

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER Pheasant Ridge Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4355 Pheasant Ridge Road Roanoke, VA 24014	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety 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 staff interview, clinical record review, and facility document review, the facility staff failed to notify the medical provider of a significant change in condition in a timely manner for two (2) of 51 residents in the survey sample, Resident #95 and Resident #6. The facility's failure to recognize, act upon, and report a heart rate of 131 beats per minute to a medical provider for approximately six hours, likely caused and/or hastened the resident's death which occurred one to two hours after being sent out to the hospital with complaints of shortness of breath and chest pain. This resulted in the identification of Immediate Jeopardy for Resident #95. The survey team informed the facility on [DATE] at 3:28 PM of the Immediate Jeopardy situation regarding Resident #95. The scope and severity were originally cited at level IV isolated. On [DATE] at 11:10 AM the Immediate Jeopardy was removed and lowered to a level III isolated. The findings included: 1. For Resident #95, the facility staff failed to recognize, act upon, and report a heart rate of 131 beats per minute to a medical provider for approximately six hours. This likely caused and/or hastened the resident's death which occurred one to two hours after being sent out to the hospital with complaints of shortness of breath and chest pain. The facility policy titled, Notification of Changes with a revised date of [DATE] was reviewed. The document read in part, 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, the resident's representative when there is a change requiring notification. Under the heading Compliance Guidelines the document read in part, 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. Under Circumstances requiring notification include item #2 read, Significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include a. Life threatening conditions, or b. Clinical complications. A policy titled Vital Signs with no review or revised date read in part, The purpose of this policy is to provide guidelines for the measurement and reporting of vital signs. Under item #4 the document read, Acceptable ranges for adults item b. Pulse: 60-100 beats per minute. Resident #95's admission Record indicated the facility admitted the resident on [DATE]. The admission Record included the diagnoses of atrial fibrillation, acute diastolic congestive heart failure, (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	takotsubo syndrome (also known as broken heart syndrome which is a temporary condition where the heart's main pumping chamber, the left ventricle weakens and changes shape. It closely mimics a heart attack.), presence of prosthetic heart valve and bacteremia. Resident #95's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed the resident had no memory impairment and was independent in making reasonable and consistent decisions. The MDS indicated the resident was independent with eating, hygiene and upper body dressing and only required minimal assistance with other tasks of activities of daily living (ADL's). Resident #95 required partial to moderate assistance with getting out of bed and could only walk around 10 feet with partial to moderate assistance. Resident #95's baseline care plan was reviewed, and it indicated that the resident was admitted on intravenous (IV) antibiotics, diuretic and anticoagulant medications, was cognitively intact, always continent of bowel and bladder and had a discharge goal of returning home. A nursing progress note dated [DATE] at 11:40 AM read, Pt [patient] picked up by transport to go to [acute care hospital] at 1140 [11:40 AM]. Pt was tachycardic [rapid heart rate] (135), had new leg swelling, and altered mental status. This nurse informed NP [name omitted] who then evaluated pt. When EMS arrived, PT's O2 was 85%. A [DATE] provider progress note titled Post Acute Care Visit #2 by the Nurse Practitioner (NP) was reviewed and read in part, .evaluated for an acute change in status. [Resident] was found to have atrial fibrillation with a rapid ventricular rate [RVR] and was noted to be dyspneic [short of breath] during conversation. atrial fibrillation and a rapid ventricular response, confirmed by physical exam and bedside 3-lead EKG. This is contributing to clinical presentation of dyspnea and likely hemodynamic instability. The recommendation for urgent transport to the emergency department was made due to the inability to obtain rapid labs to guide resuscitation and determine the degree of strain on her heart Resident #95 was admitted to the hospital on [DATE] and returned to the facility on [DATE]. The hospital Discharge summary dated [DATE] was reviewed and revealed that Resident #95 was admitted with a diagnosis of atrial fibrillation with RVR [rapid ventricular rate] and a heart rate in the 150's. On [DATE] at 11:03 AM a nursing progress note indicated that Resident #95 had a heart rate of 131 beats/minute and a blood pressure of 98/53. Under the heading Cardiovascular the note read, Skin warm and pink with brisk capillary refill (<3 seconds). No edema present. There was no documentation indicating a medical provider was notified of the elevated heart rate or that a nurse further assessed the elevated heart rate. The next clinical record entry dated [DATE] at 6:12 PM, approximately seven hours later, was from an on-call provider who documented in part, Complaint: Shortness of breath, chest pain, not feeling well Provide Current Vital Signs: 114/64 p [pulse] 80 o2 [oxygen saturation] 77 Message: Given one nitro for chest pain. Was slightly better but was sent out to hospital. [DATE], 6:12 PM. There was no indication in the note that the facility nurse had informed the on-call provider of the resident's (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	extensive cardiac history, their hospitalization just days prior when the resident was sent out with a heart rate of 135 or that the resident had a heart rate at 11:03 AM of 131. There was no documentation in Resident #95's clinical record to indicate if the resident remained stable during the seven hours or if they were checked on during the seven-hour period. The next entry in the clinical record was dated [DATE] at 1:01 AM and it read, RSD [resident] expired at [hospital]. TOD [time of death] 2052 [8:52 PM]. Family aware. A document titled, Change in Condition (SBAR)-CHC was dated [DATE] at 5:52 PM. Under the heading Situation it read, not feeling well, SOB (shortness of breath), chest pain. Under the heading Vital Signs the pulse from the 11:03 AM nurse note of 131 was documented as well as the rest of the 11:03 AM vital signs, indicating the nurse never obtained another set of vital signs. It is unclear where the pulse of 80 documented in the on-call provider note at 6:12 PM came from. Under the heading Cardiovascular Evaluation item #2 Chest pain/tightness was checked but item #6 Resting pulse <100 or <50 was not checked. On [DATE] at 9:39 AM, NP (nurse practitioner) #1 was interviewed via telephone. They said they were no longer seeing patients at the facility but remembered Resident #95 well. They stated, It was a Sunday if I'm not mistaken and the nurse had contacted me a few times that day about other residents but never said a word about [Resident #95]. When I got to the building on Monday and was informed about what happened I was shocked. I spoke to [Licensed Practical Nurse/LPN #2] about it. I wanted to know why with a heart rate of 130 and when [resident] had been sent out already just days prior and was in ICU [intensive care unit] and we were aware this was a serious problem for [resident], that required monitoring due to poor compensation, and I had made it clear that [resident] had to be watched closely, I just could not understand why I wasn't called. She [LPN #2] had contacted me within an hour of documenting that heart rate about someone else and never said a word. I would have had [resident] sent out right then if she had just told me. I asked her Monday morning what did you do about this heart rate and she told me it was [resident's] baseline and she didn't do anything. I told her you do know that she died, right? We had seven hours to intervene and do something, but she [LPN #2] just shrugged and walked away. I tried to talk to [the Director of Nursing/DON] about her [LPN #2] and all she said was I know, we've had the same problem with her before and we've talked to her, but some people just don't learn. I tried to bring the concern to the Administrator as well, many concerns but I never received a response other than we're working on it. This death could have been prevented. [Resident] died just an hour or two after getting to the hospital because [resident] was not sent out timely. On [DATE] at 10:57 AM LPN #2 was interviewed. When asked what they did for Resident #95 when they got the heart rate of 131 they stated, The C.N.A. [certified nursing assistant] got the vital signs and gave them to me and when I saw that pulse I immediately went back and checked [resident] out. I got 87 when I checked it and [resident] was fine, [resident] didn't have any complaints or anything, there were no other symptoms, so I didn't do anything. It wasn't until that evening when the C.N.A. was transferring [resident] to bed that [resident] complained about being short of breath and heart racing, so I assessed [resident] and the heart rate was quite quick and the o2 sat was low, so I sent [resident] out. When asked why she didn't document that she went and rechecked the heart rate that morning, she stated, It was a crazy day, and we had a lot going on. When asked where the on-call (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	provider got the heart rate of 80 LPN #2 could not recall a pulse of 80 and was not sure where it came from. On [DATE] at 3:28 PM, the survey team notified the Administrator and Assistant Director of Nursing (ADON) of the Immediate Jeopardy situation involving Resident #95. On [DATE] at 12:35 PM, the Administrator presented the following Immediate Jeopardy Removal Plan: Resident #95 was discharged on [DATE]. An immediate in-house evaluation for all residents currently residing in the facility completed in the last 24hrs. Vital signs, including blood pressure, pulse, respirations, and temperature, were obtained for every resident and reviewed by a licensed nurse to identify any actual or potential changes in resident conditions. Any abnormal findings identified were assessed by a licensed nurse and addressed through the facility's change in condition process, to include resident assessment, physician and family notification with implementation of any physician orders or recommendations when applicable. Licensed nursing staff will be educated by the RDCS/designee on identifying, assessing, and timely reporting a change in resident condition. A post-test will be administered and scored by the RDCS/designee to validate understanding with the expectation of 100% to pass. If 100% is not achieved, we will re-educate and re-administer the test. Staff unable to receive education due to schedule will be educated prior to their next scheduled shift. Licensed nursing staff will be educated by the ADON/designee on notifying the provider timely when a resident's change in condition is noted and on documenting the provider's response and actions taken to address the change in condition. Staff unable to receive education due to schedule will be educated prior to their next scheduled shift. The interdisciplinary team (IDT) will review all resident changes in condition five (5) days per week x 8 weeks during the daily Clinical Morning Meeting to ensure timely assessment, physician and resident/responsible party notification, implementation of interventions, and accurate EMR documentation. Any identified concerns will be addressed immediately through corrective action and follow-up changes. Facility asserts completion [DATE] at 2pm The facility's removal plan was approved as presented on [DATE] at 12:50 PM and the Administrator was notified. The facility staff presented credible evidence that the removal plan had been implemented, including vital sign evaluation reviews, staff education and post-tests as outlined in the removal plan. Interviews with staff verified education as outlined in the removal plan. (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:10 AM, the survey team verified the Immediate Jeopardy had been cleared and the Administrator was notified. No further information was provided to the survey team prior to the exit conference. 2. For Resident #6, the facility staff failed to notify the medical provider of a significant 28.6-pound weight gain with a medical history that included end stage renal disease with dialysis and alcoholic cirrhosis of the liver with ascites. A facility policy titled, Weight Monitoring, revised [DATE], specified The physician should be informed of a significant change in weight. An admission Record indicated the facility admitted Resident #6 on [DATE]. According to the admission Record, the resident had a medical history that included end stage renal disease with dependence on renal dialysis, alcoholic cirrhosis of liver with ascites, type 2 diabetes mellitus, portal hypertension, and congestive heart failure. An admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed Resident #6 had a Brief Interview for Mental Status (BIMS) summary score of 12, which indicated the resident had moderate cognitive impairment. A review of Resident #6's weight history revealed an admission weight of 164.4 pounds obtained on [DATE]. The resident was not weighed again until [DATE] at which time he weighed 193.0 pounds. The [DATE] weight identified significant weight gain of 28.6 pounds in five weeks. A dietary progress note dated [DATE] indicated a significant weight gain of 17.4%. A review of Resident #6's clinical record failed to reveal documentation of medical provider notification regarding the significant weight gain. On [DATE] at 5:19 PM, the Administrator and Regional Director of Clinical Services were notified of the concern regarding failure to notify the medical provider of a significant weight gain. No further information regarding this concern was provided prior to the exit conference on [DATE].		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on family interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure residents were free of significant medication errors for 6 of 51 sampled residents, Resident #94, Resident #2, Resident #33, Resident #95, Resident #29, and Resident #43. For Resident #94, the facility staff failed to remove the anticoagulant, Eliquis from the resident's active medication supply when discontinued on [DATE]. 12 Eliquis tablets were missing from Resident #94's Eliquis supply and were unaccounted for. Lab results obtained on [DATE] revealed a critically low hemoglobin of 6.7, a low hematocrit of 20.9, and PT/INR levels that were unable to be determined due to no clotting endpoint on the lab instrument. Resident #94 died on [DATE] while actively bleeding from the nose, mouth, urinary tract, and rectum. This resulted in the identification of Immediate Jeopardy and Substandard Quality of Care for Resident #94. The survey team informed the facility on [DATE] at 6:10 PM of the Immediate Jeopardy situation regarding Resident #94. The scope and severity were originally cited at Level IV Isolated. On [DATE] at 5:30 PM, the Immediate Jeopardy was removed and lowered to a Level III Isolated. The findings included: 1. For Resident #94, the facility staff failed to remove the anticoagulant, Eliquis from the resident's active medication supply when discontinued on [DATE]. 12 Eliquis tablets were missing from Resident #94's Eliquis supply and were unaccounted for. Lab results obtained on [DATE] revealed a critically low hemoglobin of 6.7, a low hematocrit of 20.9, and PT/INR levels that were unable to be determined due to no clotting endpoint on the lab instrument. Resident #94 died on [DATE] while actively bleeding from the nose, mouth, urinary tract, and rectum. An admission Record indicated the facility admitted Resident #94 on [DATE]. According to the admission Record, the resident had a medical history that included atrial fibrillation, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, type 2 diabetes mellitus, and bladder-neck obstruction. An admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed Resident #94 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. A [DATE] Change in Condition (SBAR) form indicated Resident #94's family member requested a re-evaluation of his medication to see if another medication could be substituted for Eliquis because it was very expensive. New medical provider orders were received on [DATE] to discontinue Eliquis and start Lovenox 80 mg/8ml inject one application subcutaneously every morning and bedtime for bridge therapy while transitioning to Coumadin (Warfarin), may discontinue when INR 2-3 for 24 hours and Warfarin (Coumadin) 5 mg by mouth. On [DATE], the medical provider ordered PT/INRs every 48 hours to start on [DATE] for transition to Warfarin (Coumadin) from Eliquis. A PT/INR was obtained on [DATE] and the INR was within therapeutic range at 2.75. PT/INRs were due on [DATE], [DATE], [DATE]; however, they were not obtained. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], the medical provider ordered a PT/INR. According to the lab report, the PT/INR blood sample was not collected until [DATE], received by the lab the following day on [DATE] at 11:14 AM and reported on [DATE] at 9:36 PM. The PT was greater than 90 (reference range 9.60-11.33) and confirmed by repeat analysis and the INR results could not be calculated as the result was greater than linearity. This result indicated the resident's blood clotting time was so prolonged that the lab's analyzer's range was exceeded. A [DATE] hospice nursing progress note read in part .Resident observed lying in bed with bloody nose from nosebleed.Resident's face cleaned and gown, sheets and pillowcase changed, soiled with blood.foley cath observed with blood-tinged urine in collection bag.instructed to hold bedtime dose of 5 mg Coumadin and AM dose of Lovenox 80 mg. According to Resident #94's [DATE] Medication Administration Record (MAR), he received the last dose of Coumadin on [DATE] and the last dose of Lovenox on [DATE] at 6:00 AM. A [DATE] hospice nursing progress note read in part Resident observed sitting up in bed with a small stream of blood coming from left nostril. Dark bloody urine observed in foley collection bag and tubing.Writer contacted [hospice physician] and given lab results for PTT and INR over the phone, order given and completed for 10mg/1ml of Vitamin K injection.At the completion of care, bleeding had stopped.Lovenox 80 mg injection discontinued and 5 mg of Coumadin held for Saturday and Sunday doses, with repeat labs for Monday morning. A [DATE] hospice nursing progress note read in part .Pt [patient] states he feels as he is dying. Pt has frank blood coming out of both nares, mouth and foley, BP 78/42. MD ordered STAT BMP [basic metabolic panel] CBC [complete blood count] and INR. Family present and repeatedly stated pt does not want to go to the hospital.foley catheter 24 F with frank blood in bag. Unable to note if any urine present due to blood. No noted clots. A second hospice nursing visit was made on [DATE], this progress note read in part Visit due to ongoing bleeding. Upon assessment, patient laying in bed oriented to person and pale in color. Blood noted to nose, in catheter bag, and out of rectum.Consulted with [hospice physician] and order received to start TXA [Tranexamic Acid] 650 mg tablet PO [by mouth] TID [three times a day] for 5 days. This nurse picked up medication from [area hospital] lobby pharmacy and delivered to facility. Tranexamic Acid is a medication used to prevent and control excessive bleeding. According to Resident #94's [DATE] MAR, he received Tranexamic 650 mg on [DATE] at 9:00 AM, 1:00 PM, and 9:00 PM. The [DATE] lab results revealed a white blood cell count of 21.81 (reference 4.5-10.5), red blood cell count of 2.51 (reference 4.3-5.8), hematocrit 20.9 (reference 42-52), critically low hemoglobin of 6.7 (reference 13.0-17.3), PT/INR results were not available as there was no clot endpoint obtained on the instrument. According to the National Institutes of Health, no end point detected indicates that the analyzer was unable to detect clot formation within the test window. Resident #94 was pronounced deceased on [DATE] at 11:20 AM in the facility. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:55 PM, Licensed Practical Nurse (LPN) #8 stated preceding his death, Resident #94 was bleeding from his nose, mouth, and foley. LPN #8 stated the bleeding was not profuse, but they had to keep wiping the blood from his nose. During an interview on [DATE] at 8:25 AM, the Hospice Registered Nurse (RN) stated Resident #94 was admitted to Hospice on [DATE] and she understood he was taking three anticoagulants and was waiting for the PT/INR results. She stated the resident was bleeding out from every orifice when he died. Resident #94's family was interviewed on [DATE] at 8:49 AM. She stated Resident #94 was taking Eliquis prior to admission to the facility and it was getting so expensive that the provider decided to switch him over to Coumadin and he was also to get Lovenox for five days. The family member stated the resident started with nose bleeds, then blood in the urine, and then bleeding from the rectum. She stated there was a steady stream of blood coming from his nose and they had to constantly wipe the blood from his nose. Nurse Practitioner (NP) #1 was interviewed on [DATE] at 11:43 AM. NP #1 stated she had spoken with Resident #94's family and they mentioned Eliquis was very expensive and they elected to switch to Coumadin using a Lovenox bridge. NP #1 stated she had trouble getting the PT/INRs completed and then Hospice took over his care, but she was still following his care to a degree. NP #1 stated she was present in the facility when the resident passed, and she went to his room, and his mouth and nose were completely caked with dried blood. She stated she assisted the staff in cleaning him up and it took over 20 minutes trying to get the caked blood out of his nose. NP #1 stated following the resident's death she asked Licensed Practical Nurse (LPN) #1 to check the medication cart to verify Resident #94's medications. NP #1 stated LPN #1 indicated the pharmacy supply card of Eliquis was still in the med cart. Based on the date of delivery and discontinuation date, there should have only been nine to ten doses missing from the card but there were 16 tablets missing and unaccounted for. NP #1 stated she immediately notified the Director of Nursing and Assistant Director of Nursing. During an interview on [DATE] at 12:15 PM, LPN #1 stated following Resident #94's death, she did discover his Eliquis medication supply card in the med cart with the card turned around backward. She stated she thought there were 11 tablets of Eliquis left in the card and stated she felt like staff were borrowing the Eliquis. When asked if she had any evidence of staff borrowing the Eliquis, she stated no. When asked why she counted the Eliquis following his death, LPN #1 stated NP #1 asked her to because she felt he was over medicated. Despite being the Unit Manager, LPN #1 denied any knowledge of Resident #94 bleeding or having blood present in the foley bag. LPN #1 stated nurses were supposed to take discontinued medications out of the med cart when discontinued. During an interview with the Director of Nursing and Assistant Director of Nursing on [DATE] at 10:06 AM, the DON stated the Eliquis medication card still being in the drawer and actually being given were two separate things. DON stated the card was turned backward and the number of Eliquis remaining in the card was correct and they were returned to the pharmacy. The DON stated she had no documentation of the NP's concern or investigation because the concern could not be substantiated. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The pharmacy billing representative was interviewed on [DATE] at 11:36 AM. She stated on [DATE] a 14-day supply of 28 tablets of Eliquis was delivered to the facility and a supply of seven tablets were returned to the pharmacy on [DATE]. Based on calculations, with the Eliquis being delivered on [DATE] and two tablets administered on [DATE], [DATE], [DATE], [DATE], and one tablet administered prior to being discontinued on [DATE], that would equal a total of nine tablets used from the 28-tablet supply. However, based on the supply returned to the pharmacy, 21 tablets were used from Resident #94's Eliquis supply card leaving 12 missing doses unaccounted for. On [DATE] at 4:00 PM, when presented with the Eliquis count returned to the pharmacy, the DON stated she was aware of the Eliquis card remaining in the cart, but it was turned around and when she did interviews with the staff she was told they used the Eliquis for another resident. The DON was unable to provide evidence of staff borrowing Resident #94's Eliquis supply. When asked if the staff knew why Resident #94 was bleeding so much and if there were any investigations done concerning this she stated they had no investigations to provide. The facility's contracted lab service was contacted on [DATE] at 5:41 PM, the STAT Lab Specialist confirmed Resident #94 had only three PT/INRs obtained in [DATE], on [DATE], [DATE], and [DATE]. This information was conveyed to the DON at 5:47 PM and she stated that was not what she wanted to hear but it is what it is. The Administrator was interviewed on [DATE] at 6:06 PM and stated there was no documentation that the Eliquis was given to the resident after it was discontinued; however, they were unable to account for the missing Eliquis tablets or provide an explanation for the increasing PT/INR and continued bleeding up until Resident #94's death. On [DATE] at 6:10 PM the survey team notified the Administrator, DON, and ADON of the Immediate Jeopardy situation involving Resident #94. On [DATE] at 2:29 PM the Administrator presented the following Immediate Jeopardy Removal Plan: 1. Resident 94 is no longer at the facility as of [DATE] 2. An immediate MAR-to-cart audit of all medication carts was conducted by the Regional Director of Clinical services to ensure discontinued medications were removed from the cart. Medications were validated per physician order. 3. All licensed nurses received education by the Assistant Director of Nursing on the five rights of medication administration. Nurses who are unable to complete the education due to schedule will receive education prior to their next scheduled shift. 4. All licensed nurses received education by the Assistant Director of Nursing on facility medication management and removal of discontinued medication from carts. Nurses who are unable to complete the education due to schedule will receive education prior to their next scheduled shift. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. The Director of Nursing/designee will review discontinued medication 5 days weekly for 3 months. Finally, the Director of Nursing/designee will ensure physical removal of any discontinued meds from the carts weekly for 3 months. Facility asserts completion [DATE] at 1pm The facility's removal plan was approved as presented on [DATE] at 2:55 PM and the Administrator was notified at 3:21 PM. The facility staff presented credible evidence that the removal plan had been implemented, including MAR to cart medication audits and staff education as outlined in the removal plan. Interviews with staff verified education as outlined in the removal plan. On [DATE] at 5:30 PM, the survey team verified that the Immediate Jeopardy had been cleared. The Administrator, ADON, and Regional [NAME] Present #1 and #2 were informed that the Immediate Jeopardy was cleared as of 5:30 PM. No further information regarding this concern was presented to the survey team prior to the exit conference on [DATE]. 2. For Resident #2, the facility staff failed to administer sliding scale Insulin Lispro as ordered by the medical provider on 19 separate occasions from [DATE] through [DATE]. A facility policy titled, Medication Administration, revised [DATE], specified, Ensure that the six rights of medication administration are followed: a. Right resident b. Right drug c. Right dosage d. Right route e. Right time f. Right documentation. An admission Record indicated the facility admitted Resident #2 on [DATE]. According to the admission Record, the resident had a medical history that included type 2 diabetes mellitus with diabetic polyneuropathy. A significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 1, which indicated the resident had severe cognitive impairment. Resident #2's comprehensive person-centered care plan included a focus initiated [DATE], that indicated the resident had diabetes mellitus. Interventions included diabetes medication as ordered by the doctor. Resident #2's medical provider orders included an order which started on [DATE] for Insulin Lispro inject as per sliding scale subcutaneously as needed in addition to basal insulin: 151-200 = 1, 201-250 = 2, 251-300 = 3, 301-350 = 4, 351-400 =5 and notify provider if administering this dose, 401-500 call provider for instructions. Insulin Lispro is a rapid-acting insulin used to lower blood sugar. Resident #2's order for basal insulin, Insulin Glargine was also started on [DATE] and instructed staff (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to administer 8 units at bedtime. Insulin Glargine is a long-acting insulin used to lower blood sugar. According to Resident #2's documented bedtime blood sugar (BS) readings on the [DATE] Medication Administration Record, they should have received Insulin Lispro based on the SS order. However, the MAR indicated the SS Insulin Lispro was not administered on the following occasions with the identified BS readings: [DATE] BS 186, [DATE] BS 200, [DATE] BS 271, [DATE] BS 315, [DATE] BS 232, [DATE] BS 378, [DATE] BS 202, [DATE] BS 188, [DATE] BS 224, [DATE] BS 359, [DATE] BS 395, [DATE] BS 228, [DATE] BS 190, [DATE] BS 243, [DATE] BS 218, [DATE] BS 266, [DATE] BS 193, [DATE] BS 187, [DATE] BS 273. On [DATE] at 3:17 PM, the Administrator, Regional [NAME] President of Operations, and the Regional Director of Clinical Services were notified of the concern of staff failing to administer Resident #2's SS Insulin Lispro as ordered on 19 occasions. No further information regarding this concern was presented prior to the exit conference on [DATE]. 3. For Resident #33, the facility staff failed to administer Insulin Glargine as ordered by the medical provider on two separate occasions. A facility policy titled, Medication Administration, revised [DATE], specified, Ensure that the six rights of medication administration are followed: a. Right resident b. Right drug c. Right dosage d. Right route e. Right time f. Right documentation. An admission Record indicated the facility admitted Resident #33 on [DATE]. According to the admission Record, the resident had a medical history that included type 2 diabetes mellitus with diabetic neuropathy. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #33's comprehensive person-center care plan included a focus area which indicated the resident had diabetes mellitus with an intervention for diabetes medication as ordered. Resident #33's medical provider orders included an order dated [DATE] for Insulin Glargine 50 units subcutaneously every morning and at bedtime. Insulin Glargine is a long-acting insulin used to lower blood sugar. A review of Resident #33's [DATE] Medication Administration Record (MAR) revealed Insulin Glargine was not administered on [DATE] at 6:00 AM and [DATE] at 6:00 AM. There was no corresponding documentation explaining the reason the medication was not administered on [DATE]. A [DATE] 6:08 AM nursing progress note indicated Insulin Glargine was held due to a blood sugar reading of 150; however, the order did not include parameters to hold the medication based on the blood sugar reading. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 5:35 PM, the Administrator and Regional Director of Clinical Services were informed of the concern regarding the failure to administer Resident #33's Insulin Glargine as ordered. No further information regarding this concern was presented to the survey team prior to the exit conference on [DATE]. 4. For resident # 95 the facility staff failed to begin administering intravenous antibiotics as ordered on admission. The admission Record for Resident #95 indicated the facility admitted the resident on [DATE] with diagnoses that included acute and subacute endocarditis, other streptococcal arthritis and bacteremia. The minimum data set (MDS) assessment with an assessment reference date of [DATE] was reviewed. Resident #95 was coded as being independent in making consistent and reasonable decisions and short-term memory was intact. The MDS captured the diagnoses of endocarditis, streptococcal arthritis and bacteremia but under the section for medications, there were no antibiotics or intravenous medications coded. The hospital Discharge summary dated [DATE] was reviewed. The primary diagnosis was listed as streptococcal bacteremia. Under the heading Start taking these medications was an entry that read, NS (normal saline) 0.9% SolP 500 ml with penicillin G potassium 20-million-unit SOLR 24 million units continuously by intravenous route through [DATE]. The facility History and Physical progress note dated [DATE] read in part, The primary focus of the visit is the transition of (resident's) intravenous antibiotic therapy. In the hospital, (resident) received a continuous infusion of 24 million units of Penicillin G. To improve mobility and allow for therapies, (the) regimen has been changed to an intermittent schedule of 4 million units infused over 30 minutes every 4 hours via PICC line (peripherally inserted central catheter placed in an upper arm vein for long-term treatments), which equates to the same total daily dose. This dosing strategy was confirmed to provide adequate medication coverage for over the four-hour intervals. The nurse progress notes were reviewed. A note dated [DATE] at 12:47 PM read, Resident arrived at facility at 11:50am via private transportation with family. DNR signed in facility. Resident takes pills whole. Last BM [DATE]. Resident 1x assist with ADLs (activities of daily living). Continent of b/b (bowel and bladder). Mechanical soft diet, thin liquids. PICC line to right arm. Continues IV abx (antibiotics) until [DATE]. Call light and personal items within reach. A progress note dated [DATE] at 2:38 PM read, Penicillin G Potassium Injection Solution Reconstituted 20000000 UNIT Use 4 million units intravenously every 4 hours for Bacteremia. A progress note dated [DATE] at 8:33 PM read, Penicillin G Potassium Injection Solution Reconstituted 20000000 UNIT Use 4 million units intravenously every 4 hours for Bacteremia until [DATE] 23:59 Held per MD. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note dated [DATE] dated at 1:09 AM read, Penicillin G Potassium Injection Solution Reconstituted 20000000 UNIT Use 4 million units intravenously every 4 hours for Bacteremia until [DATE] 23:59 Medication held, MD aware. Awaiting arrival from pharmacy. A progress note dated [DATE] at 4:58 AM read, Penicillin G Potassium Injection Solution Reconstituted 20000000 UNIT Use 4 million units intravenously every 4 hours for Bacteremia until [DATE] 23:59 Medication held, MD aware. Awaiting arrival from pharmacy. A progress note dated [DATE] at 8:12 AM read, Penicillin G Potassium Injection Solution Reconstituted 20000000 UNIT Use 4 million units intravenously every 4 hours for Bacteremia until [DATE] 23:59 held per MD and RP aware. awaiting arrival from (name omitted) infusion center. A progress note dated [DATE] at 12:13 PM read, Penicillin G Potassium Injection Solution Reconstituted 20000000 UNIT Use 4 million units intravenously every 4 hours for Bacteremia until [DATE] 23:59 held per MD and RP aware. awaiting arrival from (name omitted) infusion center. A progress note dated [DATE] at 7:32 PM read, Resident started her IV abx this shift, no adverse reaction noted. PICC line patent, dressing dry, clean, and intact. The medication administration record for [DATE] was reviewed. There was an entry dated [DATE] at 12:00 PM that read, Penicillin G potassium injection solution reconstituted 20,000,000 unit use 4 million units intravenously every 4 hours for bacteremia. The doses scheduled for 12:00 PM and 4:00 PM were coded with a 5 which according to the chart codes meant, see nurses notes. This order was discontinued on [DATE] at 4:34 PM. There was another entry dated [DATE] at 8:00 PM that read, Penicillin G potassium injection solution reconstituted 20,000,000 unit use 4 million units intravenously every 4 hours for bacteremia. The dose scheduled on [DATE] at 8:00 PM was coded with a 5. On [DATE] the 12:00 AM dose, 4:00 AM dose, 8:00 AM dose and 12:00 PM dose were all coded with a 5. This order was discontinued on [DATE] at 1:00 PM. An order entered [DATE] at 4:00 PM read, Penicillin G potassium injection solution reconstituted 20,000,000 unit use 4 million units intravenously every 4 hours for bacteremia. The [DATE] 4:00 PM and 8:00 PM doses were signed as given. According to the facility documentation the resident missed 7 doses while waiting for the medication to arrive from the infusion center. On [DATE] Resident #95 was sent out emergently to the hospital and admitted for atrial fibrillation. The resident returned to the facility on [DATE] at 9:20 PM according to the nurses notes, with orders to continue the penicillin G as previously ordered. The MAR for May was reviewed. An order for the medication was entered on [DATE] at 11:59 PM and discontinued on [DATE] at 4:00 AM. No doses were given. Another order for the penicillin was entered on [DATE] at 8 PM and the medication was signed as given at that time. According to the documentation, Resident #95 missed 5 doses of the prescribed antibiotic. On [DATE] at 9:39 AM the NP (Nurse Practitioner) who wrote the admission history and physical on [DATE] was interviewed. When asked if they were aware that Resident #95 missed 7 doses in April and 5 doses in May they stated, No, I had no idea. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:20 PM Registered Nurse (RN) #1 was interviewed. They could not recall Resident #95. When asked about the delay in starting the antibiotics they stated, I'm not surprised, the infusion center where we get our drugs is all the way in Bristol, VA. It sometimes takes days to get the medications in. The surveyor requested a policy regarding unavailable medications, but none was received by exit. On [DATE] at 4:34 PM the survey team met with the Administrator, the Regional Director of Clinical Services and the [NAME] President of Operations. This concern was discussed with them at that time. No further information was provided to the survey team prior to exit. 5. For Resident #29 the facility staff failed to ensure parameters for insulin were followed. Resident #29's admission Record revealed the resident was admitted on [DATE] with diagnoses that included type 2 diabetes mellitus with neuropathy, obesity class 2 and long-term use of insulin. The annual minimum data set (MDS) assessment with an assessment reference date of [DATE] assigned the resident a brief interview for mental status score of 10 indicating moderate cognitive impairment. The comprehensive care plan for Resident #29 included a focus for diabetes with an intervention that read, Administer insulin per order. The physician order for insulin read, Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) Inject 15 unit subcutaneously before meals and at bedtime for hyperglycemia related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65) hold for glucose < [less than] 175. The MAR (medication administration record) for [DATE] was reviewed. On [DATE] at 6:00 AM resident had a blood sugar of 147 and the insulin was signed as given. On [DATE] at 6:00 AM the blood sugar was 156 and the insulin was documented as given. On [DATE] at 9:00 PM the blood sugar was 111 and the insulin was given. On [DATE] at 4:00 PM the blood sugar was 123 and the insulin was given. On [DATE] at 6:00 AM the blood sugar was 161 and the insulin was given. On [DATE] at 11:00 AM the blood sugar was 147 and the insulin was given. The MAR for May was reviewed. On [DATE] at 6:00 AM the blood sugar was 152 and the insulin was given. On [DATE] at 6:00 AM the blood sugar was 151 and the insulin was given. On [DATE] at 4:00 PM the blood sugar was 157 and the insulin was given. The June MAR was reviewed. On [DATE] at 11:00 AM the blood sugar was 148 and the insulin was given. On [DATE] at 6:00 AM the blood sugar was 156 and the insulin was given. On [DATE] at 11:00 AM the blood sugar was 124 and the insulin was given. On [DATE] at 9:00 PM the blood sugar was 140 and the insulin was given. On [DATE] at 6:00 AM the blood sugar was 132 and the insulin was given. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	given. On [DATE] at 6:00 AM the blood sugar was 131 and the insulin was given. On [DATE] at 6:00 AM the blood sugar was 110 and the insulin was given. On [DATE] at 4:00 PM the blood sugar was 165 and the insulin was given. On [DATE] at 6:00 AM the blood sugar was 111 and the insulin was given. The July MAR was reviewed. On [DATE] at 6:00 AM the blood sugar was 174 and the insulin was given. On [DATE] at 11:00 AM the blood sugar was 172 and the insulin was given. On [DATE] at 6:00 AM the blood sugar was 135 and the insulin was given. On [DATE] at 6:00 AM the blood sugar was 131 and the insulin was given. On [DATE] at 4:34 PM the survey team met with the Administrator, the Regional [NAME] President of Operations and the Regional Director of Clinical Services. This concern was reviewed with them at that time. No further information was provided to the survey team prior to the exit. 6. For Resident #43, the facility staff failed to hold the medication Insulin aspart subcutaneous solution pen-injector (a rapid-acting, diabetic medication used to lower blood glucose) when the resident's blood glucose levels were less than (150) one-hundred fifty, as ordered by a medical provider. A review of an admission Record, disclosed Resident #43 was admitted to the facility on [DATE] with a diagnosis list that indicated diagnoses that included, but were not limited to, type 2 diabetes mellitus, alcoholic cirrhosis of liver without ascites, congestive heart failure (CHF), and hepatic encephalopathy. The most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], assigned the resident a Brief Interview for Mental Status (BIMS) summary score of 7 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A review of a medical provider Order Summary Report disclosed and order for Insulin aspart subcutaneous solution pen-injector at 100 unit/ml (milliliter) - inject 8 unit subcutaneously before meals for DM (diabetes mellitus). Hold if (blood sugar) <150 (less than one-hundred fifty) with a start date of [DATE]. A review of Resident #43's May, June, and [DATE] MARs (medication administration records) indicated Insulin aspart was administered on the following dates/times with BS (blood sugar) levels outside of the ordered parameter of holding the medication if BS <150: [DATE]-BS 138 at 6:00 AM [DATE]-BS 131 at 6:00 AM [DATE]-BS 87 at 6:00 AM (continued on next page)		

