrong.During the end of day debriefing on 04/23/2026, the Facility Administrator, the Assistant Administrator, the Regional [NAME] President of Operations, and the Director of Nursing were informed of the issue. They all stated the clocks in residents' rooms should be accurate. The Director of Nursing stated it was important for clocks to be accurate because they would help with orientation of the residents. The Director of Nursing stated the staff members should have observed that the clocks were not working.No further information was provided. 4. For Resident # 5, the facility staff failed to ensure the large clock on the bedroom wall was working. The room was shared with a roommate (Resident # 58) who was also included in the survey sample.Resident # 5 was admitted to the facility on [DATE] with the diagnoses of but not limited to: diabetes, cerebral infarction, hemiplegia and aphasia.The most recent Minimum Data Set (MDS) was a comprehensive assessment with an Assessment Reference Date (ARD) of 04/13/2026. Resident # 5's BIMS (Brief Interview for Mental Status) Score was 6 out of 15, indicating severe cognitive impairment.Review of the clinical record was conducted on 04/212026-04/28/2026.During the initial tour on 04/21/2026 at 12:30 p.m., the clock on the wall in Resident # 5's room was observed to have the time of 2:47. Resident # 5 was in the room, lying in the bed and watching television.On 04/21/2026 at 2:10 p.m., the clock had the time of 2:47. Resident # 5 was lying in bed.On 04/22/2026 at 9:40 a.m., the clock had the time of 2:47. Resident # 5 stated the clock was wrong. The hands were not moving. On 04/22/2026 at 3:00 p.m., the clock had the time of 2:47. Resident # 5 was sitting in the wheelchair near the bed.On 04/23/2026 at 8:45 a.m., the clock had the time of 2:47 Resident 5 was sitting in the wheelchair. When asked about the time, Resident # 5 stated the clock did not work. On 04/23/2026 at 12:38 p.m., the clock had the time of 2:47. Resident 5 was sitting in the wheelchair.Staff members were observed in the room picking up food trays, delivering ice and water and providing care to during the survey. No staff (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	person addressed the issue of the clock having the wrong time.On 04/23/2026 at 3:05 p.m., an interview was conducted with the Unit Manager who stated it was important for clocks to be accurate in the residents' rooms. The Unit Manager stated the clock in the rooms should have had the correct time because it was important for the orientation of the residents. The Unit Manager stated staff members should have observed the clock was wrong.During the end of day debriefing on 04/23/2026, the Facility Administrator, the Assistant Administrator, the Regional [NAME] President of Operations, and the Director of Nursing were informed of the issue. They all stated the clocks in residents' rooms should be accurate. The Director of Nursing stated it was important for clocks to be accurate because they would help with orientation of the residents. The Director of Nursing stated the staff members should have observed that the clocks were not working.No further information was provided.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on information obtained during the resident group meeting and a review of facility documents, the facility staff failed to ensure that 5 of 5 residents in the group meeting knew where the survey results binder was located without having to ask someone. The findings included:On 4/22/26 at 11:00 AM, a Resident Group meeting was held with the Resident Council President and four residents who regularly attend the group. There was consensus among all attendees that they were unaware they could review the survey book or even have access to it. No one could state where the book was located, and the president suggested that it must be behind the nurse's station. On 4/23/26 at 11:30 AM, an interview was conducted with the Director of Activities. The Activities director stated that the residents are educated in every resident council meeting on where to locate the survey results binder, and it was documented in the resident council minutes that they were provided with the information. No suggestions were offered on how the residents would be updated moving forward. On 4/28/26 at approximately 4:45 pm, a final interview was conducted with the Interim Administrator, Director of Nursing, Assistant Director of Nursing, and the Corporate Nurse Consultant. The above findings were conveyed to the administrative team, who made no comments and voiced no concerns.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on a review of facility documents and staff interviews, the facility staff failed to thoroughly investigate prospective employees' histories before hiring.The findings included: A review of current and past employees hired over the last 2 years was conducted on 4/22/26. Eleven of 25 employee records are missing at least one of the following documents: the sworn statement, the state police criminal background search, or verification of a certificate or license. On 4/22/26 at 12:20 PM, an interview was conducted with the Human Resources Director. The HR Director stated that they had conducted an in-house audit of employee records, and they identified that specific documents were missing. The HR Director also stated that they had not taken action to correct the problem, nor had they referred the matter to the Quality Assurance committee. The HR Director stated that on 4/22/26, an employee was terminated before clocking in because, on the evening of 4/21/26, the sister facility had emailed the criminal background report indicating that the employee had barrier crimes. The HR Director stated that upon receipt and review of the criminal background report, it revealed the employee had assaulted a family member and was guilty of malicious wounding and indecent exposure. This employee was hired on 4/7/26, the background check was requested on 4/8/26, and the report was received on 4/21/26. 4/22/26 at 1:20 PM, an interview was conducted with the Regional HR Director. She explained that the facility's process was to receive background checks and ensure all required documents were completed for a thorough screening. The Regional HR Director stated that it is their policy not to hire employees with past criminal prosecutions and that all new hires be screened in accordance with the policies and regulations. The Regional HR Director further said that the in-house HR Director had been experiencing issues with the online process on the state police website; therefore, they relied on the HR Director from a sister facility to obtain the documents for the facility. The Regional HR Director stated that the problem with the state police website had been resolved. On 4/24/26 at 2:15 PM, an interview was conducted with the Administrator, Assistant Administrator, Regional [NAME] President of Operations, DON, Regional Nurse Consultant, and Regional Minimum Data Set Consultant regarding the above allegation. They offered no additional information. On 4/28/26 at 3:30 PM, a final interview was conducted with the Administrator, Assistant Administrator, DON, Regional [NAME] President of Operations, Regional Nurse Consultant, and Regional Minimum Data Set Consultant. The facility's staff voiced no comments.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interviews, staff interviews, clinical record review, and facility documentation review, the facility staff failed to ensure that one (1) resident (Resident #16) and their family members were able to attend their person-centered care plan meetings, and the facility staff failed to review and revise a care plan for one (1) resident (Resident #11) of 63 residents in the survey sample. The findings included: 1.The facility staff failed to invite resident #16 and her family member to care plan meetings. Resident #16 was originally admitted to the facility 4/30/24 after an acute care hospital stay and re-admitted on [DATE]. The current diagnoses included; Type 2 Diabetes without complications and Alzheimer's Disease. The quarterly revision Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/13/26 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #16 cognitive abilities for daily decision making were severely impaired. In section GG (Functional Abilities Goals), the resident was coded as requiring set-up or cleanup assistance with oral hygiene, upper- and lower-body dressing, and eating. The resident requires supervision or touching assistance with toileting hygiene, putting on and taking off footwear, and personal hygiene. Requires partial-to-moderate assistance with showering/bathing self. The person-centered care plan revised 1/28/26 read that resident has a communication problem r/t Dementia and primary language is Spanish although she does understand and speak some English. A Goal for the resident was to make basic needs known on a daily basis. The interventions for the resident included: Allow adequate time to respond, Repeat as necessary, Do not rush, Request clarification from the resident to ensure understanding, Face when speaking, make eye contact, Turn off TV/radio to reduce environmental noise, ask yes/no questions if appropriate, Use simple, brief, consistent words/cues, Use alternative communication tools as needed, resident prefers to communicate in Spanish, Discuss with resident/family concerns or feelings regarding communication difficulty, monitor effectiveness of communication strategies and assistive devices, monitor/document for physical/ nonverbal indicators of discomfort or distress, and follow-up as needed, monitor/document residents ability to express and comprehend language, memory, reasoning ability, problem solving ability and ability to attend, monitor/document/report PRN any changes in: Ability to communicate, Potential contributing factors for communication problems, potential for improvement, provide translator as necessary to communicate with the resident. On 4/22/26 at approximately 12:35 pm, an interview was conducted with the resident's daughter (Family Member/FM #1). According to FM #1, they have never received an invitation or attended a care plan meeting. On 4/23/26 at approximately 2:53 pm, an interview was conducted with the Social Worker (SW). The SW said that care plan meetings are conducted on admission and quarterly. A review of medical records showed that two (2) care plan meetings were conducted, but it did not mention whether the resident or family members were present. