STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495348	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Nursing & Rehabilitation	237 Franklin Pike Road SE Floyd, VA 24091

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure one (1) of 24 sampled residents were free of significant medication errors, Resident #6. This failure resulted in harm to Resident #6 requiring emergency care at the hospital. The findings included: Resident #6's clinical record listed diagnoses which included but not limited to other encephalopathy, Alzheimer's disease, vascular dementia, and malignant neoplasm of sigmoid colon.Resident #6's most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 09/08/25 assigned the resident a Brief Interview for Mental Status (BIMS) score of 3 out of 15 in section C, cognitive patterns. This indicated that the resident was severely cognitively impaired.Resident #6's clinical record was reviewed and contained a Surgical Clinic History and Physical/Consultation Note which read in part, [Resident #6] presented to the ED [emergency department] on 6/29/2025 and Ed note is as follows: ?BIBA [brought in by ambulance] from . [facility name omitted] for evaluation of an episode of unresponsiveness. Per EMS [emergency medical services], patient was given another patient's medication, consisting of 150 mg Klonopin, 100 mg Sertraline, and 1 mg Benztropine. Patient is not on oxygen at baseline, but 02 [oxygen] was placed by EMS for 88% RA [room air] on scene. Pt [patient] is now 98% on 2L [liters] 02. EMS noted patient has a DNR (do not resuscitate) and adjusted 02 accordingly. Patient endorse abd [abdominal] pain but otherwise has no other medical complaints.Resident #6's clinical record contained an emergency department report dated 06/29/26 which read in part, Assessment and Plan: Patient . with history significant for dementia and CVA [cerebrovascular accident (stroke)] presents after an episode of unresponsiveness this morning after being accidentally given another patient's medication, including an unknown amount of Klonopin. We have observed [Resident #6] here for 4.5 hours. [Resident #6] is back to [their] baseline. [Their] vitals are stable . Problems Addressed: Accidental ingestion of substance, initial encounter: acute illness or injury . Condition: Stable and Improved.Resident #6's nurse's progress notes were reviewed and contained a note which read in part, 06/29/2025 11:12 Note Text: Nurse had administered medications to resident, a few moments later nurse identified she had administered another resident's medications to this resident. VS [vital signs] were immediately obtained, resident was alert and responding per base line. VS were 140/80, 98, 67, 17, 98% room air. A few moments after that staff observed that resident had eyes closed and leaning in stationary chair in common area. Blood pressure 70/54 and oxygen saturation 90%, pulse remained in the 60's. Resident with irregular respirations and not responding to verbal and touch stimulations. EMS services were immediately called. Staff placed resident in a chair that would elevate [Resident #6's] legs. Resident began to become responsive, however present with signs of agitation and hitting out. EMS services arrived and resident out of facility at 0945 [9:45 AM] to be transfer to ER for evaluation. MD notified and spouse notified.The facility administrator and staff educator were interviewed on 12/03/25 at 4:00 PM regarding Resident #6. The administrator stated they had completed a medication error report and provided a copy of the report. On 12/04/25 at 8:30 am, staff educator provided copies of a root cause analysis, immediate education provided to licensed practical nurse (LPN) #7, education provided to all staff, and medication administration observation forms for LPN #7. Staff educator stated that (continued on next page)

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

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F 0760 Level of Harm - Actual harm Residents Affected - Few	immediately upon discovery of the medication error, education was provided to LPN #7 and larger pictures of the residents were placed on the medication carts.Surveyor spoke with LPN #7 on 12/04/25 at 10:20 AM. LPN #7 stated they were working C-wing on the day of the error, and this was not her normal work assignment. LPN #7 stated they prepared and administered medications for who they thought was Resident #29 but instead was Resident #6. LPN #7 stated both residents were similar in appearance, both had beards and sat at the same place in the dining room. LPN #7 stated after administering the medications to who she thought was Resident #29, she heard staff telling Resident #29 to come to the dining room and realized she had administered the medications to Resident #6. LPN #7 stated she immediately reported the error to the director of nursing at the time. LPN #7 stated she was immediately provided with education, all staff were provided with education, and she was observed during subsequent