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

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE]-BS 136 at 4:00 PM [DATE]-BS 124 at 4:00 PM [DATE]-BS 134 at 6:00 AM [DATE]-BS 144 at 4:00 PM [DATE]-BS 97 at 6:00 AM [DATE]-BS 137 at 4:00 PM [DATE]-BS 146 at 6:00 AM [DATE]-BS 148 at 11:00 AM [DATE]-BS 127 at 6:00 AM [DATE]-BS 108 at 11:00 AM [DATE]-BS 140 at 4:00 PM [DATE]-BS 137 at 6:00 AM [DATE]-BS 106 at 4:00 PM A review of Resident #43's comprehensive person-center		

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, the facility staff failed to obtain lab testing as ordered by the medical provider for 8 of 51 sampled residents, Resident #94, Resident #2, Resident #3, Resident #5, Resident #7, Resident #8, Resident #12, and Resident #6. For Resident #94, the facility staff failed to obtain PT/INR results as ordered following the transition of Eliquis to Coumadin using a limited Lovenox bridge on four separate occasions from [DATE] through [DATE]. Lab results obtained on [DATE] and received by the lab on [DATE] resulted in a PT greater than 90 (reference range 9.60-11.33) and INR results that could not be calculated as the result greater than linearity. Resident #94 began showing signs of active bleeding on [DATE]. Additional Lab results obtained on [DATE] revealed a critically low hemoglobin of 6.7, a low hematocrit of 20.9, and PT/INR levels that were unable to be determined due to no clotting endpoint on the lab instrument. Resident #94 died on [DATE] while actively bleeding from the nose, mouth, urinary tract, and rectum. This resulted in the identification of Immediate Jeopardy for Resident #94. The survey team informed the facility on [DATE] at 6:10 PM of the Immediate Jeopardy situation regarding Resident #94. The scope and severity were originally cited at Level IV Isolated. On [DATE] at 5:30 PM, the Immediate Jeopardy was removed and lowered to a Level III Isolated. The findings included: 1. For Resident #94, the facility staff failed to obtain PT/INR results as ordered following the transition of Eliquis to Coumadin using a limited Lovenox bridge on four separate occasions from [DATE] through [DATE]. An admission Record indicated the facility admitted Resident #94 on [DATE]. According to the admission Record, the resident had a medical history that included atrial fibrillation, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, type 2 diabetes mellitus, and bladder-neck obstruction. An admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed Resident #94 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. A [DATE] Change in Condition (SBAR) form indicated Resident #94's family member requested a re-evaluation of his medication to see if another medication could be substituted for Eliquis because it was very expensive. New medical provider orders were received on [DATE] to discontinue Eliquis and start Lovenox 80 mg/8ml inject one application subcutaneously every morning and bedtime for bridge therapy while transitioning to Coumadin (Warfarin), may discontinue when INR 2-3 for 24 hours and Warfarin (Coumadin) 5 mg by mouth at bedtime. On [DATE], the medical provider ordered PT/INRs every 48 hours to start on [DATE] for transition to Warfarin (Coumadin) from Eliquis. A PT/INR was obtained on [DATE] and the INR was within therapeutic range at 2.75. This result indicated that if the next INR was between 2 - 3, Lovenox would be discontinued. PT/INRs were due on [DATE], [DATE], and [DATE]; however, they were not obtained. (continued on next page)		