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/28/26 at approximately 1:45 p.m., the above findings were shared with the Administrator, Director of Nursing, and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but none was provided. 2. The facility's staff failed to review and revise Resident #11's person-centered care plan as her status changed. Resident #11 was admitted to the facility on [DATE]. The residents' current diagnoses included a stroke with aphasia and anxiety. The Significant Change Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 2/24/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 4 out of 15. This indicated that Resident # 11's cognitive abilities for daily decision-making were severely impaired. In section GG0130 (Functional Abilities), the resident was coded as dependent with all ADL care. On 4/21/26 at approximately 2:40 PM, the resident was observed asleep in bed. A bedside drainage bag was not observed. An interview was conducted with Certified Nursing Assistant (CNA) #1 on 4/24/26. CNA #1 stated that Resident #11 had not had an indwelling catheter for at least two months. CNA #1 stated the resident was incontinent of urine and uncovered the resident's peri area to validate the information was accurate. The only indwelling catheter order identified was dated 8/03/2025. The order stated an Indwelling Urinary (Foley) Catheter to Straight Drainage, 16 French, with a 10 ml balloon, for comfort care every shift. This order was discontinued on 10/23/2025, per a nurse's note at 3:10 PM. The nurses' note didn't state the rationale for discontinuation. A review of Resident #11's care plan revealed a problem dated 6/12/2025 stating that Resident #11 currently had a 16 French indwelling catheter with a 10ml balloon for end-of-life. The goal stated that the resident will be/remain free from catheter-related trauma through the review date. The interventions included positioning the catheter bag and tubing below the bladder level and away from the entrance room door. A nurse Practitioner's progress note dated 4/21/26 revealed, in the review of systems, that the resident continued to use an indwelling catheter for urinary retention. The person-centered care plan also had a problem dated 9/08/2025 for Hospice services secondary to an end-stage diagnosis. The goal stated that the resident would remain comfortable through the next review date. The interventions included collaborating with all disciplines, family, and Hospice to meet resident needs. A review of the hospice certification note dated 2/18/26 stated the resident's certification for services would end on 2/21/26 because the resident would be discharged , as she was no longer considered terminal. On 4/28/26 at 3:30 PM, a final interview was conducted with the Administrator, Assistant Administrator, Director of Nursing (DON), Regional Nurse Consultant, and Regional Minimum Data Set Consultant. The DON stated they would need to determine whether the resident still needed the catheter.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation and staff interview, the facility staff failed to provide a resident environment free of accident hazards.The findings included: The facility staff failed to replace missing floor tiles in the kitchen, and replace a damaged dining room entry door which resulted in an accident hazard. On 4/21/26 at 11:30 AM during an observation tour of the kitchen, it was observed that floor tiles were missing on the floor when entering through the kitchen door. It was also observed that the missing tiles were placed on a pellet warmer next to the missing tiles. On 4/23/26 at 4:00 PM an interview was conducted with the Director of Maintenance. The Director of Maintenance stated that the floor tiles in the kitchen were removed a couple months ago. The Director of Maintenance also stated that due to the floor in the kitchen missing tiles, this could be an area that the staff could trip and fall. The Director of Maintenance further stated that this could be a hazard. On 4/21/26 at 11:45 AM during an observation tour of the dining room, it was observed that the entry door to the dining room was splitting apart and the bottom door hinge was not attached to the door. On 4/23/26 at 4:05 PM an interview was conducted with the Director of Maintenance. The Director of Maintenance stated that the dining room entry door is being replaced. The Director of Maintenance also stated that the door currently is propped open due to the bottom door hinge being broken. The Director of Maintenance further stated that the door could fall if the staff attempts to close the door and this could be a hazard.On 4/28/26 at 2:03 p.m., a final interview was conducted with the Administrator, Assistant Administrator, Director of Nursing, Regional Nurse Consultant, and Regional Minimum Data Set Consultant. They had no further comments and voiced no concerns regarding the above information.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, staff interview, resident interview and facility documentation, the facility staff failed to ensure staffing information was posted daily at the receptionist's desk and/or on three of three units in a prominent place and readily accessible to all residents, staff and visitors.The Findings included:During the initial tour of the facility on 04/21/2026, there was no observation of the daily posting of the nurse staffing information on the nursing units. There was no posting noted at the receptionist's desk.On 04/22/2026 (the second day of survey), no nurse staffing information was observed on the units nor at the receptionist's desk.On 04/22/2026 at 11:00 a.m., a group interview was conducted by another surveyor with five alert and oriented individuals. The surveyor reported that each resident stated that the residents did not know where to find information about the nurse staffing each day.On 04/22/2026 during rounds at 1:20 p.m., an interview was conducted with an alert resident sitting in the hallway who stated he did not know how to determine how many staff members were working.On 04 /23/2026 at 12:50 p.m., a visitor was interviewed about the nurse staffing. The visitor stated she did not know where that information was located. The visitor stated that she visited the facility regularly but did not see that information posted.On 04/24/2026, there were no observations of the posting of the daily nurse staffing. On 04/27/2026 at approximately 11:30 a.m., an interview was conducted with the Administrator who stated that he was not sure of where the nurse staffing information was posted. The Administrator stated the surveyor should check with the Assistant Administrator. On 04/27/2026 at approximately 11:31 a.m., an interview was conducted with the Assistant Administrator who stated the nurse staffing information was posted on the bulletin board in the Human Resources Hall. The Assistant Administrator walked with the surveyor to the bulletin board where a copy of the as worked schedule for Monday, April 27, 2026, was posted. The document noted the information was for the 7a-3p shift and the census was 109. The Assistant Administrator walked with the surveyor to the receptionist's desk. The Administrator asked where the nurse posting was located. The receptionist stated it was usually located on the left lower ledge of the desk. She reached under the desk and presented a new picture frame with a stock photo under the glass. The receptionist stated they were replacing the frame. The Assistant Administrator stated the form should be posted and have name of the facility, the shift, nursing positions and the census number. The Assistant Administrator stated she did not know if the facility kept copies of the postings for 18 months.On 04/27/2026 at 11:35 a.m., an interview was conducted with the staffing coordinator who stated she usually posted the nurse staffing each day. She stated that the copies of previous postings were available but she did not know if she had them for the past 18 months. Copies were requested and received at 1:10 p.m.Review of the postings presented by the staffing coordinator revealed documentation from August 25, 2025, to March 5, 2026. There was a total of 48 sheets of paper presented for that seven-month period. Numerous dates were missing. Some of the dates had missing information including: no documentation of the daily census and several dates had blanks under the Registered Nurse time slots on the 3-11 shift, along with a few blanks on the 11-7 shift. The facility's policy stated facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents.During the end of day debriefing on 04/27/2026, the Administrator, Assistant Administrator and Director of Nursing were informed of the findings that the nurse staffing information was not posted on several dates and not readily accessible to all residents, staff and visitors. They stated that the information should have been posted but it was not. No further information was provided.