medication passes.Surveyor observed Resident #6 and Resident #29 and noted that both residents were similar in appearance.A policy titled, Medication Administration revised 11/07/2025 specified Identify resident by photo in the MAR (medication administration record).The concern of not ensuring Resident #6 was free of significant medication errors was discussed with the administrator, director of nursing, staff educator, unit managers, social worker, and business office manager on 12/04/25 at 1:45 pm.The medication Klonopin is a benzodiazepine given to control seizures and panic attacks. Sertraline is a serotonin reuptake inhibitor (SSRI) given to treat depression, panic disorders, and obsessive-compulsive disorder. Benztropine is a medication given to treat the symptoms of Parkinson's disease. No further information was provided prior to exit.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on staff interview, clinical record review, and facility document review, the facility staff failed to notify a medical provider of a change in condition for (3) three of (24) twenty-four sampled residents. Resident #5, Resident #39, and Resident #51. The findings included:1.For Resident #5 the facility staff failed to notify a medical provider of the resident's transfer to a higher level of care on 4/22/25. Resident #5's diagnosis list indicated diagnoses, which included, but not limited to Chronic Kidney Disease-Stage 4, Hypertension, Chronic Obstructive Pulmonary Disease, Atherosclerotic Heart Disease, Chronic Respiratory Failure with Hypoxia, and Diabetes Mellitus Type 2. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 9/19/25 assigned the resident a BIMS (brief interview for mental status) summary score of 3 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A review of Resident #5's census list disclosed that the resident had been transferred out of the facility on 4/22/25. A nursing progress note dated 4/22/25 read in part, .Received notification.during (Resident #5's) cardiology appoint. (appointment) that [cardiologist name omitted] noted an arrythmia and wanted resident seen at the ER (emergency room at hospital).RP.called and notified of ER transfer. This surveyor requested evidence that the medical provider was notified on 4/22/25 of Resident #5's transfer to the hospital. On 12/3/2025 at 4:24 PM, the facility administrator informed this surveyor that no evidence could be located that the medical provider was notified of Resident #5's transfer to the ER from cardiology on 4/22/25. This concern was discussed at the end of day meeting on 12/3/25 at 5:41 PM with the administrator, director of nursing, staff scheduler, staff educator, MDS coordinator, human resource director, social services assistant, unit manager #1, unit manager #2, and unit manager #3. Surveyor requested and received a facility policy titled, Notification of Changes which read in part, .The facility must.consult with the resident's physician.when there is a change requiring such notification. Circumstances requiring notification include.4. A transfer or discharge of the resident. No further information regarding this concern was presented to the survey team prior to the exit conference on 12/4/25. 2. For Resident #39 the facility staff failed to notify the medical provider of a blood glucose level of 56 and failed to notify the medical provider when insulin was held. Resident #39's diagnoses list included but not limited to type 2 diabetes mellitus with hyperglycemia. Resident #39's most recent minimum data set with an assessment reference date of 10/11/25 assigned the resident a brief interview for mental status score of 3 out of 15 in section C, cognitive (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	patterns. This indicates that the resident is severely cognitively impaired. Resident #39's comprehensive care plan was reviewed and contained a plan for . had Diabetes Mellitus. Interventions for this care plan include Diabetes medications as ordered by doctor. Monitor/document for side effects and effectiveness. Resident #39's clinical record was reviewed and contained a physician's order summary which read in part, Lantus SoloStar Subcutaneous Solution Pen-Injector 100 UNIT/ML (Insulin Glargine). Inject 2 unit subcutaneously at bedtime for glucose management related to DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65), and Metformin HCL ER Oral Tablet Extended Release 24 Hour 500 MG (Metformin HCl). Give 1 tablet by mouth one time a day for Glucose Management related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65). Resident #39's electronic medication record for the month of July 2025 was reviewed and contained entries which read in part, Lantus SoloStar Subcutaneous Solution Pen-Injector 100 UNIT/ML (Insulin Glargine). Inject 2 unit subcutaneously at bedtime for glucose management related to DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65), and Metformin HCL ER Oral Tablet Extended Release 24 Hour 500 MG (Metformin HCl). Give 1 tablet by mouth one time a day for Glucose Management related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65). The entry for Lantus was coded 9 on 07/06/25. Chart code 9 is equivalent to other/see nurses notes. Resident #39's nurses progress notes were reviewed and contained a note which read in part, 07/06/2025 22:25 Note Text: Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML. Inject 2 unit subcutaneously at bedtime for glucose management related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65). 