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], the medical provider ordered a PT/INR. According to the lab report, the PT/INR blood sample was not collected until [DATE], received by the lab the following day on [DATE] at 11:14 AM and reported on [DATE] at 9:36 PM. The PT was greater than 90 (reference range 9.60-11.33) and confirmed by repeat analysis and the INR results could not be calculated as the result greater than linearity. This result indicated the resident's blood clotting time was so prolonged that the lab's analyzer's range was exceeded. A nursing progress note dated [DATE] at 5:35 AM indicated Lovenox was held to see stat result of PT/INR. A [DATE] hospice nursing progress note read in part .Resident observed lying in bed with bloody nose from nosebleed.Resident's face cleaned and gown, sheets and pillowcase changed, soiled with blood.foley cath observed with blood-tinged urine in collection bag.instructed to hold bedtime dose of 5 mg Coumadin and AM dose of Lovenox 80 mg. A [DATE] hospice nursing progress note read in part Resident observed sitting up in bed with a small stream of blood coming from left nostril. Dark bloody urine observed in foley collection bag and tubing.Writer contacted [hospice physician] and given lab results for PTT and INR over the phone, order given and completed for 10mg/1ml of Vitamin K injection.At the completion of care, bleeding had stopped.Lovenox 80 mg injection discontinued and 5 mg of Coumadin held for Saturday and Sunday doses, with repeat labs for Monday morning. A [DATE] hospice nursing progress note read in part .Pt [patient] states he feels as he is dying. Pt has frank blood coming out of both nares, mouth and foley, BP 78/42. MD ordered STAT BMP [basic metabolic panel] CBC [complete blood count] and INR. Family present and repeatedly stated pt does not want to go to the hospital.foley catheter 24 F with frank blood in bag. Unable to note if any urine present due to blood. No noted clots. A second hospice nursing visit was made on [DATE], this progress note read in part Visit due to ongoing bleeding. Upon assessment, patient laying in bed oriented to person and pale in color. Blood noted to nose, in catheter bag, and out of rectum.Consulted with [hospice physician] and order received to start TXA [Tranexamic Acid] 650 mg tablet PO [by mouth] TID [three times a day] for 5 days. This nurse picked up medication from [area hospital] lobby pharmacy and delivered to facility. Tranexamic Acid is a medication used to prevent and control excessive bleeding. The [DATE] lab results revealed a white blood cell count of 21.81 (reference 4.5-10.5), red blood cell count of 2.51 (reference 4.3-5.8), hematocrit 20.9 (reference 42-52), critically low hemoglobin of 6.7 (reference 13.0-17.3), PT/INR results were not available as there was no clot endpoint obtained on the instrument. According to the National Institutes of Health, no end point detected indicates that the analyzer was unable to detect clot formation within the test window. Resident #94's clinical record failed to include evidence that the facility medical provider or hospice were notified of the [DATE] abnormal lab results including the critically low hemoglobin and the inability to obtain PT/INR results due to no clot endpoint. The lab report indicated the Director of Nursing (DON) reviewed the results on [DATE] at 3:56 PM. This was over four and a half hours after (continued on next page)		

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the resident's death. Resident #94 was pronounced deceased on [DATE] at 11:20 AM in the facility. During an interview on [DATE] at 10:55 PM, Licensed Practical Nurse (LPN) #8 stated preceding his death, Resident #94 was bleeding from his nose, mouth, and foley. LPN #8 stated the bleeding was not profuse, but they had to keep wiping the blood from his nose. Nurse Practitioner (NP) #1 was interviewed on [DATE] at 11:43 AM. NP #1 stated she had spoken with Resident #94's family member and Eliquis was very expensive and they elected to switch to Coumadin using a Lovenox bridge. NP #1 stated she had trouble getting the PT/INRs completed. NP #1 stated she was present in the facility when the resident passed, and she went to his room, and his mouth and nose were completely caked with dried blood. She stated she assisted the staff in cleaning him up and it took over 20 minutes trying to get the caked blood out of his nose. The facility's contracted lab service was contacted on [DATE] at 5:41 PM, the STAT Lab Specialist confirmed Resident #94 had only three PT/INRs obtained in [DATE], on [DATE], [DATE], and [DATE]. This information was conveyed to the DON at 5:47 PM and she stated that was not what she wanted to hear but it is what it is. On [DATE] at 6:10 PM the survey team notified the Administrator, DON, and Assistant DON of the Immediate Jeopardy situation involving Resident #94. On [DATE] at 2:29 PM the Administrator presented the following Immediate Jeopardy Removal Plan: 1. Resident #94 is no longer in the facility as of [DATE]. 2. An immediate audit of all current residents who have had an order for a PT/INR Lab within the past 60 days, were reviewed Regional Director of Clinical Services to ensure completion. The audit revealed that only one current resident is being monitored with those labs. The resident was not affected by the deficient practice. 3. DON/designee will review all lab orders during morning clinical 5 days weekly. Then they will verify that the order has been entered into the lab servicing portal. Orders will be entered into the lab book to be drawn. DON/designee will verify lab completion with the next business day. 4. All Licensed nurses were educated by the Assistant Director of Nursing on the lab ordering procedure to include step by step process from time of receipt of the order, up to monitoring results and taking appropriate action done in-person or over the phone. Any nurses who did not receive the education will be educated prior to their next scheduled shift. 5. Weekly audits by the Director of Nursing/designee will be completed of all PT/INR labs to ensure compliance for 3 months. Facility asserts completion [DATE] at 1pm (continued on next page)		

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Department of Health & Human Services
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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ESBL infection. Treat with Macrobid and follow need for change to therapy. A review of Resident #2's clinical record failed to reveal urinalysis results following the [DATE] and [DATE] provider visits. A medical provider progress note dated [DATE] revealed increased confusion during nighttime. Due to the patient's age and clinical presentation, a urinary tract infection is being considered as a potential underlying cause for her change in mental status. A urinalysis with culture and sensitivity will be obtained to evaluate for a urinary tract infection. A urinalysis report dated [DATE] was present in the clinical record which showed 4+ bacteria, 51-100 white blood cells, 2+ nitrite and the culture was positive for E. coli. During an interview on [DATE] at 3:55 PM, the Regional Director of Clinical Services (RDSCS) stated there were no reports of a urinalysis done on [DATE] or [DATE], only the current one dated [DATE]. During a meeting on [DATE] at 5:19 PM, the Administrator and RDSCS were notified of the concern regarding the missing urinalysis tests for Resident #2. No further information regarding this concern was presented prior to the exit conference on [DATE]. 3. For Resident #3, the facility staff failed to obtain PT/INRs as ordered by the medical provider. A facility policy titled, Laboratory Services and Reporting, revised [DATE], specified The facility must provide or obtain laboratory services to meet the needs of its residents. An admission Record indicated the facility admitted Resident #3 on [DATE]. According to the admission Record, the resident had a medical history that included chronic obstructive pulmonary disease, history of anticoagulant use, and history of venous thrombosis and embolism. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed Resident #3 had a Brief interview for Mental Status (BIMS) score of 8 which indicated the resident had moderate cognitive impairment. Resident #3's clinical record indicated the resident had been prescribed and taking Warfarin due to a deep vein thrombosis. Warfarin is an anticoagulant used to thin the blood. Resident #3's medical provider orders included an order dated [DATE] to obtain a PT/INR on [DATE]; however, the lab was not obtained until [DATE]. Resident #3's medical provider orders included an order dated [DATE] to obtain a PT/INR on [DATE]; however, it was never obtained. Resident #3's medical provider orders included an order dated [DATE] to obtain a PT/INR on [DATE]; however, the lab was not obtained until [DATE]. (continued on next page)		

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:55 PM, the Regional Director of Clinical Services verified the PT/INR findings. He also stated previously the medical providers entered and approved their own orders which caused orders to be entered and not seen by nursing. He stated new orders are now entered into a cue for nursing staff to process. During a meeting on [DATE] at 5:19 PM, the Administrator and RDCS were notified of the concern regarding Resident #3's PT/INR results. No further information regarding this concern was presented prior to the exit conference on [DATE]. 4. For Resident #5, the facility staff failed to obtain a complete blood count (CBC) and a comprehensive metabolic panel (CMP) as ordered by the medical provider. A facility policy titled, Laboratory Services and Reporting, revised [DATE], specified The facility must provide or obtain laboratory services to meet the needs of its residents. An admission Record indicated the facility admitted Resident #5 on [DATE]. According to the admission Record, the resident had a medical history that included sepsis due to Escherichia coli, urinary tract infection (UTI), and acute kidney failure. An admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. Resident #5's comprehensive person-centered care plan included a focus area dated [DATE], that indicated the resident was at risk for dehydration related to recent septicemia, UTI, multidrug resistant organism, and intravenous antibiotics. Interventions directed the staff to obtain and monitor lab/diagnostic work as ordered. A nursing progress note dated [DATE] at 1:39 PM indicated Resident #5 was seen by the nurse practitioner and new orders were received for a CBC and CMP. A review of Resident #5's clinical record failed to reveal evidence that the CBC and CMP were obtained. During an interview on [DATE] at 3:55 PM, the Regional Director of Clinical Services stated he did not have results for a CBC or CMP ordered on [DATE], he only had results from an order on [DATE]. No further information was provided prior to the exit conference on [DATE]. 5. For Resident #7, the facility staff failed to obtain a urinalysis with culture and sensitivity as ordered by the medical provider. A facility policy titled, Laboratory Services and Reporting, revised [DATE], specified The facility must provide or obtain laboratory services to meet the needs of its residents. (continued on next page)		

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An admission Record indicated the facility admitted Resident #7 on [DATE]. According to the admission Record, the resident had a medical history that included sepsis due to other specified staphylococcus, urinary tract infection, type 2 diabetes mellitus, and Alzheimer's Disease. An admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE]. Revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. Resident #7's comprehensive person-centered care plan included a focus area dated [DATE], that indicated the resident had an indwelling catheter, a history of BPH (benign prostatic hyperplasia), obstructive uropathy, recent urinary tract infection (UTI) with risk for further UTIs or infection. Interventions included labs as ordered. Resident #7's medical orders included an order dated [DATE] at 8:11 PM for a urinalysis with micro, reflex to urine culture. Resident #7 was seen by the Nurse Practitioner (NP) on [DATE]. The progress note revealed The patient presents with AMS [altered mental status] manifested by staff reports of increased confusion, hallucinations, and anxiety. This is most likely a delirium secondary to an infectious process, given the concurrent suspicion for a urinary tract infection. The progress note also revealed The patient has an indwelling Foley catheter and foul-smelling urine, raising high suspicion for a catheter-associated urinary tract infection (CAUTI). This is the most likely trigger for his acute delirium. A urinalysis with culture and sensitivity has been ordered to confirm the diagnosis and guide potential antimicrobial therapy. A review of Resident #7's clinical record failed to reveal results of a urinalysis obtained following the [DATE] medical provider order. During an interview on [DATE] at 3:55 PM, the Regional Director of Clinical Services (RDCS) stated they had no evidence that the urinalysis was done, they only had urinalysis results obtained on [DATE]. No further information was provided prior to the exit conference on [DATE]. 6. For Resident #8 the facility staff failed to obtain the physician ordered laboratory tests for oxcarbazepine level, felbamate level and lamotrigine level. Resident #8's clinical record listed diagnoses which included but not limited to epilepsy, unspecified, not intractable, without status epilepticus. Resident #8's most recent quarterly minimum data set with an assessment reference date of [DATE] coded the resident as having both long- and short-term memory problems with severely impaired cognitive skills for daily decision making. Section N, medications, coded the resident as receiving anticonvulsant medications. Resident #8's comprehensive care plan was reviewed and contained a plan for . has a seizure disorder with recurrent seizures. Interventions for the care plan included Obtain and monitor lab/diagnostic (continued on next page)		

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	work as ordered, Report results to MD and follow up as indicated. Resident #8's clinical record contained a physician's order summary which read in part, Labs: Oxcarbazepine level, felbamate level, lamotrigine level one time only for 3 days ordered on [DATE]. Surveyor could not locate the results of these tests. The physician's order summary also contained an order for lamotrigine, felbamate, and oxcarbazepine level on time only for labs for 1 day ordered on [DATE]. Surveyor could not locate the results for the felbamate level in the resident's clinical record. Surveyor requested and was provide with a facility policy entitled, Laboratory Services and Reporting which read in part, The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law. The concern of not obtaining physician ordered laboratory tests was discussed with the administrator and regional director of clinical services on [DATE] at 5:15 pm. No further information was provided prior to exit. 7. For Resident #12 the facility staff failed to obtain physician ordered laboratory tests. Resident #12's clinical record listed diagnoses which included but not limited to hemiplegia and hemiparesis following cerebral infarction affecting non-dominant right side, moderate protein-calorie malnutrition, epilepsy, unspecified, and obstructive and reflux uropathy, unspecified. Resident #12's most recent quarterly minimum data set with an assessment reference date of [DATE] assigned the resident a brief interview for mental status score of 3 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #12's comprehensive care plan was reviewed and contained a plan for . has a seizure disorder. Interventions for this care plan included Obtain and monitor lab/diagnostic work as ordered . Resident #12's clinical record contained a physician's order summary which read in part, Culture-Other fluid from nephrostomy tube at connection site one time only for infection for 3 days-order date [DATE], CBC (complete blood count), BMP (basic metabolic panel), Magnesium one time a day for infectious work up for 1 day-order date [DATE], CBC-BMP-Mag one time only until [DATE]-order date [DATE] and Blood culture, CBC CMP (comprehensive metabolic panel) on time only for 1 day-order date [DATE]. Surveyor could not locate the results of the labs ordered on [DATE] and [DATE] and could not locate the BMP/Magnesium level ordered on [DATE] or the blood culture ordered on [DATE]. Surveyor requested and was provide with a facility policy entitled, Laboratory Services and Reporting which read in part, The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law. (continued on next page)		

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The concern of not obtaining physician ordered laboratory tests was discussed with the administrator and regional director of clinical services on [DATE] at 5:15 pm. No further information was provided prior to exit. 8. For Resident #6, the facility staff failed to obtain the provider ordered laboratory test ammonia level. Resident #6's diagnoses included cirrhosis of the liver with ascites and portal hypertension. Section C (cognitive patterns) of Resident #6's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of [DATE] included a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment for daily decision making. Review of the comprehensive care plan identified an intervention to obtain laboratory testing as ordered or as needed. Review of the clinical record revealed provider orders dated [DATE] and [DATE] for ammonia levels. The clinical record included the results of one ammonia level collected on [DATE], with reported results of 112 (high). Documentation in the clinical record indicated the resident intermittently refused their provider ordered lactulose. During an end of the day meeting on [DATE] at 4:00 PM, the surveyor reviewed the missing ammonia level with the Administrator, Director of Nursing (DON), and Assistant Director of Nursing. On [DATE] at 12:05 PM, the DON acknowledged that one of the two provider ordered ammonia levels had not been obtained. A facility policy titled, Laboratory Services and Reporting, revised [DATE], specified The facility must provide or obtain laboratory services to meet the needs of its residents. On [DATE] at 5:20 PM, the missing ammonia level was reviewed with the Regional Director of Clinical Services and Administrator. No additional information regarding the missed provider ordered laboratory test was provided to the survey team prior to the exit conference.		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to protect the resident's right to be free from sexual abuse and physical abuse by another resident of the facility for 1 of 39 current sampled residents, Resident #69. The facility staff failed to (1) protect Resident #69 from sexual abuse by another resident (Resident #98) on 4/15/26 and (2) protect Resident #69 from physical abuse resulting from an altercation with another resident (Resident #64) on 7/04/26. The facility's investigation determined that the altercation on 7/04/26 resulted in a closed fracture of the right fourth metatarsal neck thus constituting harm to Resident #69. The fourth metatarsal bone is a long bone located in the midfoot region connecting the midfoot to the fourth toe. The findings included: A facility policy titled, Abuse, Neglect and Exploitation, revised 10/14/25, specified, The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. An admission Record indicated the facility admitted Resident #69 on 5/27/16. According to the admission Record, the resident had a medical history that included Alzheimer's Disease, post-traumatic stress disorder, generalized anxiety disorder, and major depressive disorder. An annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/08/26, revealed Resident #69 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. Resident #69's comprehensive person-centered care plan included a focus area revised on 4/17/26, that indicated the resident had a potential for re-traumatization due to history of trauma. Resident #69 has a history of stating that she has been raped and abused and at times has sexual behaviors. Interventions directed staff to avoid situations that remind resident of the trauma. (1) A final facility synopsis of events dated 4/23/26 indicated that on 4/15/26, a staff member observed Resident #98 lying on Resident #69's bed with his penis exposed and Resident #69 was sitting in her wheelchair holding his penis. Resident #98 had a documented BIMS score of 13, which indicated he was cognitively intact. Upon interview following the observation, Resident #98 denied having his pants down and his penis exposed. Resident #69 had no recollection of the incident. The report disclosed Based upon the facility investigation, we are able to validate that this incident occurred. Resident #69 was seen by the medical provider on 4/16/26, the progress note disclosed The patient presents for evaluation of increased sexual behaviors, which is concerning in the context of her baseline impaired cognition. The patient is alert but confused and has no recollection of the event. During an interview on 7/27/26 at 11:56 AM, the facility social worker (SW) stated Resident #98 was placed on 15-minute checks following the incident and stated she thought he remained on 15-minute checks until his discharge from the facility. When asked if Resident #69 had the mental capacity to consent to sexual activity, the SW stated no. The SW stated Resident #69 had no changes in behavior following the incident. Resident #98 was discharged from the facility on 5/01/26. Resident #69 was interviewed privately in her room on 7/20/26 at 3:56 PM and asked if there had been an unclothed male resident in her bed and she placed her hand on her chest and emphatically stated no, no, no! According to Resident #69's clinical record, she had a legal guardian in place. A call was placed to Resident #69's legal guardian on 7/22/26 at 11:18 AM and a message was left requesting a return call. However, the call was not returned prior to the end of the survey. (2) Resident #69's clinical record included a nursing progress note dated 7/04/26 at 6:41 PM which read staff was alerted to two residents fighting. Staff stated that another resident was blocking the way out and pt [patient] wanted to leave the dining room, and the two were seen fighting. [Resident #69] (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	was seen with several small scratches on the right lower arm together, bruise above the elbow joint on right arm about the size of a half dollar, bruise on the back of the right arm about the size of a half dollar, and bruise on the back of the left arm the size of a quarter. Pt had no pain and due to dysphagia could not give description. Resident #69 was seen by the medical provider on 7/07/26, the progress note disclosed Patient presents with right foot swelling and toe discoloration. Previously, the etiology was unclear, but new information reveals a recent traumatic event where a wheelchair rolled over the patient's foot. This mechanism of injury is consistent with the findings. The absence of pain is atypical but does not rule out a fracture or significant soft tissue injury, especially in the context of the patient's severe dementia which may affect her ability to perceive or report pain. An X-ray of the right foot and ankle, including the toes, has been ordered to evaluate for an occult fracture given the new history of a crush injury. This will also help further assess the etiology of the swelling and discoloration. Further treatment will be determined after the X-ray results are reviewed. Resident #69 was seen by the medical provider on 7/09/26, the progress note indicated the X-rays revealed a fracture of the right fourth metatarsal neck. Resident #69 was being referred to podiatry for further evaluation and management of the fracture and ibuprofen 600 mg three times a day was ordered prophylactically for pain and inflammation for seven days. The facility's final synopsis of events dated 7/10/26 read in part .Dietary staff reported [Resident #69] and [Resident #64] were in the dining room speaking in loud voices and notified Clinical Staff that residents were having a verbal altercation. Clinical Staff observed both residents in their wheelchairs intertwined facing each other with [Resident #64] holding onto the wheelchair of [Resident #69] and not letting go. Residents were immediately separated. Both residents were assessed at the time of the incident. [Resident #69] was observed to have small scratches on her right forearm, discoloration on her bilateral arms. On 7/07/26 [Resident #69] was noted to have swelling to her right foot and ankle. X-ray results showed a fracture involving the fourth metatarsal. Based upon the facility investigation, we are able to validate that this incident occurred. No further information was provided prior to the exit conference on 7/28/26.		