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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 and Staff interview the facility staff failed to discard 2 bottles of expired insulin from 2 out of 3 medication carts. The findings included: On [DATE] at approximately 2:05 pm, a medication cart audit was conducted on the [NAME] unit, Front Hall medication Cart with Licensed Practical Nurse (LPN) #7. A bottle of Humulin R, 100 units of insulin, with an open date of [DATE]. LPN #7 said it should have been discarded after 28 days of opening.On [DATE] at approximately 2:27 pm, a medication cart audit was conducted on the Fine Unit, Cart #2, with LPN #8. Upon inspection, 1 bottle of Humulin R insulin with an open date of [DATE] was observed. LPN #8 said that it should have been discarded 28 days from the open date. LPN #8 also said that I have to get rid of it, it's no good.On [DATE] at 1:45 pm., a final interview was conducted with the Administrator, Assistant Administrator, Director of Nursing (DON), Regional Nurse Consultant, and Regional Minimum Data Set Consultant. No further information was provided

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on staff interview and facility documentation review, the facility staff failed to ensure QAPI (Quality Assurance Performance Improvement) meetings were conducted quarterly for 3 of 4 quarters sampled.The Findings included:Throughout the survey conducted 04/21/2026 - 04/28/2026, the survey team inspected and investigated the facility's systems and processes regarding correcting previously cited deficiencies and resident care concerns. It was noted the facility had failures and remained out of compliance in areas that had previously been cited as deficient during previous abbreviated surveys. The Maintenance logs and Pest control logs were reviewed by the survey team. There were issues identified.Review of the Resident Council minutes and Grievance logs revealed the facility's administration was aware of issues/concerns voiced by residents and families. The issues continued for several months without resolution.On 04/23/2026 at approximately 3:20 p.m., an interview was conducted with the Administrator who stated the facility was making improvements and renovations in the facility. He stated it was important for the facility to have a clean, comfortable homelike environment for the residents.Substandard quality of care was identified at the facility during the survey resulting in an extended survey from 04/24/2026-04/28/2026.During the end of day debriefing on 04/24/2026, the Facility Administrator, the Regional [NAME] President of Operations, Assistant Administrator, Regional Nurse Consultants and Director of Nursing were informed of the findings of the substandard quality of care that were identified by the survey team resulting in an extended survey task to be completed by the survey team. On 04/27/2026 at 4:01 p.m., an interview was conducted with the Assistant Administrator who stated she did not have any information about QAPI prior to January 2026. She stated the current administrative staff could not find documentation of any QAPI activities from the previous administrator. The Assistant Administrator stated the facility was expected to meet monthly to discuss Quality Assurance and quarterly for the QAPI meetings. She stated there was no current Performance Improvement Project being conducted. Review of four quarters revealed no documentation for last three quarters in 2025 . The only documentation was in the first quarter of 2026.During the extended survey, investigations, it was determined that the facility did not have an effective training program. The facility failed to maintain an effective training program regarding required training for employees regarding topics including but not limited to: QAPI, effective communication and behavioral health.During the end of day debriefings on 04/27/2026 and 04/28/2026, the Facility's Administrator, Assistant Administrator, Regional Nurse Consultant and Director of Nursing were informed of the findings. The governing body should have been made aware of the issues identified by the survey team. There was no documentation of the governing body being aware of and/or acting on the issues identified. The Administrator stated he would address the issues identified.No further information was provided.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview the facility's staff failed to have a functional emergency call system (Emergency Pull cord) available for a resident who ambulates to the bathroom frequently For 1 of 63 residents (Resident #16), in the survey Resident #16 was originally admitted to the facility on [DATE] after an acute care hospital stay and re-admitted on [DATE]. The current diagnoses included: Type 2 Diabetes without complications and Alzheimer's Disease. The quarterly revision Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 1/13/26, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated that Resident #16's cognitive abilities for daily decision-making were severely impaired.In section GG (Functional Abilities Goals), the resident was coded as requiring set-up or cleanup assistance with oral hygiene, upper- and lower-body dressing, and eating. The resident requires supervision or touching assistance with toileting hygiene, putting on and taking off footwear, and personal hygiene. Requires partial-to-moderate assistance with showering/bathing self. The person-centered care plan, revised 1/28/26, states that the resident has a communication problem r/t Dementia and that her primary language is Spanish, although she understands and speaks some English. A Goal for the resident was to make basic needs known daily. The interventions for the resident included: Allow adequate time to respond, Repeat as necessary, Do not rush, Request clarification from the resident to ensure understanding, Face when speaking, make eye contact, Turn off TV/radio to reduce environmental noise, ask yes/no questions if appropriate, Use simple, brief, consistent words/cues, Use alternative communication tools as needed, resident prefers to communicate in Spanish, Discuss with resident/family concerns or feelings regarding communication difficulty, monitor effectiveness of communication strategies and assistive devices, monitor/document for physical/ nonverbal indicators of discomfort or distress, and follow-up as needed, monitor/document residents ability to express and comprehend language, memory, reasoning ability, problem solving ability and ability to attend, monitor/document/report PRN any changes in: Ability to communicate, Potential contributing factors for communication problems, potential for improvement, provide translator as necessary to communicate with the resident.On 4/21/26 at approximately 11:53 pm, an initial tour of the bathroom shared by rooms [ROOM NUMBERS] was conducted on unit 1. The emergency pull alarm, located in the bathroom, appeared non-functional (it wouldn't light up or be heard at the nurses' station). Resident #16, located in room [ROOM NUMBER]A, was observed throughout the survey ambulating independently to the restroom, which has a non-operable emergency call system.On 4/24/26 at approximately 10:15 am, the emergency pull cord was checked to see if it was in operation. The emergency cord was pulled, but it didn't send an alert to the call enunciator located at the nurse's station. Certified Nurse's assistant (CNA) #3 was asked whether he could tell whether the emergency pull-cord alarm sent an alert while at the nurse's station. CNA #3 said he wasn't aware.The above information was shared with the facility staff on 4/24/26 at approximately 1:00 pm. No information was given at this time.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility staff failed to maintain an effective pest control program. Residents during the group meeting with the inspectors that represented all three nursing units, were in consensus that roaches were identified in their rooms.The findings included: On 4/22/26 at 11:00 AM, a Resident Council meeting was held with the President and four other residents who regularly attend the group meeting. All attendees agreed that the facility was not a safe, clean, comfortable, and homelike environment. 1. Resident #22 was admitted to the facility on [DATE]. The residents' diagnoses included high blood pressure and asthma. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 3/20/2026, was coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 15 out of 15. This indicated that Resident # 22's cognitive abilities for daily decision-making were intact.On 4/22/26 at approximately 11:17 AM, an interview was conducted with Resident #22. Resident #22 stated that there are large flying roaches in the facility, and the shower room is unclean. She stated that she thought they at times landed on her bed and questioned whether she should avoid showering.2. Resident #27 was admitted to the facility on [DATE]. The residents' diagnoses included diabetes and depression. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 3/7/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 0 out of 15. This indicated that Resident # 27's cognitive abilities for daily decision-making were severely impaired. Although Resident #27's BIMS score is low, staff interviews and resident statements validated that she is alert and oriented times 4.On 4/22/26 at approximately 11:22 AM, an interview was conducted with Resident #27. Resident #27 stated that there are flying roaches in the facility during the day and at night, and that they have worsened since construction began.3. Resident #43 was admitted to the facility on [DATE]. The residents' diagnoses included protein-calorie malnutrition and COPD. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 3/12/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 15 out of 15. This indicated that Resident #43's cognitive abilities for daily decision-making were intact.On 4/22/26 at approximately 11:32 AM, an interview was conducted with Resident #43. Resident #43 stated that the roaches crawl on the ceilings and walls, making it difficult to sleep. The resident also stated that they had not seen pest control treat their room for the roaches.4. Resident #108 was admitted to the facility on [DATE]. The residents' diagnosis included a non-pressure chronic ulcer, left calf, and osteoarthritis. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 4/17/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 15 out of 15. This indicated that Resident #108's cognitive abilities for daily decision-making were intact.On 4/22/26 at approximately 11:37 AM, an interview was conducted with Resident #108. Resident #108 stated that roaches are seen throughout the facility and that sightings have not improved.5. On 4/23/2026 at 2:15 p.m., a visitor in the dining room was asked about the facility. She stated that she was glad to see renovations, but wished they would do something in the old section. The visitor also stated she had seen roaches in the building.6. Resident # 109 was in the room in her wheelchair. Resident # 109 was alert, oriented (with a BIMS score of 14, indicating no cognitive impairment), and wheeled herself around the room and in the bathroom. Regarding wires that were not secure in the wiring duct raceway strip, the Maintenance Director stated, I will have to replace this-no one told me. Resident # 109 said, That is not true, y'all know about all of this stuff. Let's not talk about the roaches in my room and bathroom. The surveyor went into the bathroom, and there were four roaches on the floor: two dead and two alive (on their backs, wiggling). The Maintenance Director did not pick them up, did nothing. Observed two roach houses in the room: one under the basin and one in the corner. The Maintenance Director saw the plastic container under the toilet's on/off valve, which had accumulated water up to about two inches from the top. He stated, I did not know about (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	this, but this bathroom floods, as to why that is there. It probably attracts the roaches, too. On 04/23/2026 at 3:30 p.m., rounds were conducted with the housekeeper to review the observations. Resident # 109 said that she had told housekeeping about how dirty her room was and that the roaches crawl and fly around her room and bathroom. The surveyor and housekeeper went into the bathroom and observed roaches on the floor. The housekeeper picked them up and flushed them down the toilet. Resident # 109 was a [AGE] year-old admitted to the facility on [DATE]. Diagnoses included cerebral infarction and hemiplegia. The most recent Minimum Data Set (MDS) was an admission assessment with an Assessment Reference Date (ARD) of 03/23/2026. Resident # 109's BIMS (Brief Interview for Mental Status) Score was 14 out of 15, indicating no cognitive impairment7. The following observations were made on Unit 1, [NAME] Hall:room [ROOM NUMBER]: On 4/21/26 at approximately 12:30 pm., during the initial tour of room [ROOM NUMBER], the residents were observed lying in their beds. The resident in bed 217 A, located near the door, said, There is a wasp nest by the window. Resident #99 in bed 217 B, located near the window, said, When they sting me, I swell up. Upon visual observation of the window located between the screen window and the glass, there were 2 wasp nests. One nest was located high in the corner, resting between the bricks and screen, with what appeared to have about ten (10) round, greyish, whitish, circular, egg-looking sacs. The other cells in the same nest, which were many, appeared empty with a hexagonal-like appearance. The second nest was located high above the screen. The second nest appeared much smaller than the first nest. A live wasp was observed sitting on top of one of the empty cells. No eggs were observed in the second nest. There was about 1/4 inch gap between the outside screen and the window leading to the sill in the resident's room. Observed at the bottom of the 1/4 gap or opening appeared to be a dead wasp; air could be felt coming from the outside. Resident #99 and Resident #12 agreed they don't want to get stung, that the nest has been up there for about 3 weeks, and that the staff is aware.On 4/23/2026, during the end-of-day debriefing, the Administrator, Assistant Administrator, Director of Nursing, Regional Nurse Consultant, and Regional [NAME] President were informed of the findings. They were informed that the gap at the threshold from the hallway door to the courtyard could be a point of entry for insects and roaches. There were many resident complaints about roaches. Surveyors observed roaches in the facility. It was noted that the facility's contracted pest control company services were not completed in January and February due to a lapse in vendor payment processing. The pest control logs had been destroyed by the Maintenance Director across all units, leaving them blank and failing to reflect the pest sightings residents complained about, namely, roaches. The wasp nests in room [ROOM NUMBER] were a current issue brought to the facility's attention by the survey team, not entered into the unit's pest control log.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on staff interview and facility documentation review, the facility staff failed to develop, implement, and maintain an effective training program for all staff, including training on Communication for 5 (RN #2, RN # 3, LPN # 7, CNA # 6, CNA #7) of 5 staff records reviewed. Registered Nurse (RN), Licensed Practical Nurses (LPN) and Certified Nursing Assistant (CNA) The Findings included:Substandard Quality of Care was identified by the survey team on resulting in extended survey from 04/24/2026-04/28/2026.During the end of day debriefing on 04/24/2026, the Facility Administrator, the Regional [NAME] President of Operations, Assistant Administrator, Regional Nurse Consultants and Director of Nursing were informed of the findings of the substandard quality of care that were identified by the survey team resulting in an extended survey task to be completed by the survey team. On 04/28/2026 at 10:12 a.m., an interview was conducted with the Staff Development Coordinator in her office. The Staff Development Coordinator was asked about the training schedules and to provide documentation of the staff training. The Staff Development Coordinator stated she did not have any evidence of behavioral health training being provided to all staff. She stated some of the staff members received training on the computer. The Staff Development Coordinator was asked for a list of employees to include Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nursing Assistants (CNAs) and other disciplines.Review of the educational records of 5 nursing staff members (RN #2, RN # 3, LPN # 7, CNA # 6, CNA #7) revealed no documentation of training on behavioral health care. Staff members were asked during the survey if they had received training on communication. All responded they did not have any training on communication with a Spanish speaking resident. They stated the family of the resident would help to translate and that the Assistant Director of Nursing spoke Spanish.The training sample of 5 employees included Registered Nurse (RN), Licensed Practical Nurses (LPN) and Certified Nursing Assistants (CNA).The training records for RN #2, RN # 3, LPN # 7, CNA # 6, CNA #7 were reviewed. None of the records had documentation of education on Communication with a Spanish speaking resident.The Staff Development Coordinator stated she did not have documentation of any employees receiving training on communication with a Spanish speaking resident. There were no communication tools noted in the Spanish Speaking resident's room. There was no noted process developed and implemented by staff on how to communicate with the Spanish Speaking Resident. During the extended survey investigations, it was determined that the facility did not have an effective training program. The facility failed to maintain an effective training program regarding required training for employees regarding topics including but not limited to communication.On 04/28/2026 during the end of day debriefings, the Administrator., Assistant Administrator, Regional Nurse Consultant and Director of Nursing were made aware of the findings. They stated that all staff should receive required training including training on communication. They stated the education/training documents were maintained by the Staff Development Coordinator.No further information was provided.