56 did not administer. There is no note stating the medical provider had been notified of low blood glucose or that the medication had been held. The entry for Metformin was coded 9 on 07/07/25. Resident #39's progress notes contained a note which read in part, 07/07/2025 09:00 Note Text: Metformin HCl ER Oral Tablet Extended Release 24 Hour 500 MG. Give 1 tablet by mouth one time a day for Glucose Management related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65). did not eat breakfast; has had recent low glucose reading. There is no note stating that the medical provider had been notified of low blood glucose or that the medication had been held. Surveyor spoke with the director of nursing (DON) on 12/04/25 at 11:15 am regarding Resident #39. DON stated nursing staff should have notified the medical provider of a blood glucose reading of 56. DON also stated that nursing staff should not hold a medication without a provider order to do so. Surveyor requested and was provided with a facility policy entitled Notification of Changes which 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. Circumstances requiring notification include: 3. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. 3. Circumstances that require a need to alter treatment. The concern of not notifying the resident's medical provider of a change in condition and holding of medication was discussed with the administrator, DON, staff educator, unit managers, and business office manager on 12/04/25 at 1:45 pm. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit. 3. For Resident #51, the facility nursing staff failed to notify the provider of a 2-pound weight gain. Resident #51 had an order for daily weights and to notify the MD of a weight change of 2 or more pounds in 1 day or a 5 or more-pound change in 1 week. Resident #51 diagnoses included congestive heart failure (CHF), chronic kidney disease, and hypertension. Section C (cognitive patterns) of Resident #51's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/30/25 included a brief interview for mental status (BIMS) score of 15 out of a possible 15 points. Indicating Resident #51 was cognitively intact. Resident #51's comprehensive care plan included the focus area has CHF. Interventions included monitor/document/report as needed any signs or symptoms of CHF, weight gain unrelated to intake. Resident #51's clinical record included a provider order for daily weights, notify MD of weight change of 2 or more pounds in one day or 5 or more-pound change in one week. A review of Resident #51's 11/2025 medication administration records revealed that on 11/06/25 the resident's weight was recorded as 118.4 pounds. On 11/07/25 the weight was documented as 121.6 pounds and on 11/08/25 Resident #51's weight was documented as 124 pounds. This indicated there was a 3.2-pound increase from 11/07/25 to 11/08/25 and a 2.4-pound increase from 11/07/25-11/08/25. The nursing staff documented Resident #51's weight as 123.4 on 11/26/25 and 125.6 on 11/27/25 indicating the resident had a 2.2-pound weight increase. The surveyor was unable to find any evidence that the MD had been notified of the weight gains. On 12/03/25 at 5:40 p.m., during an end of the day meeting with the administrative staff that included the Administrator, Director of Nursing, and Nurse Educator the issue with Resident #51's notifications of weight gain to the provider were reviewed. On 12/04/25 at 1:00 p.m., the Administrator stated they did not have evidence of the weight gain notifications to the provider. During the course of the survey the facility staff provided the survey team with a copy of their policy titled, Notification of Changes. This policy read in part, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician.when there is a change requiring notification. No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on staff interview, clinical record review, and facility document review, facility staff failed to provide notification to the representative of the office of the local state long-term care ombudsman of a resident transfer to a higher level of care for (1) one of (24) twenty-four sampled residents. Resident #9. The findings included:For Resident #9, the facility staff failed to notify the office of the state long-term care ombudsman of a transfer/discharge to a higher level of care on 10/22/25. Resident #9's diagnosis list indicated diagnoses that included, but were not limited to, History of Falling, Age-Related Cognitive Decline, Osteoarthritis, Restlessness and