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F 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure competent staff to recognize a significant change in condition for one of 12 closed record reviews, Resident #95. The facility staff also failed to ensure nurse competencies, including skills assessments were completed for licensed nursing staff, Registered Nurse #7. The findings included: 1. For Resident #95 the facility staff failed to ensure nurses were competent to recognize and act appropriately when a significant change in resident condition occurred. Licensed Practical Nurse (LPN) #2 failed to recognize, act upon, and report a heart rate of 131 beats per minute to a medical provider for approximately six hours which likely caused and/or hastened the resident's death which occurred one to two hours after being sent out to the hospital with complaints of shortness of breath and chest pain. This constituted harm to Resident #2. The facility policy titled, Notification of Changes with a revised date of [DATE] was reviewed. The document read in part, 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, the resident's representative when there is a change requiring notification. Under the heading Compliance Guidelines the document read in part, 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. Under Circumstances requiring notification include item #2 read, Significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include a. Life threatening conditions, or b. Clinical complications. A policy entitled Vital Signs with no review or revised date read in part, The purpose of this policy is to provide guidelines for the measurement and reporting of vital signs. Under item #4 the document read, Acceptable ranges for adults item b. Pulse: 60-100 beats per minute. Resident #95's admission Record indicated the facility admitted the resident on [DATE]. The admission Record included the diagnoses of atrial fibrillation, acute diastolic congestive heart failure, takotsubo syndrome (also known as broken heart syndrome which is a temporary condition where the hearts main pumping chamber, the left ventricle weakens and changes shape. It closely mimics a heart attack.), presence of a prosthetic heart valve and bacteremia. Resident #95's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed the resident had no memory impairment and was independent in making reasonable and consistent decisions. The MDS indicated the resident was independent with eating, hygiene and upper body dressing and only required minimal assistance with other tasks of activities of daily living (ADL's). Resident #95 required partial to moderate assistance with getting out of bed and could only walk around 10 feet with partial to moderate assistance. Resident #95's baseline care plan was reviewed, and it indicated that the resident was admitted on (continued on next page)		

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F 0726 Level of Harm - Actual harm Residents Affected - Few	intravenous (IV) antibiotics, diuretic and anticoagulant medications, was cognitively intact, always continent of bowel and bladder and had a discharge goal of returning home. A nursing progress note dated [DATE] at 11:40 AM read, Pt [patient] picked up by transport to go to [acute care hospital] at 1140 [11:40 AM]. Pt was tachycardic [rapid heart rate] (135), had new leg swelling, and altered mental status. This nurse informed NP [name omitted] who then evaluated pt. When EMS arrived, PT's O2 was 85%. A [DATE] provider progress note titled Post Acute Care Visit #2 by the Nurse Practitioner (NP) was reviewed and read in part, .evaluated for an acute change in status. [Resident] was found to have atrial fibrillation with a rapid ventricular rate [RVR] and was noted to be dyspneic [short of breath] during conversation. atrial fibrillation and a rapid ventricular response, confirmed by physical exam and bedside 3-lead EKG. This is contributing to clinical presentation of dyspnea and likely hemodynamic instability. The recommendation for urgent transport to the emergency department was made due to the inability to obtain rapid labs to guide resuscitation and determine the degree of strain on her heart Resident #95 was admitted to the hospital on [DATE] and returned to the facility on [DATE]. The hospital Discharge summary dated [DATE] was reviewed and revealed that Resident #95 was admitted with a diagnosis of atrial fibrillation with RVR [rapid ventricular rate] and a heart rate in the 150's. On [DATE] at 11:03 AM a nursing progress note indicated that Resident #95 had a heart rate of 131 beats/minute and a blood pressure of 98/53. Under the heading Cardiovascular the note read, Skin warm and pink with brisk capillary refill (<3 seconds). No edema present. There was no documentation indicating a medical provider was notified of the elevated heart rate or that a nurse further assessed the elevated heart rate. The next clinical record entry dated [DATE] at 6:12 PM, approximately seven hours later, was from an on-call provider who documented in part, Complaint: Shortness of breath, chest pain, not feeling well Provide Current Vital Signs: 114/64 p [pulse] 80 o2 [oxygen saturation] 77 Message: Given one nitro for chest pain. Was slightly better but was sent out to hospital. [DATE], 6:12 PM. There was no indication in the note that the facility nurse had informed the on-call provider of the resident's extensive cardiac history, their hospitalization just days prior when the resident was sent out with a heart rate of 135 or that the resident had a heart rate at 11:03 AM of 131. There was no documentation in Resident #95's clinical record to indicate if the resident remained stable during the seven hours or if they were checked on during the seven-hour period. The next entry in the clinical record was dated [DATE] at 1:01 AM and it read, RSD [resident] expired at [hospital]. TOD [time of death] 2052 [8:52 PM]. Family aware. A document titled, Change in Condition (SBAR)-CHC was dated [DATE] at 5:52 PM. Under the heading Situation it read, not feeling well, SOB (shortness of breath), chest pain. Under the heading Vital Signs the pulse from the 11:03 AM nurse note of 131 was documented as well as the rest of the 11:03 AM vital signs, indicating the nurse never obtained another set of vital signs. It is unclear where the pulse (continued on next page)		

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F 0726 Level of Harm - Actual harm Residents Affected - Few	of 80 documented in the on-call provider note at 6:12 PM came from. Under the heading Cardiovascular Evaluation item #2 Chest pain/tightness was checked but item #6 Resting pulse <100 or <50 was not checked. On [DATE] at 9:39 AM, NP (nurse practitioner) #1 was interviewed via telephone. They said they were no longer seeing patients at the facility but remembered Resident #95 well. They stated, It was a Sunday if I'm not mistaken and the nurse had contacted me a few times that day about other residents but never said a word about [Resident #95]. When I got to the building on Monday and was informed about what happened I was shocked. I spoke to [Licensed Practical Nurse/LPN #2] about it. I wanted to know why with a heart rate of 130 and when [resident] had been sent out already just days prior and was in ICU [intensive care unit] and we were aware this was a serious problem for [resident], that required monitoring due to poor compensation, and I had made it clear that [resident] had to be watched closely, I just could not understand why I wasn't called. She [LPN #2] had contacted me within an hour of documenting that heart rate about someone else and never said a word. I would have had [resident] sent out right then if she had just told me. I asked her Monday morning what did you do about this heart rate and she told me it was [resident's] baseline and she didn't do anything. I told her you do know that she died, right? We had seven hours to intervene and do something, but she [LPN #2] just shrugged and walked away. I tried to talk to [the Director of Nursing/DON] about her [LPN #2] and all she said was I know, we've had the same problem with her before and we've talked to her, but some people just don't learn. I tried to bring the concern to the Administrator as well, many concerns but I never received a response other than we're working on it. This death could have been prevented. [Resident] died just an hour or two after getting to the hospital because [resident] was not sent out timely. On [DATE] at 10:57 AM LPN #2 was interviewed. When asked what they did for Resident #95 when they got the heart rate of 131 they stated, The C.N.A. [certified nursing assistant] got the vital signs and gave them to me and when I saw that pulse I immediately went back and checked [resident] out. I got 87 when I checked it and [resident] was fine, [resident] didn't have any complaints or anything, there were no other symptoms, so I didn't do anything. It wasn't until that evening when the C.N.A. was transferring [resident] to bed that [resident] complained about being short of breath and heart racing, so I assessed [resident] and the heart rate was quite quick and the o2 sat was low, so I sent [resident] out. When asked why she didn't document that she went and rechecked the heart rate that morning, she stated, It was a crazy day, and we had a lot going on. When asked where the on-call provider got the heart rate of 80 LPN #2 could not recall a pulse of 80 and was not sure where it came from. The employee file for LPN #2 was reviewed. LPN #2 was hired less than one year ago. The file included an orientation checklist that indicated required education was provided during the orientation period. There was a copy of the Notification of Changes in LPN #2's file but there were no dates or signatures to indicate when it had been reviewed or by who. There was no evidence of any hands-on skills validation noted in the file. No further information was provided to the survey team prior to the exit conference. 2. The facility staff failed to ensure Registered Nurse (RN) #7 demonstrated skill competencies and (continued on next page)		

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F 0726 Level of Harm - Actual harm Residents Affected - Few	completed required retraining after scoring below expected facility standards on the skills competency assessment. On [DATE] at 10:15 AM, the surveyor requested from Human Resources Staff #1 required training for RN #7. Human Resource Staff #1 provided the surveyor with a copy of a document titled, Section C Skills Competency Assessment For Nurse Staff this document read in part, .If your overall performance or competency is rated below the minimum competency level, you must participate in additional training and that performance or competency must be reassessed. This document was dated 02/2026, identified RN #7 as a new hire and included scores below the required expected standards in the following areas Sit to Stand Lift, Glucometer, Nebulizer Administration, CPAP and BIPAP, Tracheostomy Suctioning, Enteral Medication Pass, Life Vest, Hemovac and JP Drain, Left Ventricular Device, and Medical Systems and Processes. The bottom portion of this competency assessment contained the following evaluation check boxes: Employee is competent to perform the above tasks independently and without supervision. Employee's level of competence is below 2. Note the date to reassess competency. Both sections were left unmarked, and no completion date or evaluator sign-off was documented. On [DATE] at 1:46 PM, Human Resources Staff #1 stated they were unable to locate further evidence of the required training for RN #7. This staff further identified the educator as the former Assistant Director of Nursing, who had resigned during the survey. The Administrator was able to provide the surveyor with a copy of an Education In-service Attendance Record dated [DATE] indicating RN #7 attended training on admission order entry and discharge summary review process. No other training records were provided. The above issue was reviewed with the Regional Director of Clinical Services and the Administrator on [DATE] at 5:20 PM. No further information regarding this issue was provided to the survey team prior to the exit conference.		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, clinical record review and facility document review the facility staff failed to protect residents from misappropriation of medications for 4 of 51 residents, Resident #12, Resident #44, Resident #90, and Resident #91. The findings included: 1. For Resident #12 the facility staff failed to protect the resident from misappropriation of the Schedule II narcotic pain medication, oxycodone. Resident #12's clinical record listed diagnoses which included but not limited to rheumatoid arthritis, unspecified, contracture of muscle, right shoulder, and hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side. Resident #12's most recent quarterly Minimum Data Set with an Assessment Reference Date of 06/29/26 assigned the resident a Brief Interview for Mental Status score of 3 out of 15 in section C, cognitive patterns. This indicated that the resident was severely cognitively impaired. Section J, health management, coded the resident as receiving scheduled pain medication. Resident #12's comprehensive care plan was reviewed and contained a plan for . is at risk for alterations in pain r/t (related to) RA (rheumatoid arthritis), CVA (cerebrovascular accident), PEG (percutaneous endoscopic gastrostomy) placement, and generalized pain, neuropathy. Resident #12's clinical record contained a physician's order summary which read in part, oxycodone HCl Oral Tablet 5 mg (Oxycodone HCl). Give 1 tablet by mouth every 8 hours for pain. Resident #12's narcotic control sheets for the months of June and July 2026 were reviewed on 07/27/26. The control sheets for the dates of 06/01/26-06/12/26 revealed a dispensed amount of 56 tablets and a received amount of 30 tablets. The control sheet for the dates of 06/21/26-06/26/26 revealed a dispensed amount of 12 tablets and a received amount of 12 tablets. The control sheet for the dates of 07/04/26-07/14/26 revealed a dispensed amount of 88 tablets and a received amount of 30 tablets. The control sheet for the dates of 07/18/26 revealed a dispensed amount of 8 tablets and a received amount of 8 tablets. The control sheet dated 07/21/26 revealed a dispensed amount of 30 tablets and a received amount of 30 tablets. There were no control sheets for the dates of 06/13/26-06/21/26, 06/27/26-07/04/26, or 07/15/25-07/18/26. Surveyor spoke with pharmacy technician #5 on 07/27/26 at 10:08 am regarding Resident #12's oxycodone. Pharmacy technician #5 stated the pharmacy sent 88 tablets from a prescription for 90 tablets on 06/24/26, leaving 2 tablets out so facility could pull from emergency supply. This was divided into two cards of 30 tablets each, and one card of 28 tablets. Pharmacy technician #5 stated the pharmacy sent 8 tablets from a 9-tablet order on 07/17/26, leaving one out so facility could pull from emergency supply. Of these 96 tablets sent from the pharmacy, a total of 58 were unaccounted for. Surveyor spoke with pharmacy technician #6 on 07/27/26 at 4:22 pm regarding Resident #12's oxycodone. Pharmacy technician #6 stated a delivery of 56 tablets, divided by one card of 30 tablets (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and one card of 26 tablets, was delivered to the facility on [DATE] and a delivery on 12 tablets was delivered to the facility on [DATE]. Of these 68 tablets sent from the pharmacy, a total of 26 tablets were unaccounted for. This is a cumulative total of 84 tablets unaccounted for. Surveyor spoke with the regional director of clinical services (RDCS) and administrator on 07/28/26 at 9:12 am regarding Resident #12's missing oxycodone. RDCS stated they are aware of the missing medications and have started an investigation, which is ongoing. Administrator stated they have reported this to the police and Office of Licensure and Certification on 07/17/26. RDCS stated they have been unable to locate the medications or the control sheets. RDSC stated, We can't substantiate or unsubstiate drug diversion since we have no medication cards. We've been at a loss, we have no cards, no control sheet, or no destruction file. Surveyor requested and was provided with the final facility synopsis of events dated 07/24/26 which read in part, This letter is to serve as our final report for an FRI (facility reported incident) submitted to your office on 07/17/26, it was reported that there was a potential of misappropriation of Oxycodone HCL ordered for . (omitted); . (Resident #12) . (Resident #12) is ordered 5 mg Oxycodone HCL every 8 hours for pain. On 6/24/2026 new script was sent to the pharmacy to reorder the medication. The medication was received in the facility and receipt of medication was signed in by . (assistant director of nursing). It was reported to this writer on 7/17/2026, that earlier in the week the medication needed to be re-ordered for both residents and a new script needed to be obtained .At the time the investigation is ongoing, there is inconclusive evidence of any misappropriation. Should we learn more information that would lead us to a different conclusion, we will contact your office at that time . This was signed by the administrator. Surveyor requested and was provided with a facility policy entitled Acceptance of Medication and Controlled Substances which read in part, Policy: To ensure medications and controlled substances are properly accounted for in accordance with Federal Regulations. Medications will be delivered to the facility by the pharmacy and 2 nurses will sign the medications into the facility on the pharmacy delivery slip. Surveyor was also provided with a facility policy entitled Abuse, Neglect, and Exploitation which read in part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . 'Misappropriation of Resident Property' means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. Surveyor spoke with RDCS on 07/28/26 at 2:12 pm regarding Resident #12's oxycodone. RDCS stated the facility will absolutely reimburse residents for missing narcotics. RDCS stated they talked with business office manager and will write off last two months of narcotics. The concern of Resident #12's missing narcotics was discussed with the administrator and RDCS on 07/28/26 at 2:15 pm. No further information was provided prior to exit. (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. For Resident #44, the facility staff failed to protect the resident from the misappropriation of the Schedule II narcotic medication Oxycodone. The facility staff were unable to account for 30 tablets of Oxycodone 5 mg. Resident #44's diagnoses included osteoarthritis of knee and polyneuropathy. Section C (cognitive patterns) of Resident #44's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 04/28/2026 included a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. Section J (Health Conditions) was coded to indicate the resident received a scheduled pain management regimen. The resident's comprehensive care plan identified pain as a focus area with interventions including administration of analgesics. Resident #44's clinical record included a provider order for Oxycodone oral tablet 5 mg two times a day for pain, hold if asleep or sedated. The order date was documented as 12/27/2025. A review of the Medication Administration Records (MARs) for 07/2026 revealed that on 07/17/2026 at 9:00 AM, 07/18/2026 at 9:00 AM and 07/18/2026 at 9:00 PM the facility nursing staff documented a 5 for the Oxycodone, 5=Hold/See Nurse Notes. Corresponding progress notes documented the following: 07/17/2026, the provider documented Resident #44 was out of Oxycodone and the pharmacy requires a new script to fill. Resident not currently complaining of pain. 07/17/2026 at 2:38 PM, Registered Nurse (RN) #1 documented the medication being held per MD. 07/18/2026 at 9:42 AM, ordered, waiting on delivery. 07/18/2026 at 10:22 PM, waiting on pharmacy to deliver. On 07/17/2026, the facility Administrator submitted a facility synopsis of events indicating they were investigating the potential of misappropriation of the narcotic medication Oxycodone for this resident. On 07/28/2026 at 11:20 AM, Resident #44 stated he was taking pain medication for his knees, hips, and ribs from an old injury. Stated there may have been a couple of times when he did not receive his pain medication but reported no current concerns. On 07/28/2026, the Administrator provided the surveyor with a copy of a narcotic count sheet indicating that on 06/24/2026 the pharmacy had sent to the facility 60 tablets of Oxycodone 5 mg for Resident #44, the facility staff could only produce narcotic count sheets/documentation accounting for 30 tablets of Oxycodone. Administrative staff acknowledged they were unable to locate additional narcotic count sheets or otherwise account for the remaining 30 tablets. Only one licensed staff had signed for this medication the Assistant Director of Nursing (ADON). (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator also provided the surveyor with a copy of a written statement documented by Licensed Practical Nurse (LPN) #3 I called the rx [pharmacy] to order Oxy [Oxycodone] for [Resident #44]. RX informed me that 60 had been sent on 6/24. I reported this to the DON [Director of Nursing]. The facility staff provided the survey team with a copies of the following policies: Abuse, Neglect and Exploitation with a revision date of 10/14/2025, that read in part, .The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. Acceptance of Medication and Controlled Substances effective date 01/15/2015, this policy read in part, To ensure medications and controlled substances are properly accounted for.2 nurses will sign the medications into the facility on the pharmacy delivery slip. During an interview on 07/28/2026 at 2:10 PM, the Regional Director of Clinical Services (RDCS) stated the facility had purchased hardback narcotic record books, would discontinue use of the free-floating narcotic count sheets, and would write off the previous two months of Oxycodone charges for Resident #44. On 07/30/2026 at 10:30 AM, pharmacy personnel #9 confirmed they had sent to the facility 60 tablets of 5 mg Oxycodone on 06/24/2026 and 30 tablets on 07/23/2026. Indicating 30 tablets of Oxycodone were unaccounted for. No further information regarding this issue was provided to the survey team prior to the exit conference. 3. For Resident #90 the facility staff failed to protect the resident from misappropriation of the medication oxycodone. The resident was discharged on 8/1/25. Resident #90's clinical record listed diagnoses which included but not limited to; chronic pain, muscle weakness. chronic pulmonary edema, limitation of activities due to disability, and cellulitis of lower right limb. Resident #90's most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 03/19/25 assigned the resident a Brief Interview for Mental Status (BIMS) score of 15 out of 15 in section C, cognitive patterns. This indicated that the resident was cognitively intact. Section J, health management, coded the resident as receiving scheduled pain medication. Resident #90's comprehensive care plan was reviewed and contained a plan for . has pain r/t [related to] chronic pain, history of rib fracture and liver disease. Resident #90's clinical record contained a physician's order summary which read in part, oxycodone HCl Oral Tablet 5 mg (Oxycodone HCl). Give 1 tablet by mouth every 6 hours for pain/discomfort give one tablet q6h [every 6 hours] with a 325 Tylenol. Surveyor spoke with Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 7/16/26 (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 8:45 am and requested the April 2025 controlled substance narcotic sheets. It was reported they would need to go to the shed to access the older documents. May 2025 sheets had been provided but not all of April 2025 provided. Surveyor spoke with DON on 07/16/2026 at 2:30 pm and asked to discuss the controlled substance narcotic sheet dated 4/22/25 to 4/29/25. Only the front page of the sheet had been provided and the DON stated she did not have the sheet herself. She was unable to explain how a copy was provided to the surveyor when she did not have a copy. Review of the electronic medical administration record (eMAR) for Resident #90 showed that the oxycodone was documented on the eMAR, as administered per the physician's order, on 4/20/25 and 4/22/25 with three doses missing on the narcotic sheet; 4/21/25 with four doses missing on the narcotic control sheet; 4/24/25, 4/25/25, 4/26/25, 4/27/25, and 4/28/25 with one dose missing. The narcotics control sheet showed that one tablet was removed on each of these days during the entries signed for and no indication of what happened to the missing medication was documented. On 4/27 and 4/28/25, the eMAR showed two doses to be given daily while the narcotic control sheet reflected three (out of four) doses given. When the sheet was reviewed with the DON, it was confirmed medications were not documented or accounted for. Surveyor spoke with pharmacy tech supervisor #7 on 07/28/26 at 5:04pm regarding Resident #90's billing for oxycodone. Pharmacy tech supervisor #7 explained that the company had a new system but was able to confirm that the medication was billed to Resident #90's insurance for 120 tablets filled on 4/11/25. The facility had called on 4/28/25 to have 30 tablets sent on 4/30/25 and another 90 tablets sent on 5/4/25, both transactions to billed to the facility to offset the charges on 4/11/25. During the end of day meeting with the Administrator, the DON and the ADON, it was reported that there was a staff nurse identified as the alleged perpetrator who terminated employment during the process of their facility-based investigation regarding the missing controlled substances with both Resident #90 and Resident #91. The staff nurse had not signed any of the controlled medications within their narcotics binder and refused a drug screen. Other staff nurses that would have access to the same hall med cart were drug screened during that time. A report had been filed with state agency, ombudsman and law enforcement. A review of the Facility Synopsis of Events dated 4/28/25, and the addendum dated 5/9/25, revealed, on 04/27/25, the facility discovered a bottle of liquid Hydromorphone 24ml missing and control signature log missing for Resident #91 and 60 Oxycodone 5mg missing with control signature sheets for Resident #90. Multiple staff members were identified and interviewed regarding the missing medication based on their assignments with the medication cart and dates in question. A police report filed with investigation, Adult Protective Services (APS) report filed, and Ombudsman contacted. Staff in question were drug screened, with all results being negative and were suspended during the investigation. All employees received education for 5 Rights of Medications, misappropriation of resident property, and the protocol for receiving medications from pharmacy. All employees were originally cleared but new information came to light, and a further investigation revealed evidence of further missing medications. The new evidence was investigated, along with narcotics sheets and medical documentation. The nurse in question refused to submit a drug screen and was terminated. The facility could not definitively prove that the nurse was responsible for the original missing medications reported on 4/28/25 but did believe her to be responsible. The DON (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reported an ongoing review of measures taken to ensure the residents remain free from narcotic diversion. DON reports creating a method of checks and balances she would oversee including; making sure yellow sheets are placed in box, doing a review of each cart to make sure all medications in and continuing to provide education to the staff. The DON stated that Resident #90 never went without his medication had not been charged for the medication. Surveyor requested and was provided with a facility policy titled Acceptance of Medication and Controlled Substances which read in part, Policy: To ensure medications and controlled substances are properly accounted for in accordance with Federal Regulations. Medications will be delivered to the facility by the pharmacy, and 2 nurses will sign the medications into the facility on the pharmacy delivery slip. Surveyor was also provided with a facility policy titled Abuse, Neglect, and Exploitation which read in part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. 'Misappropriation of Resident Property' means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. The concern of Resident #90's missing narcotics was discussed with the Administrator and Regional Director of Clinical Services on 07/28/26 at 2:15 pm. No further information was provided prior to exit. 4. For Resident #91, the facility staff failed to protect the resident from misappropriation of a Schedule II narcotic medication, liquid hydromorphone that was prescribed for the resident. The facility and pharmacy determined the liquid medication had been replaced with what appeared to be water. Resident #91 was admitted to the facility on [DATE] with a diagnosis list which indicated diagnoses, included but not limited to, unspecified atrial fibrillation, acute myocardial infarction, unspecified, acute on chronic systolic (congestive) heart failure, hypertensive heart disease with heart failure, type 2 diabetes mellitus with diabetic neuropathy, unspecified. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/29/2025 assigned the resident a Brief Interview for Mental Status (BIMS) summary score of 7 out of 15, indicating resident had moderate cognitive impairment. A medical provider order with a start date of 04/21/2026 specified hydromorphone HCL (belongs to the class of medications called opioid (narcotic) analgesics. It is a strong mu-opioid receptor agonist used to manage moderate to severe pain) oral liquid 1mg/ml (milligram/milliliter). Give 1ml by mouth every 4 hours for pain. A review of Resident #91's April 2025 Medication Administration Record (MAR) revealed two doses of liquid hydromorphone as not being administered on 04/23/2025 at 0400 (4:00 AM) and 0800 (8:00 AM). (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The medication was discontinued on 04/23/2025 at 10:38 AM at the time of the resident's death. On 07/15/2026 at 10:50 AM, an interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) regarding a medication discrepancy. The DON stated that on the evening of 04/27/2025, a staff nurse reported a narcotic discrepancy during the shift-change count. The DON and ADON subsequently conducted a comprehensive audit of all facility narcotics. During this audit, Resident #91's liquid hydromorphone was observed to have an abnormal color and consistency. The DON verified with the facility pharmacist that the medication appeared to have been replaced with water. According to the DON, the facility implemented corrective actions following the incident. All employees received mandatory education on the Five Rights of Medication Administration, misappropriation of resident property, and pharmacy delivery protocols. Additionally, the DON stated that the facility initiated a new protocol establishing checks and balances for receiving pharmacy deliveries. A facility synopsis of events file for the incident was received and reviewed. A Timeline report was provided by the facility Administrator and reviewed. The facility synopsis of events included the dates and times for the facility's investigation, including interviews with staff and residents and when notifications had been made to Law Enforcement, Adult Protective Services and the local state Ombudsman. The report summarized that the facility performed drug screening on facility nurses and one staff nurse resigned and one refused the mandatory drug screen and was terminated. A facility policy titled, Inventory of Controlled Medications with a revision date of 08/01/18, read in part, Procedure 1. The community should maintain separate individual controlled medication records on all Schedule II medications and any drug with a potential for abuse or diversion in the form of a declining inventory, using the Controlled Substances Declining Inventory Record should contain.2.8 Signature of person observing, assisting with or administering the drug. A facility policy titled, Controlled Substances, that read in part, Procedure: 2. When a controlled substance is administered to a resident, it must be recorded on the resident's Medication Sheet as well as a separate Controlled Substance/Schedule II Narcotic Sheet that is created for each prescription. 3. In addition to the Medication Sheet and the Schedule II Narcotic Sheet, the number of controlled substances on hand must be counted and verified at the end of each shift. The Narcotic Sign In Sheet must be completed at the end of each shift every day. The outgoing Nurse or her designee* will count all controlled substances being stored at the residence while the oncoming nurse or his or her designee watches. Both staff members sign that the count and verification have been completed. A facility policy titled Abuse, Neglect, and Exploitation which read in part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . 'Misappropriation of Resident Property' means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. (continued on next page)		