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interviews, staff interviews, and clinical record reviews, the facility staff failed to ensure language interpreter services were available to allow effective communication for a Spanish-speaking resident for for 1 resident of 63 residents (Resident #16) in the survey sample. The findings include:Resident #16 was originally admitted to the facility on [DATE] after an acute care hospital stay and re-admitted on [DATE]. The current diagnoses included: Type 2 Diabetes without complications and Alzheimer's Disease. The quarterly revision Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 1/13/26, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated that Resident #16's cognitive abilities for daily decision-making were severely impaired. In section GG (Functional Abilities Goals), the resident was coded as requiring set-up or cleanup assistance with oral hygiene, upper- and lower-body dressing, and eating. The resident requires supervision or touching assistance with toileting hygiene, putting on and taking off footwear, and personal hygiene. Requires partial-to-moderate assistance with showering/bathing self. The person-centered care plan, revised 1/28/26, states that the resident has a communication problem r/t Dementia and that her primary language is Spanish, although she understands and speaks some English. A Goal for the resident was to make basic needs known daily. The interventions for the resident included: Allow adequate time to respond, Repeat as necessary, Do not rush, Request clarification from the resident to ensure understanding, Face when speaking, make eye contact, Turn off TV/radio to reduce environmental noise, ask yes/no questions if appropriate, Use simple, brief, consistent words/cues, Use alternative communication tools as needed, resident prefers to communicate in Spanish, Discuss with resident/family concerns or feelings regarding communication difficulty, monitor effectiveness of communication strategies and assistive devices, monitor/document for physical/ nonverbal indicators of discomfort or distress, and follow-up as needed, monitor/document residents ability to express and comprehend language, memory, reasoning ability, problem solving ability and ability to attend, monitor/document/report PRN any changes in: Ability to communicate, Potential contributing factors for communication problems, potential for improvement, provide translator as necessary to communicate with the resident. A review of the resident's History and Physical (H&P) read Resident has a language barrier. Assistance with one of two nurses, with one able to speak Spanish. On 4/28/26 at approximately 12:45 pm., a brief interview was conducted with the Director of Nursing (DON). The DON said that an interpretation document is kept at the nurse's station on the resident's unit. Various interviews were conducted with staff on the [NAME] unit:On 4/28/26 at approximately 1:00 pm, an interview was conducted with Certified Nursing Assistant (CNA) #4, who said she's caring for Resident #16 but is not aware of any facility interpreter services. On 4/28/26 at approximately 1:15 pm., an interview was conducted with CNA #8, who said that he was not aware that there was interpreter services information at the facility. On 04/28/26 at approximately 1:45 p.m., the above findings were shared with the Administrator, Director of Nursing (DON) and Corporate Consultant. The DON said that she will educate the staff concerning interpreter services.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident has the right to receive notices in a format and a language he or she understands. Based on information obtained during the resident group meeting, and a review of facility documents, the facility staff failed to ensure that 5 of 5 residents in the group meeting knew the location of the list of contact names, addresses, and phone numbers of the State agencies, ombudsman and adult protective services.The findings included:On 4/22/26 at 11:00 AM, a Resident Group meeting was held with the Resident Council President and four residents who regularly attend the group. There was a consensus among all attending the meeting that they were unaware of how to contact the relevant agencies, such as the ombudsman, adult protective services, or other state offices. On 4/23/26 at 11:30 AM, an interview was conducted with the Director of Activities. The Activities director stated that residents are educated at every resident council meeting on the ombudsman and where to find the contact information, and that this was documented in the resident council minutes. The activities director stated she would invite the ombudsman to the resident group meeting going forward. On 4/28/26 at approximately 4:45 pm, a final interview was conducted with the Interim Administrator, Director of Nursing, Assistant Director of Nursing, and the Corporate Nurse Consultant. The above findings were conveyed to the administrative team, who made no comments and voiced no concerns.

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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 observations, staff interviews, and a review of facility documentation, the facility staff failed to inform the resident's representative of a change in condition and failed to update the resident representative's phone numbers for 1 of 63 residents (Resident #99) in the survey sample.The findings include: Resident #99 was originally admitted to the facility 3/07/25 after an acute care hospital stay and re-admitted on [DATE]. The current diagnoses included; Allergic Rhinitis and Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease. The annual Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 3/12/26, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated that Resident #99's cognitive abilities for daily decision-making were intact In section GG (Functional Abilities), the resident was coded as dependent in transfers, locomotion, dressing, toileting, personal hygiene, and Shower/bathe self. Eating and oral hygiene were coded as requiring setup help. The person-centered care plan, revised 3/20/26, read that the resident has an Activity of Daily Living self-care performance deficit relating to impaired balance, weakness, and shortness of breath (SOB) with exertion. The Goal was for the resident to maintain her same level of functioning with ADLs. The interventions for the resident include Bathing/Showering: Check nail length and trim and clean on bath day, and as necessary. Report any changes to the nurse. The resident requires extensive assistance by (1) staff with (SPECIFY bathing/showering) (SPECIFY FREQ) and as necessary. A review of a physician's progress note dated 4/21/26 at 9:45 a.m., read that the resident was seen for acute visit for hypoxemia with low oxygen saturation to 70-80s and chills. She has a significant medical history of morbid obesity, hypo-ventilatory syndrome, functional quadriparesis, bedbound, chronic respiratory failure with oxygen dependence, COPD, hypertension, CAD, chronic pain syndrome, GERD, asthma, anemia, and neuropathy. Patient experienced acute hypoxemia with oxygen saturation dropping to the 70s-80s along with chills. Coordinated Duo Neb treatment x2 with the nurse, after which oxygen saturation improved to 89%. Chills subsided after increasing the room temperature. Vitals remained stable, and the patient was afebrile. She denies congestion, cough, shortness of breath, chest pain, nausea, vomiting, diarrhea, or constipation today. The swab for COVID-19, flu, and RSV was negative. Will order CBC, CMP, and CXR to further evaluate hypoxemia and chills. A review of the facility face sheet revealed the following: The Emergency Contact #1 listed Family Member (FM) #2 as being the emergency contact #1 and Power of Attorney (POA). The Emergency contact listed FM #3 as being the second contact. On 4/21/26 at approximately 12:30 pm, during the initial tour, Resident #99 was observed resting in bed with the covers pulled up; the room felt very warm. The resident said she wasn't feeling good today. On 4/21/26 at