Agitation, and Unspecified Fracture of Upper End of Left Humerus. The most recent significant change minimum data set (MDS) with an assessment reference date (ARD) of 11/14/25, assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A nursing progress note dated 10/22/25 read in part, .Placed call to EMS (emergency medical services) for transport out to ED (emergency department at hospital). This surveyor requested evidence that the office of the state long-term care ombudsman was notified of the transfer/discharge for Resident #9 on 10/22/25. On 12/3/2025 4:23 PM, the facility administrator informed this surveyor the facility does not notify the ombudsman if a resident is just transferred out to the hospital and the resident comes right back because the resident was not discharged . This concern was discussed at the end of day meeting on 12/3/25 at 5:41 PM with the administrator, director of nursing, staff scheduler, staff educator, MDS coordinator, human resource director, social services assistant, unit manager #1, unit manager #2, and unit manager #3. This surveyor requested and received a facility policy titled, Transfer and Discharge which read in part, .5. The facility will maintain evidence that the notice was sent to the Ombudsman.10. Emergency Transfers to Acute Care.h. The Social Services Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman.No further information regarding this concern was presented to the survey team prior to the exit on 12/4/25.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on staff interview, clinical record review and facility document review, facility staff failed to process a medical provider order for (1) one of (20) twenty sampled residents, Resident #4 and the facility staff failed to follow physician orders for (1) one of (24) twenty-four sampled residents Resident #39. The findings included: 1. For Resident #4, the facility nursing staff failed to process a provider order for the medication Fluticasone Propionate inhaler. This provider ordered this medication on 11/26/25 and the order was not processed until 12/01/25. Resident #4's diagnoses included acute and chronic respiratory failure and chronic obstructive pulmonary disease (COPD). Section C (cognitive patterns) of Resident #4's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/14/25 included a brief interview for mental status (BIMS) score of 3 out of a possible 15 points. Per the MDS manual a score of 3=severe impairment in cognitive skills for daily decision making. Resident #4's comprehensive care plan included the focus area COPD. Interventions included administer medications as ordered. Resident #4's clinical record included the following progress notes that read in part, Provider progress note with date of service of 11/26/25. Assessment and Plan.COPD.Discontinue budesonide nebs due to nonformulary. Attempt fluticasone HFA 220 mcg 2 puffs inhaled twice daily with a spacer device. Nursing progress note transcribed on 12/01/25 by Licensed Practical Nurse (LPN) #1 Medication discrepancy noted.Nurse processed physician request to DC [discontinue] budesonide and start fluticasone but failed to do so. Physician notified of failure to follow recommendation and family notified of medication discrepancy. Orders have been corrected and processed. During an interview with LPN #1 on 12/04/25 at 11:45 a.m., this staff stated Resident #4 had a partial box of the medication budesonide and the nursing staff wanted to see if that medication could be exhausted prior to starting a new medication. The order was never processed, and they found the omission when completing a medication review audit. The facility staff were able to provide evidence that this order was transcribed on 12/01/25. On 12/04/25 at 1:45 p.m., during a meeting with the administrative staff that included the Administrator, Director of Nursing, LPN #1, and Nurse Educator the issue with the provider order not being processed on 11/26/25 was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #39 the facility staff failed to follow physician's orders 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 - Few	insulin. Resident #39's diagnoses list included but not limited to type 2 diabetes mellitus with hyperglycemia. Resident #39's most recent minimum data set with an assessment reference date of 10/11/25 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 #39's comprehensive care plan was reviewed and contained a plan for . had Diabetes Mellitus. Interventions for this care plan include Diabetes medications as ordered by doctor. Monitor/document for side effects and effectiveness. Resident #39's clinical record was reviewed and contained a physician's order summary which read in part, Humalog KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro). Inject 2 unit subcutaneously before meals to aid in control of blood glucose related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9). hold for blood glucose at or below 90, Lantus SoloStar Subcutaneous Solution Pen-Injector 100 UNIT/ML (Insulin