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to exit on 07/28/2026.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, resident interview, staff interview, clinical record review and facility document review the facility staff failed to provide ADL (activities of daily living) care for 7 of 51 sampled residents, Resident #8, Resident #12, Resident #71, Resident #3, Resident #10, Resident #13, and Resident #89. The findings included: 1.For Resident #8 the facility staff failed to provide evidence of showers and/or bed baths. Resident #8's clinical record listed diagnoses which included but not limited to cerebral palsy, unspecified, unspecified intellectual disabilities, abnormal posture, and epilepsy, unspecified. Resident #8's most recent quarterly minimum data set with an assessment reference date of 06/16/26 coded the resident as having both long- and short-term memory problems with severely impaired cognitive skills for daily decision making. Section GG, functional abilities, coded the resident as dependent in the area of shower/bathe self. Resident #8's comprehensive care plan was reviewed and contained a care plan for . has an ADL self-care performance deficit r/t (related to) requires total care, Non ambulatory ID (intellectual disabilities), CP (cerebral palsy) Seizure D/o (disorder), contracture UE/LE (upper extremity/lower extremity). Interventions for this care plan included Showers/bathing per schedule. Resident #8's clinical record was reviewed and contained ADL shower sheets for the months of May, June, and July 2026. These shower records indicate that resident's shower days are Monday and Thursday. For the month of May 2026, the shower sheets were coded NA on 05/04/26, 09,09 on 05/07/26, 09,09 on 05/11/26, blank on 05/14/26, 09,09 on 05/18/26, blank on 05/21/26, 09,09 on 05/25/26 and 09,09 on 05/28/26. Code 09,09 is equivalent to Not applicable-Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. This indicated that the resident did not receive any showers for the month of May 2026. There was no documentation of resident receiving bed baths for the month of May. The ADL shower sheet for the month of June 2026 was coded 01,01 on 06/01/26, 09,09 on 06/04/26, blank on 06/08/26 and 06/11/26, 09,09 on 06/15/26, blank on 06/18/26, 01,01 on 06/22/26, 01,01 on 06/25/26 and blank on 06/29/26. Code 01,01 is equivalent to dependent. This shower sheet indicates that the resident received three showers in the month of June, with no documentation of resident receiving any bed baths for the month. The ADL shower sheet for the month of July 2026 was blank on 07/02/26, 07/06/26, 07/09/26, 07/13/26, coded 01,01 on 07/16/26 and 07/20/26, blank on 07/23/26 and 07/27/26. This sheet indicates that the resident has received 2 showers for the month of July, with no documentation of any bed baths for the month. Surveyor requested and was provided with a facility policy entitled, Activities of Daily Living which read in part, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs choices, ensure a resident's abilities in ADLs do not deteriorate unless (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	deterioration is unavoidable. 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The concern of the facility not having evidence of Resident #8 receiving showers and/or bed baths was discussed with the administrator and regional director of clinical services on 07/27/26 at 5:15 pm. No further information was provided prior to exit. 2. For Resident #12 the facility staff failed to provide evidence of showers and/or bed baths. Resident #12's clinical record listed diagnoses which included but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side and contracture of muscle, right shoulder. Resident #12's most recent quarterly minimum data set with an assessment reference date of 06/29/26 assigned the resident brief interview for mental status score of 3 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Section GG, functional abilities, coded the resident as needing partial/moderate assistance with shower/bath self. Resident #12's comprehensive care plan was reviewed and contained a plan for . has a self-care/mobility performance deficit r/t (related to) Sepsis, CVA (cerebrovascular accident) with residual hemiparesis to R (right) non dominant side, COPD (chronic obstructive pulmonary disease), Respiratory failure, epilepsy, PCM, Dysphagia and aphasia, RA (rheumatoid arthritis), Right shoulder contracture. Interventions for this care plan included Bathing/Showering: Provide sponge bath when a full bath or shower cannot be tolerated and Bathing/Showering: The resident requires up to substantial assistance via 1-2 staff as needed. Resident #12's clinical record was reviewed, and no ADL shower sheets could be located. There was no documentation related to showers and/or bed baths. Surveyor requested and was provided with a facility policy entitled, Activities of Daily Living which read in part, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The concern of the facility not having evidence of Resident #12 receiving showers and/or bed baths was discussed with the administrator and regional director of clinical services on 07/27/26 at 5:15 pm. No further information was provided prior to exit. 3. For Resident #71 the facility staff failed to provide evidence of showers and/or bed baths. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #71's clinical record listed diagnoses which included but not limited to cerebral palsy and hemiplegia, unspecified affecting right non-dominant side. Resident #71's most recent annual minimum data set with an assessment reference date of 06/10/26 assigned the resident a brief interview for mental status score of 9 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired. Section GG, functional abilities, coded the resident as dependent for shower/bathe self. Resident #71's comprehensive care plan was reviewed and contained a plan for . has an ADL (activities of daily living) self-care performance deficit r/t (related to) weakness, impaired mobility, L (left) hemi with contractures, CP (cerebral palsy)/Brain injury at 2 years old, ID/MR (intellectual disability/mental retardation). Interventions for this care plan include Stretcher showers per shower schedule and PRN (as needed) and Assist with ADL's as needed. Surveyor observed Resident #71 on 07/22/26 at 9:35 am. Resident's fingernails on left hand observed to be long and jagged, toenails observed to be long and curled upward. Resident #71's clinical record was reviewed and contained ADL shower sheets for the months of May, June and July 2026, which indicated the resident's shower days are Monday and Thursday. The shower sheet for May was coded NA on 05/04/26, 09,09 on 05/07/26, 09,09 on 05/11/26, blank on 05/14/25, 09,09 on 05/18/26, blank on 05/21/26, 09,09 on 05/25/26, and 09,09 on 05/28/26. Code 09,09 is equivalent to Not applicable-Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. This indicates that the resident did not receive any showers for the month of May 2026, and there is no documented evidence of bed baths. Resident #71's ADL shower sheets for the month of June were coded 09,09 on 06/01/26, 01,01 on 06/04/26, blank on 06/08/26 and 06/11/26, 01,01 on 06/15/26, blank on 06/18/26, 01,01 on 06/22/26 and 06/25/25 and blank on 06/29/26. Code 01,01 is equivalent to dependent. This indicates that the resident received 4 showers in June 2026. There was no documented evidence of bed baths in the clinical record. Resident #71's ADL shower sheets for the month of July were blank on 07/02/26, 07/06/26, 07/09/26, 07/13/26, coded 01,01 on 07/16/26 and 07/20/26, and blank on 07/23/26 and 07/27/26. This indicates that the resident has received 2 showers for the month of July. There was no documented evidence of bed baths in the clinical record. Surveyor requested and was provided with a facility policy entitled, Activities of Daily Living which read in part, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The concern of the facility not having evidence of Resident #71 receiving showers and/or bed baths was discussed with the administrator and regional director of clinical services on 07/27/26 at 5:15 pm. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to exit. 4. For Resident #3, the facility staff failed to ensure the resident was provided with a shower and/or full bath at least twice per week. A facility policy titled, Activities of Daily Living (ADLs) with a revision date of 11/07/2025 specified under the heading, Policy Care and services will be provided for the following activities of daily living, Item #1, Bathing. A review of an admission Record, disclosed Resident #3 was admitted to the facility on [DATE] with a diagnosis list that indicated diagnoses that included, but were not limited to, chronic obstructive pulmonary disease, morbid obesity, weakness, and abnormalities of gait/mobility. The most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/03/2026, assigned the resident a Brief Interview for Mental Status (BIMS) summary score of 8 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. Section GG (Functional Abilities) Item GG0130 E. was coded as (02) indicating the resident required substantial/maximal assistance with showering/bathing self. A review of the comprehensive person-centered care plan specified Resident #3 had an ADL self-care performance deficit related to right tibia fracture and obesity. An intervention associated with the focus specified to provide a sponge bath when a full bath or shower could not be tolerated. A review of Resident #3's Shower/Bathing Task Record disclosed the resident's scheduled shower days were Monday and Thursday. A thirty-day look-back of the shower record disclosed, No Data Found, indicating that no showers/baths were provided/documented for the resident in the past 30 days. The Director of Nursing and Assistant Director of Nursing were not available for interview during the time of the survey. This concern was discussed at the end of day (pre-exit) meeting on 07/27/2026 at 5:19 PM, with the Administrator and Regional Director of Clinical Services. No further information was provided prior to exit on 07/28/2026. 5. For Resident #10, the facility staff failed to ensure the resident was provided with a shower and/or full bath at least twice a week. A facility policy titled, Activities of Daily Living (ADLs) with a revision date of 11/07/2025 specified under the heading, Policy Care and services will be provided for the following activities of daily living, Item #1, Bathing. A review of an admission Record, disclosed Resident #10 was admitted to the facility on [DATE] with a diagnosis list that indicated diagnoses that included, but were not limited to, acute and chronic (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	respiratory failure with hypercapnia, acute and chronic respiratory failure with hypoxia, morbid obesity with alveolar hypoventilation, muscle weakness, unsteadiness on feet, and abnormalities of gait and mobility. The most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/07/2026, assigned the resident a Brief Interview for Mental Status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. Section GG (Functional Abilities) Item GG0130 E. was coded as (03) indicating the resident required partial/moderate assistance with shower/bathing self. On 07/20/2026 at 3:32 PM, Resident #10 was observed/interviewed and stated the staff work short on the weekends and she does not always get her showers/baths. A review of the comprehensive person-centered care plan specified Resident #10 had an ADL self-care performance deficit related to activity intolerance, fatigue, impaired balance, limited mobility, pain, and wounds. Interventions associated with the focus specified the resident required partial/limited assistance with bed baths and/or tub/showers (washing and drying hair and body 3x (three times) per week and PRN (as needed) and to provide the resident a sponge bath when a full bath/shower could not be tolerated. A review of Resident #10's clinical record revealed the resident's scheduled shower days were Wednesday and Saturday. A review of a Shower/Bathing Task Record thirty-day look-back disclosed the resident received a shower/bath on 07/04/2026. There were no entries from 07/05/2026 through 07/10/2026. 07/11/2026 was coded as 09, 09 indicating not applicable. From 07/12/2026 through 07/14/2026, there were no entries. 07/18/2026 was coded as NA, NA (not applicable.) From 07/19/2026 through 07/21/2026 there were no entries. On 07/22/2026 the record disclosed the resident received a shower/bath. The Director of Nursing and Assistant Director of Nursing were not available for interview during the time of the survey. This concern was discussed at the end of day (pre-exit) meeting on 07/27/2026 at 5:19 PM, with the Administrator and Regional Director of Clinical Services. No further information was provided prior to exit on 07/28/2026. 6. For Resident #13, the facility staff failed to ensure the resident was provided with a shower and/or full bath at least twice a week. A facility policy titled, Activities of Daily Living (ADLs) with a revision date of 11/07/2025 specified under the heading, Policy Care and services will be provided for the following activities of daily living, Item #1, Bathing. A review of an admission Record, disclosed Resident #13 was admitted to the facility on [DATE] with a diagnosis list that indicated diagnoses that included, but were not limited to, post-traumatic stress (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disorder, Alzheimer's disease, vascular dementia, and history of transient ischemic attack (TIA). The most recent significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/11/2026, assigned the resident a Brief Interview for Mental Status (BIMS) summary score of 12 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. Section F (Preferences for Customary Routine and Activities) Item F0400 was coded as (2) Somewhat important for the resident to choose between a tub bath, shower, bed bath, or sponge bath. Section GG (Functional Abilities) Item GG0130 E. was coded as (04) indicating the resident needed supervision or touching assistance for showers/bathing self. A review of the comprehensive person-centered care plan specified Resident #13 had an ADL self-care performance deficit related to dementia and limited mobility. An intervention associated with the focus specified the resident required assistance to provide a bath/shower. A review of Resident #13's Shower/Bathing Task Record thirty-day look-back, disclosed the resident received a shower on 07/01/2026. Further review indicated the resident was out of the facility from 07/03/2026 through 07/05/2026. A review of the shower/bathing record disclosed no showers/baths were provided/documented from 07/06/2026 through 07/13/2026. The shower/bathing records did not identify the resident's shower days schedule. The Director of Nursing and Assistant Director of Nursing were not available for interview during the time of the survey. This concern was discussed at the end of day (pre-exit) meeting on 07/27/2026 at 5:19 PM, with the Administrator and Regional Director of Clinical Services. No further information was provided prior to exit on 07/28/2026. 7. Resident #89's admission Record revealed the facility admitted the resident on 11/25/24 with diagnoses that included acute and chronic cholecystitis post-surgery, metabolic encephalopathy, need for assistance with personal care, other abnormalities of gait and mobility, and dementia. The minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/3/25 assigned the resident a brief interview for mental status (BIMS) score of 7 indicating severe cognitive impairment. Resident #89 was coded as being frequently incontinent of bowel and bladder. The resident was also coded as having two falls since admission. Resident #89's care plan included a focus area that read, (Resident name omitted) has bladder incontinence r/t (related to) impaired mobility. Interventions included, Clean peri-area with each incontinent episode. A Weekly Skin Integrity Review with an effective date of 12/3/24 indicated the resident had no skin issues. A weekly Skin Integrity Review with an effective date of 12/10/24 revealed resident #89 had MASD (moisture associated dermatitis) to peri area. On 12/17/24 the Weekly Skin Integrity Review revealed Peri area red/inflamed orders for treatment in place. On 12/24/24 the Weekly Skin Integrity (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review revealed that the redness to the peri area continued and stated there was a treatment in place. On 12/31/24 the Weekly Skin Integrity Review stated, MASD-healing well, treatment order in place. The Documentation Survey Report, which is where the care that the Certified Nursing Assistants (C.N.A.'s) provide is documented, was reviewed for December 2024. The document included a section for ADL-Personal Hygiene to be documented on page 2 of 20. There were blanks for the night shift on 12/1/24, 12/4/24, 12/13/24, 12/14/24, 12/27/24, 12/28/24, 12/29/24 and 12/31/24. On 7/21/26 at 1:20 PM Registered Nurse (RN) #1 was interviewed. They stated they were the Unit Manager for Unit 2. They did not recall much about Resident #89. When asked what the holes in the documentation meant to them they stated, It means somebody didn't document. When asked if there was another way to confirm that the resident got the care they needed they stated, I mean we can pull the schedule but that will just show who was here. On 7/21/26 at 1:40 PM C.N.A. #4 was interviewed. They did not remember Resident #89. When asked what the holes in the documentation meant they stated, It means somebody didn't document. When asked if there was another way to confirm the resident was provided the needed care with no documentation for several shifts they stated, Not that I'm aware of. On 7/21/26 at 4:34 PM the survey team met with the Administrator, the Regional [NAME] President of Operations and the Regional Director of Clinical Services. This concern was reviewed with them at that time. No further information was provided to the survey team prior to the exit.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility document review, the facility staff failed to follow medical provider orders for (11) eleven of (51) fifty-one sampled residents, Resident #9, Resident #10, Resident #13, Resident #43, Resident #8, Resident #48, Resident #33, Resident #69, Resident #42, Resident #55, and Resident #79. Findings included: 1. For Resident #9, the facility staff failed to obtain a pulse ox reading (a quick, painless measurement of the percentage of oxygen in the blood and pulse rate) as ordered by a medical provider. A review of an admission Record, disclosed Resident #9 was admitted to the facility on [DATE] with a diagnosis list that indicated diagnoses that included, but were not limited to, major depressive disorder, history of venous thrombosis and embolism, urinary catheter, and symbolic dysfunction. The most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/17/2026, assigned the resident a Brief Interview for Mental Status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A medical provider order dated 07/20/2026 disclosed an order for, pulse ox every shift for monitoring for 3 days with a start date of 07/20/2026 and an end date of 07/23/2026. On 07/24/2026, a review of the July 2026 Medication Administration Record (MAR) was completed and revealed that pulse ox monitoring was not completed on 07/22/2026 on evening and night shift and a pulse ox was not obtained on 07/23/2026 on any shift. The Director of Nursing and Assistant Director of Nursing were not available for interview during this time of the survey. This concern was discussed on 07/24/2026 at 1:24 PM in a meeting with the Administrator and Regional Director of Clinical Services. No further information was provided prior to exit on 07/28/2026. 2. For Resident #10, the facility staff failed to administer the medications buspirone (an anti-anxiety medication), lidocaine external patch (a topical anesthetic agent used to numb nerve endings), and oxycontin (opioid analgesics to treat pain) and the facility staff failed to perform accuchecks (a blood glucose monitoring system) as ordered by a medical provider. A review of an admission Record, disclosed Resident #10 was admitted to the facility on [DATE] with a diagnosis list that indicated diagnoses that included, but were not limited to, acute and chronic respiratory failure with hypercapnia, acute and chronic respiratory failure with hypoxia, morbid obesity with alveolar hypoventilation, muscle weakness, unsteadiness on feet, and abnormalities of gait and mobility. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/07/2026, assigned the resident a Brief Interview for Mental Status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of a medical provider Order Summary Report disclosed the following ordered medications: Buspirone 15 mg (milligrams) give 1 tablet by mouth three times a day for depression. The order had a start date of 10/17/2025. Accucheck TID (three times a day) for monitoring. The order had a start date of 02/10/2026 and an end date of 07/08/2026. Lidocaine external patch, apply to Right shoulder topically one time a day for pain. The order had a start date of 04/04/2026. Oxycodone-acetaminophen oral tablet 5-325 mg, give one tablet by mouth every 6 hours for pain. The order had a start date of 06/10/2026. A review of Resident #10's June 2026 MAR (Medication Administration Record) disclosed accuchecks were not performed on 06/09/2026 at 6:00 AM, 06/14/2026 at 11:00 AM, or on 06/23/2026 at 6:00 AM. A review of nursing progress notes did not disclose a reference depicting a reason the accuchecks were not performed. Further review of the June 2026 MAR disclosed the lidocaine patch was not administered on 06/14/2026. Oxycodone was not administered on 06/14/2026 at 12:00 PM, and buspirone was not administered on 06/14/2026 at 2:00 PM. A review of nursing progress notes did not disclose a reference depicting a reason the medications were not administered. A review of the July 2026 MAR disclosed oxycodone was not administered on 07/09/2026 at 6:00 PM. A review of nursing progress notes did not disclose a reference depicting a reason the medication was not administered. The Director of Nursing and Assistant Director of Nursing were not available for interview during the time of the survey. This concern was discussed at the end of day (pre-exit) meeting on 07/27/2026 at 5:19 PM, with the Administrator and Regional Director of Clinical Services. A facility policy titled, Medication Administration with a revision date of 11/07/2025, specified under the heading, Policy, Medications are administered by licensed nurses.as ordered by the physician in accordance with professional standards of practice. No further information was provided prior to exit on 07/28/2026. 