approximately 7:40 pm, a phone call was made to the residents' Family Member #2 (power of attorney (POA) and emergency contact #1). A voice message was left. On 4/21/26 at approximately 7:42 pm, a phone call was made to FM #2. A voice message could not be left. On 4/22/26 at approximately 4:40 pm, a phone call was made to the resident's FM #3 (emergency contact #2) concerning the resident's change in condition. Phone number not working. On 4/22/26 at approximately 4:50 pm, a phone number was provided for FM #3 by the resident. On 4/22/26 at approximately 4:53 pm, a telephone call was made to FM #3 (Emergency Contact #2). FM #3 was asked if she had received a phone call from the facility staff concerning Resident #99's change in condition. FM #3 stated that she did not receive a call from anyone yesterday (4/21/26). A review of the resident's medical record did not reveal that FM #2 nor FM #3 were notified or attempted to be notified on 4/21/26 of the resident's change in condition. On 4/22/26 at approximately 5:55 pm, an end-of-day meeting was conducted with the facility staff. The Director of Nursing (DON) was asked about Resident #99, who was notified yesterday (4/21/26) regarding her change in condition. The DON said she was not informed of the CIC involving the (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident, but that the resident is her own responsible party (RP). The Policy revised date: 12/01/22 read: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, resident's representative when there is a change requiring notification. Examples of Clinical Complications: Recurrent episodes of delirium, UTI's, or onset of depression. Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: Significant change in the resident's physical, mental, or psychosocial condition, such as deterioration in health, mental, or psychosocial status; life-threatening conditions or Clinical complications. Competent Individuals: The facility must still contact the resident's physician and notify the resident's representative if known. Contact information of the resident's legal representative or family must be recorded and periodically updated. On 4/23/26 at approximately 10:44 am, a brief interview was conducted with the DON concerning a change of condition (CIC) involving Resident #99. The DON said that the provider tried to call the son but couldn't reach him. The DON also said there was no note in the medical record indicating the son was contacted on 4/21/26 during the CIC. On 4/28/26 at 1:45 pm., a final interview was conducted with the Administrator, Assistant Administrator, Director of Nursing (DON), Regional Nurse Consultant, and Regional Minimum Data Set Consultant. No further information was provided.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, it was determined that facility staff failed to ensure a grievance was filed on missing items for 1 of 63 residents in the survey sample, Resident #12. The finings included: Resident #12 was originally admitted to the facility 2/14/25 after an acute care hospital stay and re-admitted on [DATE]. The current diagnoses included; Malignant Neoplasm of the colon. The annual Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 02/17/26, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated that Resident #12's cognitive abilities for daily decision making were moderately impaired. On 04/22/2026 at 12:30 pm, during the initial tour, Resident #12 said she's been missing 2 cases of cranberry juice, 1 case of Ensure Clear, bodywash, perfume, baby powder, bifocals (wearing new glasses now). I reported it to everyone, the Director of Nursing (DON) and Nurse's Aides. It's been 4 months. On 04/28/2026 at approximately 1:35 pm, the Social Worker presented a grievance document stating that she was not aware of the missing items until today. A review of a Grievance/Complaint form dated 4/21/26 read: Resident stated missing 2 boxes of Ensure. The resident will be reimbursed for 2 boxes of clear Ensure. On 4/28/26 at 1:45 pm., a final interview was conducted with the Administrator, Assistant Administrator, Director of Nursing (DON), Regional Nurse Consultant, and Regional Minimum Data Set Consultant. No further information was provided.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility's staff failed to ensure that 1 of 63 residents (Resident #11) did not have as needed Lorazepam ordered for use for greater than 14 days. The findings included: Resident #11 was admitted to the facility on [DATE]. The residents' current diagnoses included a stroke with aphasia and anxiety. The Significant Change Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 2/24/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 4 out of 15. This indicated that Resident # 11's cognitive abilities for daily decision-making were severely impaired.A review of the resident's physician order summary revealed an order dated 4/06/2026 for Lorazepam Tablet 0.5 MG; give 0.5 mg via G-Tube every 4 hours as needed for anxiety. The order lacked a stop date, and in the clinical record, there was no documentation by the physician and/or prescribing practitioner that the resident had been evaluated regarding the appropriateness of continuous as needed use of Lorazepam. As of 4/28/26, the resident had been continuously prescribed the medication for 22 days.The resident had a care plan dated 01/19/2026, which stated that the resident uses anti-anxiety medications. The goal stated that the resident will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. The interventions included observe, document, and report any adverse reactions to anti-anxiety therapy: drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Unexpected side effects are mania, hostility, rage, aggressive or impulsive behavior, and hallucination.On 4/28/26 at 3:30 PM, a final interview was conducted with the Administrator, Assistant Administrator, Director of Nursing (DON), Regional Nurse Consultant, and Regional Minimum Data Set Consultant. The DON stated that the medication should have been re-evaluated for continuous use, or the prescriber should have documented the ongoing necessity.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, facility document review, and resident interviews, it was determined that facility staff failed to report an allegation of abuse to the appropriate state agencies for 1 of 63 residents in the survey sample, Resident #12. The findings included: Resident #12 was originally admitted to the facility on [DATE] after an acute care hospital stay and re-admitted on [DATE]. The current diagnoses included: malignant neoplasm of the colon. The annual Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 02/17/26, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated that Resident #12's cognitive abilities for daily decision making were moderately impaired. On 04/22/2026 at 12:30 pm, during the initial tour, Resident #12 said that she had informed the Veterans Administration staff that she had almost fallen out of bed but was shoved back into bed by staff. The resident said that she has not experienced such treatment since then and feels safe. A review of the Facility-related Synopsis dated 9/03/25 with an incident date of 8/28/25 indicated that Resident #12 did have an incident and was shoved twice by two staff members while getting her back in bed. The names of the employees involved were unknown. The report was sent to various state agencies on 9/03/28. The conclusion: The resident couldn't provide specific dates or times of the incident that allegedly occurred. The report states that the resident felt safe in the facility. The allegation of abuse was unfounded. Current staff were interviewed and stated they were not aware of the incident. According to the Facility Related Synopsis, the incident occurred on 8/28/25 but was reported on 9/03/25. The report was filed 5 days after the alleged incident. On 4/28/26 at 1:45 pm., a final interview was conducted with the Administrator, Assistant Administrator, Director of Nursing (DON), Regional Nurse Consultant, and Regional Minimum Data Set Consultant. No further information was provided.