Glargine). Inject 2 unit subcutaneously at bedtime for glucose management related to DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65), and Metformin HCL ER Oral Tablet Extended Release 24 Hour 500 MG (Metformin HCl). Give 1 tablet by mouth one time a day for Glucose Management related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65). Resident #39's electronic medication record for the month of July 2025 was reviewed and contained entries which read in part, Humalog KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro). Inject 2 unit subcutaneously before meals to aid in control of blood glucose related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9). hold for blood glucose at or below 90, Lantus SoloStar Subcutaneous Solution Pen-Injector 100 UNIT/ML (Insulin Glargine). Inject 2 unit subcutaneously at bedtime for glucose management related to DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65), and Metformin HCL ER Oral Tablet Extended Release 24 Hour 500 MG (Metformin HCl). Give 1 tablet by mouth one time a day for Glucose Management related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65). The entry for Lantus was coded 9 on 07/06/25. Chart code 9 is equivalent to other/see nurses notes. Resident #39's nurses progress notes were reviewed and contained a note which read in part, 07/06/2025 22:25 Note Text: Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML. Inject 2 unit subcutaneously at bedtime for glucose management related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65). 56 did not administer. The entry for Metformin was coded 9 on 07/07/25. Resident #39's progress notes contained a note which read in part, 07/07/2025 09:00 Note Text: Metformin HCl ER Oral Tablet Extended Release 24 Hour 500 MG. Give 1 tablet by mouth one time a day for Glucose Management related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65). did not eat breakfast; has had recent low glucose reading. The entry for Humalog was coded 12 on 07/04/25 and 07/11/25 at 4:30 pm, with blood glucose readings of 127 and 92 respectively. Resident #39's electronic medication administration record (eMAR) for the month of September 2025 was reviewed and contained an entry which read in part, Humalog KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro). Inject 2 unit subcutaneously before meals to aid in control of blood glucose related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9). hold for blood glucose at or below 90. The eMAR was coded 12 on 09/08/25 and 09/27/25 at 6:30 am. Chart code 12 is equivalent to insulin not required. Resident #39's blood glucose was 95 on both occasions. The eMAR was coded 11 on 09/16/25 at 4:30 pm. Chart code 11 is equivalent to held per (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	parameters. Resident #39's blood glucose was 100 on this occasion. Resident #39's progress notes were reviewed and there were no notes related to the incidents. Surveyor spoke with the director of nursing (DON) on 12/04/25 at 11:15 am regarding Resident #39. DON stated nursing staff should have administered Resident #39's insulin per the physician's order, and anytime the insulin is held, they should make a note. Surveyor requested and was provided with a facility policy entitled 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. 17. Administer medication as ordered in accordance with the manufacturer specifications. The concern of not following the physician's order for the administration of insulin was discussed with the administrator, DON, staff educator, unit managers, and business office manager on 12/04/25 at 1:45 pm. No further information was provided prior to exit.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observations, staff interview, clinical record review, and facility document review, the facility staff failed to provide services and/or treatment to prevent further decrease in range of motion, including the provision of equipment for limited range of motion for (1) one of (24) twenty-four sampled residents. Resident #10. The findings included:For Resident #10, the facility staff failed to provide a right knee brace as ordered by a medical provider to prevent abduction and external rotation of the right hip for contracture management. Resident #10's diagnosis list indicated diagnoses that included, but were not limited to, Diffuse Traumatic Brain Injury, Muscle Weakness, Abnormalities of Gait and Mobility, Quadriplegia, Contracture Right Hand, Contracture Left Hand, Paraplegia, Contracture Right Knee, Contracture Left Knee, Contracture Right Ankle, Contracture Left Ankle, and Abnormal Posture. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 9/5/25, was coded in Section C (Cognitive Patterns) to indicate Resident #10 was rarely/never understood, exhibited short and long-term memory problems, and was severely impaired in decision making. On 12/2/25 at 1:54 PM, this surveyor observed Resident #10 lying in bed. This surveyor asked certified nursing assistant #1 (CNA#1) to assist in removing the sheet covering to the resident's lower extremities. Surveyor observed resident to have bilateral knee contractures and a wedge beneath the resident's hips. CNA#1 informed this surveyor Resident #10 has contractures and they use the wedge for the resident's hip areas. A right knee brace was not observed to be on Resident #10's right knee. A review of a medical provider orders included an order with a start date of 11/1/25 which read in part, .Place knee brace on right knee with wedge at hip to prevent abduction and external rotation of hip. One time a day for contracture management related to CONTRACTURE, RIGHT KNEE.aides may apply and remove and remove per schedule. A review of the December 2025 TAR (treatment administration record) was coded to reflect the right knee brace had been applied to Resident #10's right knee at 10:00 AM on 12/2/25 and removed at 15:59 (3:59 PM) on 12/2/25. On 12/3/25 at 10:40 AM, registered nurse #1 (RN#1) accompanied this surveyor to Resident #10's room. RN#1 removed the sheet covering the resident's lower extremities. This surveyor observed a wedge beneath the resident's hips. A right knee brace was not observed. RN#1 informed surveyor that the restorative aides apply the right knee brace to the resident and they were probably busy and had not made it into Resident #10's room to apply the brace yet. This surveyor spoke with RN#1 and the director of nursing (DON) and asked to speak to the restorative aides and was informed by the DON that one of the aides was on FMLA (family medical leave) and the other restorative aide was not working today. A review of the December 2025 TAR (treatment administration record) was coded to reflect the right knee brace had been applied to Resident #10's right knee at 10:00 AM on 12/3/25. A review of the person-centered comprehensive care plan disclosed a focus which read in part, .impaired physical mobility r/t (related to) traumatic brain injury with paraplegia/quadriplegia.requires staff to provide her care needs. A goal and intervention related to the focus read in part, .will receive appropriate staff support with ADLs (activities of daily living).Place knee brace on right knee with wedge at hip to prevent abduction and external rotation as ordered. This concern was discussed at the end of day meeting on 12/3/25 at 5:41 PM with the administrator, director of nursing, staff scheduler, staff educator, MDS coordinator, human resource director, social services assistant, unit manager #1, unit manager #2, and unit manager #3. On 12/4/25 this surveyor was provided with a copy of an Orthotic Maintenance and Wearing Schedule signed by a PTA (physical therapy assistant) and dated 7/30/25 which read in part, .Hip-knee Orthotic.Wearing Schedule.Daily while in chair 4 hours recommended-do not exceed 8 hrs (hours).On 12/4/25 at 10:37AM, this surveyor interviewed other staff #9 (OS#9) and she informed surveyor she wrote the orthotic maintenance and wearing schedule for Resident #10. She stated she does not write orders and this was a recommendation about the brace to the medical provider. OS#9 agreed the medical provider gave the current order to (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wear the brace daily and agreed she would recommend getting the brace wearing time increased daily for Resident #10. On 12/4/25 at 1:45 PM during the pre-exit meeting, licensed practical nurse #3 (LPN#3) provided this surveyor with two new orders for Resident #10. A review of the new orders disclosed the following: A medical provider orders with a start date of 12/4/25 read in part, .Place knee brace on right knee with wedge at hip to prevent abduction and external rotation of hip. One time daily while in bed only 4 hours recommended, aids may apply.remove per schedule. A medical provider orders with a start date of 12/4/25 read in part, place hip - knee orthotic on daily while in chair to right knee with wedge at hip to prevent abduction and external rotation of hip. 4 hours are recommended not to exceed 8 hours. Surveyor requested and received a facility policy with a revision date of 11/10/25 titled, Prevention in Decline of Range of Motion which read in part, .1. The facility.shall establish and utilize a systemic approach for prevention of decline in range of motion, including.preventative care.a. Based on the comprehensive assessment the facility will provide interventions.to maintain.range of motion.b. the facility will provide treatment and care in accordance with professional standards of practice. This includes but is not limited to.ii. Appropriate equipment (braces or splints). No further information regarding this concern was presented to the survey team prior to the exit on 12/4/25.