3. For Resident #13, the facility staff failed to administer the medication sodium chloride for 14 (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(fourteen) days as ordered by a medical provider. A review of an admission Record, disclosed Resident #13 was admitted to the facility on [DATE] with a diagnosis list that indicated diagnoses that included, but were not limited to, post-traumatic stress disorder, Alzheimer's disease, vascular dementia, and history of transient ischemic attack (TIA). The most recent significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/11/2026, assigned the resident a Brief Interview for Mental Status (BIMS) summary score of 12 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. A medical provider order dated 07/01/2026 disclosed a medication order for, sodium chloride tablet 1 GM (gram), give 2 (two) tablets by mouth three (3) times a day for hyponatremia for 14 (fourteen) days, take with meals. A review of the July 2026 MAR disclosed the medication was administered for 13 (thirteen days). The medication was administered/not administered on the following dates and times: 07/01/2026-not administered 07/02/2026-administered at 9:00 AM, 1:00 PM, and 5:00 PM 07/03/2026-administered at 9:00 AM, 1:00 PM, and 5:00 PM-resident was transferred out to the hospital 07/04/2026-hospitalized 07/05/2026-hospitalized -returned to facility-administered at 5:00 PM 07/06/2026-refused at 9:00 AM, administered at 1:00 PM and 9:00 PM 07/07/2026-administered at 9:00 AM, 1:00 PM, and 9:00 PM 07/08/2026-administered at 9:00 AM, 1:00 PM, and 9:00 PM 07/09/2026-administered at 9:00 AM, 1:00 PM, and 9:00 PM 07/10/2026-administered at 9:00 AM, 1:00 PM, and 9:00 PM 07/11/2026-administered at 9:00 AM, 1:00 PM, and 9:00 PM 07/12/2026-administered at 9:00 AM, 1:00 PM, and 9:00 PM 07/13/2026-administered at 9:00 AM, 1:00 PM, and 9:00 PM (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/14/2026-administered at 9:00 AM, 1:00 PM, and 9:00 PM 07/15/2026-administered at 9:00 AM and 1:00 PM The Director of Nursing and Assistant Director of Nursing were not available for interview during the time of the survey. This concern was discussed at the end of day (pre-exit) meeting on 07/27/2026 at 5:19 PM, with the Administrator and Regional Director of Clinical Services. A facility policy titled, Medication Administration with a revision date of 11/07/2025, specified under the heading, Policy, Medications are administered by licensed nurses.as ordered by the physician in accordance with professional standards of practice. No further information was provided prior to exit on 07/28/2026. 4. For Resident #43, the facility staff failed to administer the medications Insulin aspart and hydralazine as ordered by a medical provider. A review of an admission Record, disclosed Resident #43 was admitted to the facility on [DATE] with a diagnosis list that indicated diagnoses that included, but were not limited to, type 2 diabetes mellitus and hypertension. The most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/07/2026, assigned the resident a Brief Interview for Mental Status (BIMS) summary score of 7 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A review of a medical provider Order Summary Report disclosed the following ordered medications: Insulin aspart subcutaneous solution pen-injector.100 unit/ml (milliliter).Inject 8 unit subcutaneously before meals for DM (diabetes mellitus).Hold if (blood sugar) <150 (less than 150). with a start date of 05/19/2026. Hydralazine.10 mg (milligrams).give 1 (one) tablet by mouth three times a day for HTN (hypertension). A review Resident #43's June 2026 MAR (Medication Administration Record) disclosed Insulin aspart subcutaneous pen-injector was blank on 06/14/2026, indicating the medication was not administered. A review of nursing progress notes did not disclose a reference depicting a reason the medication was not administered. A review of the July 2026 MAR disclosed administration of hydralazine was blank on 07/06/2026 at 2:00 PM, and on 07/18/2026 at 2:00 PM, indicating the medication was not administered. A review of nursing progress notes did not disclose references depicting a reason the medication was not administered. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #43's comprehensive person-centered care plan included an intervention in the focus area of diabetes to administer medications as ordered. The Director of Nursing and Assistant Director of Nursing were not available for interview during the time of the survey. This concern was discussed at the end of day (pre-exit) meeting on 07/27/2026 at 5:19 PM, with the Administrator and Regional Director of Clinical Services. A facility policy titled, Medication Administration with a revision date of 11/07/2025, specified under the heading, Policy, Medications are administered by licensed nurses.as ordered by the physician in accordance with professional standards of practice. No further information was provided prior to exit on 07/28/2026. 5. For Resident #8 the facility staff failed to follow physician's orders for abdominal binder and failed to administer the medication metoprolol per the physician's order. Resident #8's clinical record listed diagnoses which included but not limited to gastrostomy status and epilepsy, unspecified, not intractable, without status epilepticus. Resident #8's most recent quarterly minimum data set with an assessment reference date of 06/16/26 coded the resident as having both long- and short-term memory problems with severely impaired cognitive skills for daily decision making. Resident #8's comprehensive care plan was reviewed and contained a plan for .requires tube feeding G-tube r/t (related to) Cerebral palsy, NPO (nothing by mouth), Seizure D/O (disorder), Gerd (gastroesophageal reflux disease) . Interventions for this care plan included abdominal binder around abdomen to protection Resident #8's clinical record contained a physician's order summary which read in part, Abdominal binder on at all times every shift for Peg tube stability and Metoprolol Tartrate Oral Tablet 50 MG (Metoprolol Tartrate). Give 50 mg via G-Tube every morning and at bedtime hold for HR (heart rate) < 60 or SBP (systolic blood pressure) < 110 mmHG (millimeters of mercury) related to Essential (Primary) Hypertension. Resident #8's electronic medication administration record for the month of June 2026 was reviewed and contained an entry as above. This entry was coded 11 06/01/26. Chart code 11 is equivalent to Held Per Parameters. Resident #8's blood pressure was documented as 119/82 and there was no pulse documented. Resident #8's clinical record was reviewed and contained progress notes which read in part, 5/27/2026 19:59 Note Text: Abdominal binder on at all times every shift for Peg tube stability. no binder in place, 06/01/2026 05:28 Note Text: Metoprolol Tartrate Oral Tablet 50 MG. Give 50 mg via G-Tube every morning and at bedtime for hold for HR < 60 or SBP < 110 mmHG related to Essential (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Primary) Hypertension, 06/14/2026 06:33 Note text: check for skin breakdown under abdominal binder every 2 hours for skin integrity. observe for skin breakdown, redness, swelling, or discoloration and is skin w/d (warm/dry) to touch. no abdomen binder in place, and 06/17/2026 01:36 Note Text: check for skin breakdown under abdominal binder every 2 hours for skin integrity observe for skin breakdown, redness, swelling, or discoloration and is skin w/d to touch. no abdominal binder in place. The concern of not following the physician's order for administration of metoprolol and abdominal binder was discussed with the administrator and regional director of clinical services on 07/27/26 at 5:15 pm. No further information was provided prior to exit. 6. For Resident #48 the facility staff failed to follow the physician's order for weights related to an as needed medication. Resident #48's clinical record listed diagnoses which included but not limited to chronic combined systolic (congestive) and diastolic (congestive) heart failure and hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease. Resident #48's most recent quarterly minimum data set with an assessment reference date of 07/03/26 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #48's comprehensive care plan was reviewed and contained a plan for The resident is on diuretic therapy r/t (related to) hypertension, chf (congestive heart failure). Interventions for this care plan included administer diuretic medications as order by physician. Monitor for side effects and effectiveness. Resident #48's clinical record contained a physician's order summary which read in part, Furosemide Oral Tablet 20 MG (Furosemide). Give 1 tablet by mouth every 24 hours as needed for weight gain of > 3 lbs in 48 hours OR > 5 lbs in 1 week related to CHRONIC COMBINED SYSTOLIC (CONGESTIVE) AND DIASTOLIC (CONGESTIVE) HEART FAILURE (I50.42). Resident #48's electronic medication administration record for the month of July 2026 was reviewed and contained an entry as above. There were no weights recorded in relation to this order. Resident #48's weight record was reviewed and there were no weights documented after 05/20/26. The concern of not following the physician's order for weights related to an as needed medication was discussed with the administrator and regional director of clinical services on 07/27/26 at 5:15 pm. No further information was provided prior to exit. 7. For Resident #33, the facility staff failed to follow a medical provider order for the administration of (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Aldactone (Spironolactone). Aldactone (Spironolactone) is a diuretic medication used to treat high blood pressure and heart failure. An admission Record indicated the facility admitted Resident #33 on 4/21/23. According to the admission Record, the resident had a medical history that included hypertensive heart and chronic kidney disease with heart failure. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/03/26, revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #33's comprehensive person-centered care plan included a focus area which indicated the resident had altered cardiovascular status related to congestive heart failure, and hypertension. Interventions instructed staff to administer medication as ordered. Resident #33's medical provider orders included an order dated 6/16/26 for Aldactone (Spironolactone) 50 mg by mouth one time a day for heart failure. A review of Resident #33's July 2026 Medication Administration Record (MAR) revealed Aldactone (Spironolactone) was not administered on 7/12/26 at 9:00 AM. A corresponding nursing progress note dated 7/12/26 at 9:59 AM indicated Aldactone was not administered and staff were waiting on delivery from the pharmacy. A review of the facility in-house medication supply inventory, Omnicell, indicated Spironolactone 25 mg tablets were available for resident use. On 7/27/26 at 5:35 PM, the Administrator and Regional Director of Clinical Services were notified of the concern regarding Resident #33's Aldactone (Spironolactone). No further information was provided prior to the exit conference on 7/28/26. 8. For Resident #69, the facility staff failed to follow a medical provider order for a urology consult. An admission Record indicated the facility admitted Resident #69 on 5/27/16. According to the admission Record, the resident had a medical history that included Alzheimer's Disease with early onset. An annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/08/26, revealed Resident #69 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. Resident #69's comprehensive person-centered care plan included a focus area revised 2/17/25 which indicated the resident was incontinent with risk for urinary tract infection (UTI). Interventions included urology consult as ordered or needed initiated on 3/13/26. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #69's medical provider orders included an order dated 1/30/26 for a urology consult. Resident #69 was seen by the medical provider on 1/30/26. The progress note revealed history of nephrolithiasis [kidney stones] who presents with bleeding and pain concerning for a recurrent kidney stone. Her presentation is similar to a prior stone event. A larger stone was known to be present on imaging last year. Her baseline dementia limits her ability to provide a detailed history. Currently, she is not in acute distress and denies pain, which may suggest she has already passed a stone. The progress note also indicated We will consult Urology for further evaluation and management of possible kidney stone. Resident #69's clinical record did not include any evidence that the resident was evaluated by urology following the medical provider's order on 1/30/26. On 7/24/26 at 1:24 PM during a meeting with the Administrator and Regional Director of Clinical Services, evidence of a urology consult for Resident #69 was requested. During an interview on 7/27/26 at 12:05 PM, the facility social worker stated she would follow up with medical records to see if Resident #69 had been out to a urology appointment. The social worker did not return with any additional information. No further information was provided prior to the exit conference on 7/28/26. 9. Resident #42, facility staff failed to obtain/monitor a pulse ox (oxygen saturation) as ordered by medical provider. An admission Record indicated the facility admitted Resident #42 on 06/23/2026. According to the admission Record, the resident had a medical history including diagnoses that were not limited to, type 2 diabetes mellitus without complications, dysphagia, oropharyngeal phase, and other symbolic dysfunctions and other lack of coordination. The most recent admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/29/2026, assigned Resident #42 a Brief Interview for Mental Status (BIMS) summary score 10 of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. For Resident #42, a medical provider order entry dated 06/19/2026 stated, Pulse ox every shift for monitoring. (AM shift (day), PM shift (night) to obtain an oxygen saturation (O2 sat) reading to monitor residents circulating oxygen level.) A review of the vitals record disclosed that oxygen saturation levels were not obtained on the following dates/shifts: 07/01/2026 &ndash; PM shift 07/04/2026 &ndash; AM or PM shift (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/05/2026 – AM or PM shift 07/06/2026 – PM shift 07/07/2026 – PM shift 07/08/2026 – PM shift 07/11/2026 – PM shift 07/12/2026 – PM shift 07/13/2026 – PM shift 07/14/2026 – PM shift Resident #42 had a medical provider order dated 6/19/2026 that stated, Assess resident for pain every shift: Non-pharmacological interventions: 1=relaxation, 2=light touch, 3=imagery, 4=exercise, 5=music 6=N/A, 7=other see progress note. Document corresponding code and pain level in supplemental documentation. A review of the vitals record revealed that pain levels were not documented on the following dates: 07/03/2026 07/06/2026 07/07/2026 07/11/2026 07/12/2026 07/13/2026 07/16/2026 These concerns were discussed on 07/21/2026 at 4:04 PM during the end of day meeting with the Administrator, [NAME] President of Operations, and Regional Director of Clinical Services. On 07/22/2026 at 3:03 PM Licensed Practical Nurse #1 (LPN#1) was interviewed and stated, Vitals are typically checked by the aides, and it is the responsibility of the primary nurse to follow-up and make sure they are obtained as well as any shift orders. 07/22/2026 at 3:15 PM, the Interim Director of Nursing (IDON), stated It is the responsibility of the (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nursing management to check the re-cap summaries each day and follow-up to make sure that the weights, vitals and other required orders are being followed and documented. As you can see, we have clearly had a problem with that. A Facility policy titled, Pain Management stated, The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This policy read in part, Policy Explanation and Compliance Guidelines: The facility will utilize a systematic approach for recognition, assessment, treatment and monitoring of pain. Recognition: 1. In order to help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will: b. Evaluate the resident for pain and the cause(s) upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs (e.g. after a fall, change in behavior or mental status, new pain or an exacerbation of pain). No further information was provided during exit survey on 07/28/2026. 10. For Resident #55, facility staff failed to monitor efficacy of pain management interventions. An admission Record indicated the facility admitted Resident #55 on 07/02/2026. According to the admission Record, the resident had a medical history including but not limited to, Colles' fracture of right radius, subsequent encounter for closed fracture with routine healing, type 2 diabetes mellitus without complications, and unspecified dementia. The most recent admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/08/2026, assigned Resident #55 a Brief Interview for Mental Status (BIMS) summary score of 6 of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A review of Resident #55's medical provider orders revealed an order dated 07/02/2026 for multi-shift pain assessments and outcome tracking. The order stated to assess the resident for pain every shift utilizing nonpharmacological intervention (NPI) codes: 1=relaxation, 2=light touch, 3=imagery, 4=exercise, 5=music, 6=N/A (not applicable), 7=other, see progress note and to document the corresponding code and pain level in the supplemental documentation every shift for monitoring. A second medical provider order dated 07/02/2026, stated to monitor the outcome of the intervention every shift using corresponding codes: I-Improved, U-unchanged, W-worsened (call MD) every shift for monitoring. Put in corresponding code from above. A review of Resident #55's July 2026 Medication Administration Record (MAR) indicated one medication intervention for pain, oxycodone oral tablet 5mg (milligrams). Give 0.5mg (one half tablet) by mouth every 6 hrs. (hours) as needed for pain. (Standard pain scale is 0 through 10, 0 being no pain and 10 expressing the worst.) A review of Resident #55's Treatment Administration Record (TAR) disclosed on 07/04/2026, a day (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shift nurse documented pain level of 5 with a non-pharmaceutical intervention (NPI) level as 6 N/A (not applicable). No pain medication was documented as administered. The outcome of the intervention was documented as unchanged. No progress note was discovered to indicate the intervention had been effective, or a re-evaluation of the resident's pain level was completed. On 07/10/2026, the MAR reflected the resident received oxycodone on day shift and was coded as effective for pain re-evaluation. The TAR indicated a night shift nurse documented pain level as 4 with NPI level as 1 for relaxation and the outcome of the intervention was documented as unchanged. Oxycodone was not administered and no progress note was discovered to indicate the intervention had been effective, or a reevaluation of the resident's pain level was completed. On 07/11/2026 and 07/12/2026, the TAR documentation was identical for both the day shift and the night shift across both days. Nurses consistently documented a pain level of 4 with a NPI code of 1 for relaxation and the outcome of the interventions as unchanged. Oxycodone was not administered and no progress notes were discovered to indicate the intervention had been effective, or a re-evaluation of the resident's pain level was completed for the consecutive shifts. On 07/13/2026 a day shift nurse documented the resident's pain as a level 6. The NPI was coded as 1 and an outcome of unchanged. Oxycodone was not administered and no progress notes were discovered to indicate the interventions had been effective, or a re-evaluation of the resident's pain level was completed for either shift. 07/14/2026, the MAR indicated the resident received oxycodone on day shift and E was documented as effective for pain re-evaluation. During the night shift, the resident's pain was documented as level 7. A nurse documented a NPI code of 1 and an outcome of unchanged. Oxycodone was not administered and no progress note was discovered to indicate the intervention had been effective, or a re-evaluation of the resident's pain level was completed for the shift. On 07/15/2026 at 9:15 AM, an interview was conducted with Licensed Practical Nurse #1, (LPN#1) the unit manager. LPN #1 recalled that she knew the non-pharmaceutical interventions had been working for Resident #55 and that the resident reported relief. LPN #1 stated that she probably should have made a note about when the methods were or were not effective. She further disclosed that Resident #55 did not have pain medication available at the time of admission and had to wait for the pharmacy to deliver it, noting that standing orders like acetaminophen are entered by a nurse if a resident were to need it. LPN #1 was unable to provide any further information related to the unavailable documentation noting the efficacy of interventions. 07/15/2026 at 3:15 PM, interview was conducted with Resident #55 and the resident stated that staff bring pain medication if asked, that it is a pill, and that they are taking good care of them. On 07/15/2026 at 3:45 PM, this concern was discussed with the Director of Nursing and Assistant Director of Nursing. A facility policy titled Documentation in Medical Record with a revision date of 11/07/2025 specified, Each resident's medical record shall contain accurate representation of the actual experiences of the (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Under the heading, Policy Explanation and Compliance Guidelines Item 4. Principles of documentation include but are not limited to. a. Documentation shall be factual, objective and resident centered.ii. Record descriptive and objective information based on first-hand knowledge of the assessment, observation, or service provided. No further information was provided prior to exit on 07/28/2026. 11. For Resident #79, the facility nursing staff failed to obtain provider ordered blood pressures prior to administering the hypertensive medication Hydralazine and failed to administer a provider ordered PPD (tuberculosis skin test) on 0712/2026. Section C (cognitive patterns) of Resident#79's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 07/15/2026 included a Brief Interview for Mental Status (BIMS) score of 8, indicating Resident #79 was moderately impaired in cognitive skills for daily decision making. The comprehensive care plan identified the area of hypertension. Interventions included obtain vital signs as ordered. Review of the clinical record revealed the following provider orders: 07/09/2026: Hydralazine 25 mg, administer one tablet by mouth twice daily for hypertension, hold for systolic BP less than 130. 07/09/2026: PPD Step1 one time a day every 12 months starting on the 12 th for annual PPD. Review of the 07/2026 Medication Administration Records (MARs) revealed that on 07/17/2026, nu[TRUNCATED]		