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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 family and staff interviews and a review of the clinical record, the facility staff failed to provide discharge information for 2 of 63 residents in the survey sample (Residents #114 and #120). The findings included: 1. For Resident# 114, the facility failed to provide any discharge instructions to the resident at the time of discharge AMA (against medical advice.) Resident # 114 was admitted to the facility on [DATE] with the diagnoses of but not limited to: sepsis, hypertension, diabetes, pneumonia and Chronic Obstructive Pulmonary Disease. It was too soon for the completion of an Minimum Data Set (MDS) assessment because Resident left within 3 days of admission. There was documentation that coding of Resident #114's BIMS (Brief Interview for Mental Status) Score was 12 out of 15, indicating moderate cognitive impairment. Review of the clinical record was conducted on 04/24/2026-04/28/2026. Review of the clinical record revealed that Resident # 114 left the facility against medical advice (AMA) on 03/09/2026. Review of the Facility policy titled Transfer and Discharge (including AMA) dated 11/01/2020, reviewed/revised 12/01/2022 revealed the statement that it was the policy to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility except in limited situations when the health and safety of the individual or other residents are endangered. Under 8. Discharge Against Medical Advice (AMA), there were three bullet points that included a) The resident and family should be informed of the risks and benefits of staying in the facility, and the alternatives to both. b) documentation of notification should be entered in the nurses notes by the nursing department. The social services designee should document any discussions held with the resident/family in the social services progress notes, if present. c) Notify Adult Protection Services or other entity, as appropriate if self-neglect is suspected. Document accordingly. Under 9. Anticipated Transfers or Discharges-initiated by the resident, it was written that a discharge summary would be completed by the nurse and included in the recap of the resident's stay that include diagnoses, course of illness/treatment or therapy, pertinent lab, radiology and consultation results, a final summary of the resident's status, reconciliation of all pre-discharge medications with the pos-discharge medications (both prescribed and over the counter) and a post discharge plan of care that is developed with the participation of the resident, and the resident's representative (s) which will assist the resident to adjust to his or her new living environment. The nursing progress note written on 03/09/2026 at18:01 (6:01 p.m.) stated Resident # 114 left with his daughter. Signed AMA paperwork understood leaving AMA. Resident stable and no signs of distress noted. There was no documentation of any paperwork being given to the resident at (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharge. On 04/27/2026 at 2:45 p.m., an interview was conducted with the Discharge planner who stated the nursing staff would provide the discharge summary for the resident at the time of the discharge, On 04/27/2026 at 3:20 p.m., an interview was conducted with the Director of Nursing who stated that discharge summaries were provided to residents with planned discharges. The Director of Nursing stated that when residents leave against medical advice, no information is given to them. The Director of Nursing stated no recapitulation of the stay would be given to the residents at the time of discharge if they sign out AMA. When asked if this was punitive, the Director of Nursing stated that the facility's policy was for discharge summaries to be given to residents with anticipated transfers or discharges but not to those discharging against medical advice. On 04/27/2026 during the end of day debriefing, the Administrator, Assistant Administrator, Director of Nursing and Regional Nurse Consultant were informed of the findings that the facility made no effort to assist Resident # 114 to adjust to the new living arrangement because of signing out AMA. No further information was provided. 2. The facility staff failed to ensure the admitting facility received the necessary admissions documents. Resident #120 was originally admitted to the facility on [DATE] and discharged on 2/28/26 after an acute care hospital stay. The current diagnoses included: Displaced intertrochanteric fracture of the left Femur. The 5-day Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 2/16/26, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated that Resident #120's cognitive abilities for daily decision making were intact. In section GG (Functional Abilities Goals), the resident was coded as requiring supervision or touch assistance with sit-to-lie, lie-to-sit on the edge of the bed, and sit-to-stand. Coded as requiring moderate assistance with chair/ bed to chair transfer, toilet transfer, and coded as requiring setup assistance with roll to left or right. Coded as requiring partial to moderate assistance with toileting hygiene, shower/bathe self, lower body dressing, and putting on and taking off footwear. Coded as requiring set-up or clean-up assistance with eating and oral hygiene. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 2/27/24, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated that Resident #6's cognitive abilities for daily decision making were moderately impaired. In section GG (Functional Abilities Goal), the resident was coded as requiring supervision with eating, oral hygiene, and hygiene, requiring substantial/maximal assistance with toileting and showering/bathing. A review of progress notes dated 2/28/26 read: 11:20 am, son arrives to take Resident back home. Resident son is here to take her back home. Called (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Unit Manager (UM) left a message due to no discharge orders in chart. Called a spoke with on - call supervisor re: discharge. await call back 11:38 am, spoke with on call supervisor, gave the go ahead to discharge resident back with son to facility. The On call instructed to give resident son the non-narcotic medication. 12:09 pm, Resident discharge home with son. via wheelchair. all belongings were given to resident/son. The on-call supervisor instructed me to give non-narcotic medication to resident/son due to not having signed prescriptions. No signs of distress noted. A review of the discharge summary revealed that vital signs were completed on the day of discharge (2/28/26) at 9:39 am. The final disposition read that the resident was discharged to assisted living and left via wheelchair, accompanied by family. The reason for discharge was improvement in condition. The discharge summary was signed and dated by the Registered Nurse. No signatures were provided by the resident or her family member. On 4/23/26 at approximately 5:00 pm, an interview was conducted with Registered Nurse (RN) #3 concerning Resident #120. RN #3 said the resident was discharged with a walker, non-narcotic medications, and no wound care needed because the area on her hip was closed. RN #3 also said they had an eight-hour drive to make. On 4/23/26 at approximately 8:00 pm., a phone interview was conducted with the complainant. The complainant said the Physical Therapist stated that the resident was doing well in therapy and would be ready for discharge on [DATE]. The Complainant also said that discharge papers weren't sent because the resident went AMA. On 4/28/26 at approximately 9:45 am, an interview was conducted with the Admissions Director (AD). The AD said that she brought the resident to the facility through admissions. The AD said, I remember when she left. Her son took her. We didn't know she was leaving. There was no discharge date for the resident. On 4/28/26 at approximately 9:50 am, an interview was conducted with the Business Office Manager (BOM). The BOM said that the resident went AMA, We called her Veterans Administration (VA) caseworker to inform her of the AMA. On 4/28/26, an interview was conducted with Certified Nursing Assistant (CNA) #3. CNA #3 said he helped her pack her belongings on the day that she left. On 4/28/26 at approximately 10:30 am, a phone interview was conducted with the Admissions Director (AD) at the admitting facility. The AD said that she received only a face sheet and a PASRR (Pre-admission Screening and Resident Review) from the discharging facility. The AD also said the facility reported she left AMA, so they weren't going to send the paperwork. The AD said that the family was really stressed out. The resident had to stay in a hotel from 2/28/26 to 3/04/26. I was informed by the VA not to admit the resident unless I received the paperwork from the discharging facility. The AD said they didn't receive any other documents. No H&P, no clinical notes, no medication list. I got in trouble because I admitted her on 3/06/26. On 4/28/26 at approximately 2:25 pm, an interview was conducted with the Director of Nursing (DON). The DON said the resident left Against Medical Advice (AMA). The DON also said that the Power of Attorney (POA) would have to request a form to send medical records to the other facility.

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	495241	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thalia Gardens Rehabilitation and Nursing	4142 Bonney Road Virginia Beach, VA 23452

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the clinical record and staff interviews, the facility staff failed to ensure that the Minimum Data Set (MDS) assessment was accurately completed for 1 of 63 residents (Resident #39) in the survey sample. The findings included: Resident #39 was admitted to the facility on [DATE]. The resident's current diagnoses included liver cirrhosis, diabetes, and status post right foot trans metatarsal amputation. The admission MDS assessment, with an assessment reference date (ARD) of 4/6/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 15 out of 15. This indicated that Resident # 39's cognitive abilities for daily decision-making were intact. In section N0415. High-Risk Drug Classes: Use and Indication, the resident was coded as taking an anticoagulant, and the indication for use was documented. A review of the resident's Physician's Order Summary (POS) failed to reveal an order for an anticoagulant. A review of the resident's care plan also failed to identify the resident's use of an anticoagulant. A further review of the physician's progress note dated 4/7/2026 revealed that the medication was not documented. An interview was conducted with the MDS Coordinator on 4/24/26 at approximately 11:50 AM. The MDS Coordinator stated that, after reviewing the clinical record, the MDS for the 4/6/2026 admission was not coded accurately. The MDS Coordinator also stated that, because the resident had not been taking an anticoagulant, the MDS assessment would be corrected accordingly. On 4/28/26 at 3:30 PM, a final interview was conducted with the Administrator, Assistant Administrator, Director of Nursing (DON), Regional Nurse Consultant, and Regional Minimum Data Set Consultant. The Regional Minimum Data Set Consultant stated that the correction to the MDS had been made.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility's staff failed to ensure that 1 of 63 residents (Resident #11), who were unable to perform activities of daily living (ADL), received all necessary services.The findings included:Resident #11 was admitted to the facility on [DATE]. The residents' current diagnoses included a stroke with aphasia and anxiety. The Significant Change Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 2/24/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 4 out of 15. This indicated that Resident # 11's cognitive abilities for daily decision-making were severely impaired. In section GG0130 (Functional Abilities), the resident was coded as dependent with all ADL care. On 4/21/26 at approximately 2:40 PM, the resident was observed asleep in bed. The resident's fingernails were observed to be approximately 1.75 inches beyond the tips of the fingers, and they were discolored. Observations were also made of scratches to the resident's thighs and the right arm. An interview was conducted with Certified Nursing Assistant (CNA) #1 on 4/24/26. CNA #1 stated it was an oversight, and the resident's nails would be manicured. On 4/28/26 at 3:30 PM, a final interview was conducted with the Administrator, Assistant Administrator, Director of Nursing (DON), Regional Nurse Consultant, and Regional Minimum Data Set Consultant. The DON stated that the resident's nails had been cut and cleaned, and that this was necessary for the resident's safety and infection control.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, and clinical record review, the facility staff failed to follow the physician's order for the oxygen flow rate for 1 of 63 residents (Resident # 99) in the survey sample. The findings included: Resident #99 was originally admitted to the facility on [DATE] after an acute care hospital stay and re-admitted on [DATE]. The current diagnoses included: allergic Rhinitis and Type 2 Diabetes Mellitus with diabetic chronic kidney disease, morbid obesity, hypoventilatory syndrome, functional quadriparesis, bedbound, chronic respiratory failure with oxygen dependence, COPD, hypertension, CAD, chronic pain syndrome, GERD, asthma, anemia, and neuropathy. The annual Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 3/12/26, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated that Resident #99's cognitive abilities for daily decision-making were intact In sectionGG(Functional Abilities), the resident was coded as dependent with transfers, locomotion, dressing, toileting, personal hygiene, and Shower/bathe self, coded as requiring setup help with eating and oral hygiene. The person-centered care plan, revised 3/20/26, read that the resident has an Activity of Daily Living self-care performance deficit relating to impaired balance, weakness, and shortness of breath (SOB) with exertion. The Goal was for the resident to maintain her same level of functioning with ADLs. The interventions for the resident include Bathing/Showering: Check nail length and trim and clean on bath day, and as necessary. Report any changes to the nurse. The resident requires extensive assistance by (1) staff, as necessary. The March 2025 Physician Order Summary (POS) noted that Resident #99 receives continuous Oxygen at 3 liters/min via nasal cannula for a COPD diagnosis. Receive every shift, active 05/13/2025.During the initial tour on 4/21/26 at approximately 12:30 pm, Resident #99 was observed lying in bed, oxygen concentrator set to 5 liters per minute via nasal cannula (n/c). The resident said she had trouble breathing earlier this morning.On 4/22/26 at approximately 4:45 pm., a brief observation was made of the oxygen concentrator. The resident was observed lying in bed receiving 5 liters per nasal cannula.On 4/23/26 at approximately 5:10 pm, a brief interview was conducted with Registered Nurse (RN) #4 concerning Resident #99's oxygen flow rate. RN #4 indicated that she would have to verify the physician's orders. RN #4 verified the orders and said that the resident should be receiving 3 liters of 02 but will check the flow rate in the resident's room. RN #4 was informed that the resident's oxygen flow rate was set at 5 liters x 3 days. RN #4 was observed checking the residents' flow rate and saying that she just changed it back to 3 liters.On 4/24/26 at approximately 1:00 pm., the above concern was shared during the end-of-day meeting. In attendance were the Regional VP of Operations, the Regional Dietary Manager, the Director of Nursing, the Administrator in training, and the Regional Maintenance Director. No concerns were voiced, nor was any other information provided.

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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, staff interviews, and a review of the clinical record, the facility staff failed to ensure proper technique was utilized to achieve the ordered dose of medication for 1 of 63 residents (Resident 23) in the survey sample. The findings included: Resident #23 was admitted to the facility on [DATE]. The residents' current diagnoses included cataracts and anxiety. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 4/6/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 9 out of 15. This indicated that Resident #23's cognitive abilities for daily decision-making were moderately impaired. During the medication pass on 4/23/2026 at approximately 7:56 AM, the Assistant Director of Nursing (ADON) brought a single-dose package of Ativan 1 milligram (mg) to the medication cart for Registered Nurse (RN) #4 to administer to Resident #23. RN #4 opened the package and, using gloves, broke the tablet in half; one half was wasted, and the other half was administered to Resident #23. A review of the Physician's order dated 4/23/2026 revealed an order that stated Ativan Tablet 1 mg; Give 0.5 tablet by mouth one time only for anxiety. A nurse's note dated 4/23/2026 at 9:16 AM stated that a one-time order for Ativan 0.5 mg was received from the Nurse Practitioner for Resident #23 because of anxiety. The nurse's note further stated that a one-time authorization was obtained from the pharmacy to remove one Ativan 1 mg tablet from the stat box. The ADON stated that half of the 1 mg tablet was wasted, and the other half (0.5 mg) was administered as ordered.On 4/28/26 at 3:30 PM, a final interview was conducted with the Administrator, Assistant Administrator, Director of Nursing (DON), Regional Nurse Consultant, and Regional Minimum Data Set Consultant. The DON stated that the 1 mg Ativan tablet should not have been broken by hand, as their policy requires the use of a tablet splitter to ensure accuracy and minimize contact with the scored tablet.