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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, staff interview, clinical record review, and facility document review, the facility staff failed to provide pharmacy services to meet the needs of the residents for nine of 51 residents, Residents #23, #44, #92, #8, #12, #2, #6, #33, and #90. The findings include: 1. For Resident #23, the narcotic count sheet did not accurately reflect the amount of liquid Phenobarbital on hand. The narcotic count sheet documented there were 233 ml's of Phenobarbital. During a narcotic count with Licensed Practical Nurse (LPN) #1 the liquid Phenobarbital measured more than 300 ml's. Resident #23's diagnoses included epilepsy. Section C (cognitive patterns) of Resident #23's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 05/05/2026 included a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. The comprehensive care plan identified the focus area of seizures and included the intervention to give seizure medication as ordered. On 07/16/2026 at 2:30 PM, the surveyor conducted a controlled substance count with LPN #1. This cart contained a bottle of liquid Phenobarbital that was identified as belonging to Resident #23. The controlled narcotic count sheet documented 233 ml's remaining; however, the observation of the bottle revealed more than 300 ml's remaining. During this observation, LPN #1 stated the facility's practice required the outgoing and incoming nurses to perform and verify narcotic counts during shift change. LPN #1 stated she had assumed responsibility for the medication cart to assist with the medication pass and had not counted the narcotics. LPN #1 identified LPN #4 as having completed the narcotic count. LPN #4 stated she was aware the count was over but did not realize the discrepancy exceeded the documented amount by that much. Per the request of the surveyor the Director of Nursing (DON) verified the amount of Phenobarbital remaining in the bottle and confirmed the narcotic count sheet did not match the actual quantity on hand. Review of the facility policy titled, Controlled Substances effective date 11/30/2014 read in part, .the number of controlled substances on hand must be counted and verified at the end of each shift. The Narcotic Sign in Sheet must be completed at the end of each shift every day. The outgoing Nurse or her designee will count all controlled substances being stored at the residence while the oncoming nurse or his or her designee watches. Both staff member sign that the count and verification has been completed. In the event the count does not match the controlled substances on hand, the Executive (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director will be notified immediately. During an end of the day meeting on 07/27/2026 at 5:20 PM with the Administrator and Regional Director of Clinical Services the issue with the Phenobarbital count discrepancy was reviewed. The RDCS stated they had obtained a Phenobarbital level on this resident with no issues identified. Resident #23's clinical record included Phenobarbital levels obtained on 07/17/2026 (21.2) and 07/18/2026 (19.7). The reference range was documented as 15-40. No additional information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #44, the facility staff failed to ensure proper accountability of the Schedule II narcotic, Oxycodone. The facility staff were unable to account for 30 tablets of Oxycodone. Resident #44's diagnoses included osteoarthritis of knee and polyneuropathy. Section C (cognitive patterns) of Resident #44's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 04/28/2026 included a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. Section J (Health Conditions) was coded to indicate the resident received a scheduled pain management regimen. The resident's comprehensive care plan identified pain as a focus area with interventions including administration of analgesics. The clinical record contained a provider order dated 12/27/2025 for Oxycodone 5 mg two times daily for pain, hold if asleep or sedated. On 07/17/2026, the provider documented Resident #44 was out of Oxycodone and the pharmacy requires a new script to fill. Resident not currently complaining of pain. Registered Nurse (RN) #1 documented the medication was being held per MD. On 07/17/2026, the facility Administrator submitted a facility synopsis of events indicating the facility staff were investigating the potential misappropriation of Resident #44's Oxycodone. A review of the Medication Administration Records (MARs) for 07/2026 revealed that on 07/18/2026 at 9:00 AM and 9:00 PM the facility nursing staff documented a 5 for the Oxycodone, 5=hold see nurse notes. Corresponding nursing notes documented the following: 07/18/2026 at 9:42 AM, ordered, waiting on delivery. 07/18/2026 at 10:22 PM: waiting on pharmacy to deliver. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of narcotic count sheets revealed the pharmacy delivered to the facility 60 tablets of Oxycodone 5 mg for Resident #44 on 06/24/2026. Facility staff were only able to produce narcotic count sheets accounting for 30 of these tablets. The administrative staff acknowledged they were unable to locate a narcotic count sheet or any other documentation accounting for the remaining 30 tablets. In addition, only one licensed nurse the Assistant Director of Nursing (ADON) had signed for receipt of the medication, the facility policy required two licensed nurses to verify and sign for controlled substances upon delivery. The ADON had resigned during the survey and was not interviewed. A written statement from Licensed Practical Nurse (LPN) #3 documented that the pharmacy confirmed 60 tablets had been delivered on 06/24/2026, and the discrepancy was reported to the Director of Nursing (DON). Review of the facility policy titled, Acceptance of Medication and Controlled Substances effective date 01/15/2015, read in part, To ensure medications and controlled substances are properly accounted for.2 nurses will sign the medications into the facility on the pharmacy delivery slip. During an interview on 07/28/2026 at 2:10 PM, the Regional Director of Clinical Services (RDCS) stated the facility had purchased hardback narcotic record books, would discontinue use of the free-floating narcotic count sheets, and would write off the previous two months of Oxycodone charges for Resident #44. On 07/30/2026 at 10:30 AM, pharmacy personnel #9 confirmed they had sent to the facility 60 tablets of 5 mg Oxycodone on 06/24/2026 and 30 tablets on 07/23/2026. Indicating 30 tablets of Oxycodone were unaccounted for. No further information regarding this issue was provided to the survey team prior to the exit conference. 3. For Resident #92, the controlled count sheets for the narcotic medications Suboxone and Oxycodone did not match the documentation of what had been administered. This was a closed record review. Resident #92's diagnoses included end stage renal disease, diabetes, epilepsy, and osteoarthritis. Resident #92's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 07/01/2025 included a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Section J (health conditions) was coded to indicate the resident experienced pain occasionally and were on a pain medication regimen. The comprehensive care plan identified the focus area of pain. Resident #92's clinical record included an order dated 07/15/2025 for Suboxone give 1 sublingually three times a day. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Suboxone narcotic count sheets for 07/2025 revealed that on 07/17/2025 nursing staff documented removal of one tablet of Suboxone at 6:00 AM, 9:00 AM, 2:00 PM, and 9:00 PM. Review of the Medication Administration Record (MAR) documented administration at 9:00 AM, 1:00 PM, and 9:00 PM only. There was no documentation to support administration of the tablet removed at 6:00 AM. Additionally, on 07/31/2025 the nursing staff documented they had removed one tablet of Suboxone at 6:00 AM from the narcotic supply; however, the surveyor was unable to locate corresponding documentation on the MAR indicating the medication had been administered. The controlled substance count records/narcotic count sheets did not reconcile with the medication administration documentation. Further review of the clinical record revealed a provider order dated 07/15/2025 for Oxycodone 5 mg, one tablet by mouth every 6 hours as needed for pain. Review of the narcotic count sheet documented removal of one tablet at 1:30 PM and 8:00 PM on 07/16/2025. However, the surveyor was unable to locate documentation on the MAR or elsewhere in the clinical record indicating the medication had been administered. The narcotic count sheet did not reconcile with the medication administration documentation. The facility policy titled, Controlled Substances effective date 11/30/2014, read in part, .The staff must also maintain strict records of the controlled substances stored in the residence as well as the dose given to the resident. It is essential to make certain the resident requiring the controlled substance receives it as ordered by the physician. When a controlled substance is administered to a resident, it must be recorded on the resident's Medication Sheet as well as a separate Controlled Substance/Schedule II Narcotic Sheet that is created for each prescription. On 07/28/2026 at 5:20 PM, the Regional Director of Clinical Services and the Administrator were informed of the discrepancies identified between the narcotic count sheets and the MARs. No further information regarding this issue was provided to the survey team prior to the exit conference. 4. For Resident #8 the facility staff failed to ensure the medications scopolamine and glycopyrrolate were available for administration. Resident #8's clinical record listed diagnoses which included but not limited to dysphasia following unspecified cerebrovascular disease, dysphagia, oropharyngeal phase, and disturbances of salivary secretion. Resident #8's most recent quarterly minimum data set with an assessment reference date of 06/16/26 coded the resident as having both long- and short-term memory problems with severely impaired cognitive skills for daily decision making. Resident #8's comprehensive care plan was reviewed and contained a plan for . has potential for altered respiratory status/difficulty breathing r/t (related to) NPS (nothing by mouth), gastrostomy status/enteral feed, potential for excessive oral secretions. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #8's clinical record contained a physician's order summary which read in part, Scopolamine Transdermal Patch 72 Hour 1 MG/3 Days. Apply 1 mg transdermally one time a day every 3 day(s) for secretions and Glycopyrrolate Oral Tablet 1 MG. Give 1 mg via G-Tube every morning and at bedtime for excessive secretions. Resident #8's electronic medication administration record for the months of April 2026 and June 2026 were reviewed and contained entries as above. The entry for scopolamine was coded 9 on 04/03/26 and 06/08/26, and coded 5 on 06/17/26. Chart code 9 is equivalent to Other/See Nurse Notes. Chart code 5 is equivalent to Hold/See Nurse Notes. The entry for glycopyrrolate was coded 9 on 04/04/26. Resident #8's progress notes were reviewed and contained notes which read in part, 04/03/2026 08:33 Note Text: Scopolamine Transdermal Patch 72 Hour 1 MG/3 Days. Apply 1 mg transdermally one time a day every 3 day(s) for secretions. 1x hold per MD . (name omitted), 04/04/2026 06:16 Note Text: Glycopyrrolate Oral Tablet 1 MG. Give 1 mg via G-tube every morning and at bedtime for excessive secretions. not available, 06/08/2026 08:12 Note Text: Scopolamine Transdermal Patch 72 Hour 1 MG/3 Days. Apply 1 mg transdermally one time a day every 3 day(s) for secretions. n/a (not applicable) rx (prescription)/np (nurse practitioner) made aware, and 06/17/2026 12:29 Note Text: Scopolamine Transdermal Patch 72 Hour 1 MG/3 Days. Apply 1 mg transdermally one time a day every 3 day(s) for secretions. Surveyor spoke with physician on 07/22/26 at 12:10 pm regarding Resident #8's medications. Physician stated, It doesn't look like a provider order was put in to hold, it was just that one time. When asked if they were notified, physician stated, I don't recall being notified, maybe just in passing in the hall, told me med wasn't available and was it ok to hold. I didn't actually ever see this resident for the first time until 04/15/26. The concern of Resident #8's medications not being available for administration was discussed with the administrator and regional director of clinical services on 07/27/26 at 5:15 pm. No further information was provided prior to exit. 5. For Resident #12 the facility staff failed ensure a schedule II narcotic was correctly accounted for. The facility was unable to account for 84 oxycodone 5 mg tablets. Resident #12's clinical record listed diagnoses which included but not limited to rheumatoid arthritis, unspecified, contracture of muscle, right shoulder, and hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side. Resident #12's most recent quarterly minimum data set with an assessment reference date of 06/29/26 assigned the resident a brief interview for mental status score of 3 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Section J, health management, coded the resident as receiving scheduled pain medication. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #12's comprehensive care plan was reviewed and contained a plan for . is at risk for alterations in pain r/t (related to) RA (rheumatoid arthritis), CVA (cerebrovascular accident), PEG (percutaneous endoscopic gastrostomy) placement, and generalized pain, neuropathy. Resident #12's clinical record contained a physician's order summary which read in part, oxycodone HCl Oral Tablet 5 mg (Oxycodone HCl). Give 1 tablet by mouth every 8 hours for pain. Resident #12's narcotic control sheets were for the months of June and July 2026 were reviewed on 07/27/26. The control sheets for the dates of 06/01/26-06/12/26 revealed a dispensed amount of 56 tablets and a received amount of 30 tablets. The control sheet for the dates of 06/21/26-06/26/26 revealed a dispensed amount of 12 tablets and a received amount of 12 tablets. The control sheet for the dates of 07/04/26-07/14/26 revealed a dispensed amount of 88 tablets and a received amount of 30 tablets. The control sheet for the dates of 07/18/26 revealed a dispensed amount of 8 tablets and a received amount of 8 tablets. The control sheet dated 07/21/26 revealed a dispensed amount of 30 tablets and a received amount of 30 tablets. There were no control sheets for the dates of 06/13/26-06/21/26, 06/27/26-07/04/26, or 07/15/25-07/18/26. Surveyor spoke with pharmacy technician #5 on 07/27/26 at 10:08 am regarding Resident #12's oxycodone. Pharmacy technician #5 stated the pharmacy sent 88 tablets from a prescription for 90 tablets, leaving 2 tablets out so facility could pull from emergency supply. This was divided into two cards of 30 tablets each, and one card of 28 tablets. Pharmacy technician stated the pharmacy sent 8 tablets from a 9-tablet order, leaving one out so facility could pull from emergency supply. Of these 96 tablets sent from the pharmacy, a total of 58 were unaccounted for. Surveyor spoke with pharmacy technician #6 on 07/27/26 at 4:22 pm regarding Resident #12's oxycodone. Pharmacy technician #6 stated a delivery of 56 tablets, divided by one card of 30 tablets and one card of 26 tablets, was delivered to the facility on [DATE] and a delivery on 12 tablets was delivered to the facility on [DATE]. Of these 68 tablets sent from the pharmacy, a total of 26 tablets were unaccounted for. This is a cumulative total of 84 tablets unaccounted for. Surveyor spoke with the regional director of clinical services (RDCS) and administrator on 07/28/26 at 9:12 am regarding Resident #12's missing oxycodone. RDCS stated they are aware of the missing medications and have started an investigation, which is ongoing. Administrator stated they have reported this to the police and Office of Licensure and Certification on 07/17/26. RDCS stated they have been unable to locate the medications or the control sheets. RDSC stated, We can't substantiate or unsubstantiate drug diversion since we have no medication cards. We've been at a loss, we have no cards, no control sheet, or no destruction file. Surveyor requested and was provided with a facility policy entitled Acceptance of Medication and Controlled Substances which read in part, Policy: To ensure medications and controlled substances are properly accounted for in accordance with Federal Regulations. Medications will be delivered to the facility by the pharmacy and 2 nurses will sign the medications into the facility on the pharmacy delivery slip. The concern of not correctly accounting for Resident #12's oxycodone was discussed with the (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administrator and regional director of clinical services on 07/27/26 at 5:15 pm. No further information was provided prior to exit. 6. For Resident #2, the facility staff failed to ensure the medication Suvorexant was available for administration on two separate occasions. A facility policy titled, Medication Shortages/Unavailable Medications, revised 8/01/24, specified If a medication is unavailable during normal Pharmacy hours: A Facility nurse should call Pharmacy to determine the status of the order, which may be found on [name omitted] under the Pharmacy Connection menu. If the medication has not been ordered, the licensed Facility nurse should place the order or reorder for the next scheduled delivery. If the next available delivery causes delay or a missed dose in the resident's medication schedule, Facility nurse should obtain medication from the Emergency Medication Supply to administer dose. If the medication is not available in the Emergency Medication Supply, Facility staff should notify Pharmacy and arrange for a STAT delivery, if medically necessary. An admission Record indicated the facility admitted Resident #2 on 11/19/24. According to the admission Record, the resident had a medical history that included vascular dementia and insomnia. A significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/19/26, revealed Resident #2 had a Brief Interview for Mental Status score of 1 which indicated severe cognitive impairment. Resident #2's comprehensive person-centered care plan included a focus area indicating the resident was receiving hypnotic medication for insomnia with interventions that included but were not limited to administer medications as ordered by the physician. Resident #2's medical provider orders included an order dated 4/29/26 for Suvorexant 10 mg by mouth at bedtime for insomnia. A review of Resident #2's Medication Administration Records for April 2026 through July 2026 revealed Suvorexant was not administered on 5/11/26 or 6/1/26. A 5/11/26 10:28 PM nursing progress note documented the Suvorexant was on order from the pharmacy and not available in the Omnicell. A 6/01/26 10:42 PM nursing progress note indicated the Suvorexant was again on order. On 7/27/26 at 5:19 PM, the Administrator and Regional Director of Clinical Services were notified of the concern regarding the unavailability of Suvorexant for Resident #2 No further information was provided regarding this concern prior to the exit conference on 7/28/26. 7. For Resident #6, the facility staff failed to ensure the medication sildenafil citrate was available for administration on two separate occasions. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility policy titled, Medication Shortages/Unavailable Medications, revised 8/01/24, specified If a medication is unavailable during normal Pharmacy hours: A Facility nurse should call Pharmacy to determine the status of the order, which may be found on [name omitted] under the Pharmacy Connection menu. If the medication has not been ordered, the licensed Facility nurse should place the order or reorder for the next scheduled delivery. If the next available delivery causes delay or a missed dose in the resident's medication schedule, Facility nurse should obtain medication from the Emergency Medication Supply to administer dose. If the medication is not available in the Emergency Medication Supply, Facility staff should notify Pharmacy and arrange for a STAT delivery, if medically necessary. An admission Record indicated the facility admitted Resident #6 on 6/08/26. According to the admission Record, the resident had a medical history that included end stage renal disease, pulmonary hypertension, portal hypertension, and congestive heart failure. An admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/14/26, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) summary score of 12, which indicated the resident had moderate cognitive impairment. Resident #6's clinical record included an order dated 6/08/26 for sildenafil citrate 20 mg by mouth three times a day for pulmonary hypertension. A review of the resident's June and July 2026 Medication Administration Records (MARs) revealed sildenafil citrate was not administered on 6/10/26 9:00 AM and 7/09/26 9:00 AM. Corresponding nursing progress notes dated 6/10/26 10:22 AM and 7/09/26 at 11:04 AM indicated sildenafil citrate was not administered due to one-time holds-pharmacy to send. A review of the in-house emergency medication supply inventory revealed sildenafil citrate was not maintained in the in-house inventory. On 7/27/26 at 5:19 PM, the Administrator and Regional Director of Clinical Services were notified of the concern regarding the unavailability of sildenafil citrate on 6/10/26 and 7/09/26 resulting in two missed doses for Resident #6. No further information was provided regarding this concern prior to the exit conference on 7/28/26. 8. For Resident #33, the facility staff failed to administer Phenylephrine as ordered by the medical provider. An admission Record indicated the facility admitted Resident #33 on 4/21/23. According to the admission Record, the resident had a medical history that included chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/03/26, revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #33's comprehensive person-centered care plan included a focus area which indicated the resident had altered respiratory status, difficulty breathing related to respiratory failure, asthma, and allergies. Intervention instructed staff to administer medication as ordered. Resident #33's medical provider orders included an order dated 5/11/26 for Phenylephrine 10 mg by mouth every six hours for five days for congestion. A review of Resident #33's May 2026 Medication Administration Record (MAR) revealed Phenylephrine was not administered on 5/11/26 12:00 PM, 5/11/26 6:00 PM, 5/12/26 midnight, 5/12/26 6:00 AM, 5/13/26 midnight, 5/13/26 6:00 AM, 5/16/26 midnight, and 5/16/26 6:00 AM. Nursing progress notes on 5/11/26 11:25 AM, 5/12/26 12:54 AM, 5/12/26 6:28 AM, 5/13/26 6:12 AM, 5/13/26 12:31 AM, 5/16/26 1:34 AM, and 5/16/26 6:19 AM indicated the medication was not in the cart/available for administration. On 7/27/26 at 5:35 PM, the Administrator and Regional Director of Clinical Services were notified of the concern regarding the unavailability of Phenylephrine. No further information was provided prior to the exit conference on 7/28/26. 9. For Resident #90 the facility staff failed to ensure a schedule II narcotic was correctly accounted for. The facility was unable to account for 60 oxycodone 5 mg tablets. Resident #90's clinical record listed diagnoses which included but not limited to chronic pain, muscle weakness, chronic pulmonary edema, limitation of activities due to disability, and cellulitis of lower right limb. Resident #90's most recent quarterly minimum data set (MDS) with an assessment reference date of 03/19/25 assigned the resident a brief interview for mental status (BIMS) score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident was cognitively intact. Section J, health management, coded the resident as receiving scheduled pain medication. Resident #90's comprehensive care plan was reviewed and contained a plan for . has pain r/t chronic pain, history of rib fracture and liver disease. Resident #90's clinical record contained a physician's order summary which read in part, oxycodone HCl Oral Tablet 5 mg (Oxycodone HCl). Give 1 tablet by mouth every 6 hours for pain/discomfort give one tablet q6h [every 6 hours] with a 325 tylenol. Resident #90's electronic medication administration record (eMAR) for the month of April and May 2025 were reviewed and reconciled with the narcotic control sheet. The eMAR contained an entry which read in part, oxycodone HCl Oral Tablet 5 mg (Oxycodone HCl). Give 1 tablet by mouth every 6 hours for pain/discomfort give one tablet q6h with a 325 Tylenol. The oxycodone was documented on the eMAR as administered per the physician's order on 4/20/25 and 4/22/25 with three doses missing on the narcotic sheet; 4/21/25 with four doses missing on the narcotic control sheet; (continued on next page)		

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/24/25, 4/25/25, 4/26/25, 4/27/25, and 4/28/25 with one dose missing. The narcotics control sheet showed that one tablet was removed on each of these days during the entries signed for and no indication of what happened to the missing medication was documented. On 4/27 and 4/28/25, the eMAR showed two doses to be given daily while the narcotic control sheet reflected three (out of four) doses given. Surveyor spoke with the director of nursing (DON) and (ADON) on 7/16/26 at 8:45 am, requested April 2025 controlled substance narcotic sheets. Surveyor spoke with DON on 07/16/2026 at 2:30 pm, the narcotic control sheet reviewed with the DON, and it was determined medications were not documented or accounted for. Surveyor spoke with pharmacy tech supervisor #7 on 07/28/26 at 5:04 pm regarding Resident #90's billing for oxycodone. Pharmacy tech supervisor #7 was able to confirm that the 120 tablets were filled on 4/11/25. The facility had called on 4/28/25 to have 30 tablets sent on 4/30/25 and another 90 tablets sent on 5/4/25. Review of the facility policy titled, Controlled Substances effective date 11/30/2014 read in part, .the number of controlled substances on hand must be counted and verified at the end of each shift. The Narcotic Sign in Sheet must be completed at the end of each shift every day. The outgoing Nurse or her designee will count all controlled substances being stored at the residence while the oncoming nurse or his or her designee watches. Both staff member sign that the count and verification has been completed. In the event the count does not match the controlled substances on hand, the Executive Director will be notified immediately. The concern of Resident #12's missing narcotics was discussed with the administrator and regional director of clinical services on 07/28/26 at 2:15 pm. No additional information regarding this issue was provided to the survey team prior to the exit conference.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and facility document review, the facility staff failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility kitchen. Findings included: On 07/20/2026 at 12:01 PM, an initial tour/observation of the facility kitchen was conducted with the Dietary Manager (DM). On 07/20/2026 at 12:04 PM during the initial tour of the facility kitchen, Dietary Cook/Aide #1 (DCA#1) was observed preparing food on the tray line with visible hair uncontained and extending past the hairnet boundaries to the shoulders all the way around her head. DCA#1 stated she was hot and sweaty and the hair must have fallen out. DCA#1 left the food prep area and adjusted the hair net, placing all the uncontained hair strands into the hairnet. An observation of a juice machine was conducted and boxes of apple, orange, and lemonade juices were observed on the shelf below the machine with hoses running from the boxes up to the juice machine unit above. The three (3) hoses were noted with a moderate amount of black substances inside the tubes and the orange juice had juice laying in the middle of the tube approximately 4-5 inches long. The outside of the tubes were noted to be sticky. When asked how often the hoses are cleaned, the DM stated he didn't know how to clean them and stated the juice boxes were empty. The DM stated they were waiting for juice to be delivered and agreed the hoses were dirty and stated they are cleaned once a week. The walk-in refrigerator was observed with the following findings: Two (2) pieces of watermelon were observed wrapped in plastic wrap with no label or date. One (1) box of zucchini was observed with no date of receipt noted on the box and the zucchini were observed to be soft, spongy, and squishy to touch with signs of decomposition and browning on the skins in several spots. One (1) box containing three (3) heads of raw cabbage was observed with a receipt date of 07/01/2026. The box contained loose, dislocated, wilted leaves and a moderate amount of brown spots were observed on the three (3) heads of cabbage. The DM agreed the cabbage should have been discarded. Two (2) bags of prepared salad mix were observed on the second shelf with a received date of 07/08/2026 marked on each bag. The salad mixes were noted to have brown lettuce throughout the packages. A large covered square container of American Cheese Slices was observed with a sticker on the lid that read, Opened 6/16/26. Discard 7/16/26. The DM stated he was told that cheese does not go bad and to just change the sticker. The DM stated he would discard all the items from the walk-in refrigerator. These concerns were discussed at the end of day meeting on 07/21/2026 at 4:04 PM with the Administrator, [NAME] President of Operations, and Regional Director of Clinical Services. Requested, but did not receive a facility policy on food labeling and storage. No further information was provided prior to exit on 07/28/2026.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on staff interview, clinical record review, and facility document review, the facility staff failed to review and revise the comprehensive person-centered care plan for 3 of 51 sampled residents, Resident #94, Resident #2, and Resident #12. The findings included: 1. For Resident #94, the facility staff failed to revise the comprehensive person-centered care plan (CP) when hospice services were initiated. A facility policy titled, Comprehensive Care Plans revised 11/14/25 specified The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. An admission Record indicated the facility admitted Resident #94 to the facility on 1/23/26. According to the admission Record, the resident had a medical history that included sepsis due to Serratia, urinary tract infection (UTI), type 2 diabetes mellitus, and chronic obstructive pulmonary disease. An admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/29/26, revealed Resident #94 had a Brief Interview for Mental Status (BIMS) score of 9 which indicated the resident had moderate cognitive impairment. Resident #94's medical provider orders included an order dated 4/20/26 for Hospice to evaluate and treat. A hospice nursing admission note dated 4/21/26 indicated Resident #94 was admitted with a primary diagnosis of chronic obstructive pulmonary disease and acute and chronic respiratory failure with hypoxia. A review of Resident #94's CP failed to reveal a care plan focus regarding end of life, hospice services and care coordination. During a meeting on 7/27/26 at 5:19 PM, the Administrator and Regional Director of Clinical Services were notified of the concern regarding Resident #94's CP. No further information was provided prior to the exit conference on 7/28/26. 2. For Resident #2, the facility staff failed to review and revise the comprehensive person-centered care plan when restorative services for ambulation were discontinued. A facility policy titled, Comprehensive Care Plans revised 11/14/25 specified The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission Record indicated the facility admitted Resident #2 on 11/19/24. According to the admission Record, the resident had a medical history that included vascular dementia and type 2 diabetes mellitus with diabetic polyneuropathy. A significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/19/26, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 1, which indicated the resident had severe cognitive impairment. Resident #2's comprehensive person-centered care plan included a focus area initiated 4/20/26, that indicated the resident was to ambulate with rolling walker and minimum assist up to 50 feet six days a week with the restorative program. A review of Resident #2's clinical record failed to reveal evidence of the resident participating in the restorative program and receiving assistance to ambulate six days a week. During an interview on 7/24/26 at 12:08 PM, Restorative Certified Nursing Assistant #1 stated Resident #2 was no longer on the restorative program caseload and service was discontinued about a month ago. On 7/27/26 at 5:19 PM, the Administrator and Regional Director of Clinical Services were notified of the concern regarding Resident #2's restorative care plan remaining active despite services being discontinued. No further information regarding this concern was presented prior to the exit conference on 7/28/26. 3. For Resident #12 the facility staff failed to revise the care plan to include the use of a prophylactic antibiotic. Resident #12's clinical record listed diagnoses which included but not limited to obstructive and reflux uropathy, unspecified. Resident #12's most recent quarterly minimum data set with an assessment reference date of 06/29/26 assigned the resident a brief interview for mental status score of 3 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #12's comprehensive care plan was reviewed and contained a plan for . has incontinence at times, she has obstructive uropathy with a Hx (history of) nephrostomy tubes with recurrent dysfunction recent removal. Resident #12's clinical record was reviewed and contained a physician's order summary which read in part, Fosfomycin Tromethamine Oral Pack 3 GM (Fosfomycin Tromethamine). Give 1 packet by mouth one time a day every Tue for UTI (urinary tract infection) treatment and PPx (prophylaxis). Surveyor could find where this treatment had been added to the care plan. Surveyor requested and was provided with a facility policy entitled, Care Plan Revisions Upon Status (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Change which read in part, The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. The concern of not revising the resident's care plan was discussed with the administrator and regional director of clinical services on 07/27/26 at 5:20 pm. No further information was provided prior to exit.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on staff interview, clinical record review and facility document review, the facility staff failed to meet professional standards of practice for the documentation of medication administration for 2 of 51 residents, Resident #12 and Resident #90. The findings included:1.For Resident #12 the facility staff documented the narcotic medication oxycodone as being administered, when no oxycodone was documented as removed from the narcotic supply. Resident #12's clinical record listed diagnoses which included but not limited to rheumatoid arthritis, unspecified, contracture of muscle, right shoulder, and hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side. Resident #12's most recent quarterly minimum data set with an assessment reference date of 06/29/26 assigned the resident a brief interview for mental status score of 3 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Section J, health management, coded the resident as receiving scheduled pain medication. Resident #12's comprehensive care plan was reviewed and contained a plan for . is at risk for alterations in pain r/t (related to) RA (rheumatoid arthritis), CVA (cerebrovascular accident), PEG (percutaneous endoscopic gastrostomy) placement, and generalized pain, neuropathy. Resident #12's clinical record contained a physician's order summary which read in part, oxycodone HCl Oral Tablet 5 mg (Oxycodone HCl). Give 1 tablet by mouth every 8 hours for pain. Resident #12's electronic medication administration record (eMAR) for the month of June 2026 was reviewed and reconciled with the narcotic control sheet. The eMAR contained an entry which read in part, oxycodone HCl Oral Tablet 5 mg (Oxycodone HCl). Give 1 tablet by mouth every 8 hours for pain. The oxycodone was documented on the eMAR as administered per the physician's order on 06/01/26, 06/02/26, and 06/03/26, but the narcotics control sheet only documented one tablet removed on each of these days. The oxycodone was documented on the eMAR as administered per the physician's order on 06/22/26 and 06/23/26, but the narcotics control sheet documented no tablets removed on 06/22/26 and two tablets removed on 06/23/26. Surveyor requested and was provided with a facility titled, Medication Administration which read in part, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 10. Ensure that the six rights of medication are followed: f. Right documentation. 20. Sign MAR (medication administration record) after administered .21. If medication is a controlled substance, sign narcotic book. The concern of not following professional standards for documenting medications for Resident #12 was discussed with the administrator and regional director of clinical services on 07/27/26 at 5:15 pm. No further information was provided prior to exit. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #90, the controlled count sheets for the narcotic medication Oxycodone did not match the documentation of what had been administered. The facility reported missing 60 Oxycodone (out of 120) for Resident #90 during an facility wide audit of controlled medications. Resident #90's clinical record listed diagnoses which included but not limited to chronic pain, muscle weakness, chronic pulmonary edema, limitation of activities due to disability, and cellulitis of lower right limb. Resident #90's most recent quarterly minimum data set (MDS) with an assessment reference date of 03/19/25 assigned the resident a brief interview for mental status (BIMS) score of 15 out of 15 in section C, cognitive patterns. This indicated that the resident was cognitively intact. Section J, health management, coded the resident as receiving scheduled pain medication. Resident #90's comprehensive care plan was reviewed and contained a plan for . has pain r/t chronic pain, history of rib fracture and liver disease. Resident #90's electronic medication administration record (eMAR) for the month of April and May 2025 were reviewed and reconciled with the narcotic control sheet. The eMAR contained an entry which read in part, oxycodone HCl Oral Tablet 5 mg (Oxycodone HCl). Give 1 tablet by mouth every 6 hours for pain/discomfort give one tablet q6h [every 6 hours] with a 325 Tylenol. The oxycodone was documented on the eMAR as administered per the physician's order on 4/20/25 and 4/22/25 with three doses missing on the narcotic sheet; 4/21/25 with four doses missing on the narcotic control sheet; 4/24/25, 4/25/25, 4/26/25, 4/27/25, and 4/28/25 with one dose missing. The narcotics control sheet showed that one tablet was removed on each of these days during the entries signed for and no indication of what happened to the missing medication was documented. On 4/27 and 4/28/25, the eMAR showed two doses to be given daily while the narcotic control sheet reflected three (out of four) doses given. Surveyor spoke with Licensed Practical Nurse (LPN) #3 on 7/16/25 at 10:40 pm who reports having education on controlled substances, the 5 rights of medication administration, abuse, neglect and exploitation and misappropriation of property. She reports that when a controlled substance is administered to a resident the documentation must be filled out according to policy with two nurses to verify counts, charting each medication administration including pain levels and communication with the provider. Surveyor requested and was provided with a facility policy titled, Medication Administration which read in part, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 10. Ensure that the six rights of medication are followed: f. Right documentation. 20. Sign MAR (medication administration record) after administered .21. If medication is a controlled substance, sign narcotic book. The concern of Resident #12's missing narcotics was discussed with the administrator and regional director of clinical services on 07/28/26 at 2:15 pm. No further information was provided prior to exit.		