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure medications were available for administration for (1) one of (24) twenty-four sampled residents, Resident #4. The findings included:The facility staff failed to ensure the provider ordered medication Fluticasone Propionate inhaler was available for administration on 12/01/25 and 12/02/25.Resident #4's diagnoses included acute and chronic respiratory failure and chronic obstructive pulmonary disease (COPD).Section C (cognitive patterns) of Resident #4's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/14/25 included a brief interview for mental status (BIMS) score of 3 out of a possible 15 points. Per the MDS manual a score of 3=severe impairment in cognitive skills for daily decision making.Resident #4's comprehensive care plan included the focus area COPD. Interventions included administer medications as ordered.Resident #4's clinical record included a provider order for the medication Fluticasone Propionate inhaler 2 puffs every 12 hours for acute and chronic respiratory failure. Date of order 12/01/25 start date 12/01/25 at 9:00 p.m.A review of Resident #4's medication administration records (MARs) for 12/2025 revealed that for 12/01/25 at 9:00 p.m. and 09/02/25 at 9:00 a.m. the facility nursing staff documented a 5 for this medication. Per the preprinted code on the MAR a 5=Hold/See Nurse Notes.On 12/01/25 at 10:34 p.m., the nursing staff documented they were .awaiting arrival from pharmacy. for this medication.On 12/02/25 at 10:31 a.m., the nursing staff documented they had contacted the pharmacy regarding the unavailability of this medication.On 12/03/25 at 5:40 p.m. and again on 12/03/25 at 1:45 p.m., during meetings with the administrative staff of the facility to include the Administrator, Director of Nursing, and Nurse Educator. The staff were notified that Resident #4 did not have their provider ordered medication available for administration on 12/01 and 12/02/25. The Nurse Educator identified the facility as using a local pharmacy for a backup pharmacy.A policy regarding unavailable medications was requested from the facility but was never provided to the surveyor prior to the exit conference.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on staff interview, clinical record review, and facility document review, the facility staff failed to follow-up on pharmacy recommendations for (3) three of (24) twenty-four sampled residents, Resident #11, Resident #12, and Resident #23. The findings included:1. For Resident #11, the facility staff failed to follow up on a pharmacy recommendation for 07/15/25. The facility staff were unable to locate this recommendation. Resident #11's diagnoses included chronic obstructive pulmonary disease, protein calorie malnutrition, adult failure to thrive, and vascular dementia. Section C (cognitive patterns) of Resident #11's significant change in status minimum data set (MDS) assessment with an assessment reference date (ARD) of 09/17/25 was coded 1/1/3 to indicate this resident had problems with long- and short-term memory and was severely impaired in cognitive skills for daily decision making. Resident #11's clinical record included a progress note dated 07/15/25. The pharmacist had transcribed that a medication regimen review had been completed and to see their .report for any noted irregularities and/or recommendations. During the record review the surveyor was unable to locate this report. On 12/03/25 at 5:40 p.m. during an end of the day meeting with the administrative staff of the facility to include the Administrator, Director of Nursing, and Nurse Educator. These staff were asked for the missing pharmacy recommendation. On 12/04/25 at 1:20 p.m., the Administrator and Staff Educator stated to the survey team that there was an issue with their software system in 07/25, the pharmacist was unable to access the system, and they now had a different pharmacist. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #12 the facility staff failed to follow up on a pharmacy recommendation on 7/15/25. Resident #12's diagnosis list indicated diagnoses that included, but were not limited to, Anxiety Disorder, Malignant Neoplasm of Prostate, Muscle Wasting and Atrophy, Cognitive Communication Deficit, and Chronic Pain. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 9/13/25, assigned the resident a BIMS (brief interview for mental status) summary score of 3 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A medication regimen review (MRR) dated 7/15/25 read in part, .[x] See report for any noted irregularities and/or recommendations. Evidence of the MRR recommendations for 7/15/25 could not be located on the clinical record and this surveyor requested evidence of the pharmacy recommendations report. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #12's comprehensive person-centered care plan disclosed a focus which read in part, .uses psychotropic medications to manage his depression and anxiety related to dementia. A review of the interventions associated with this focus included an intervention which read in part, .Consult with pharmacy, MD (medical doctor) to consider dosage reduction when clinically appropriate at least quarterly . On 12/4/25 at 1:20 PM, the administrator and registered nurse #1 (RN#1) informed this surveyor they do not have a copy of the 7/15/25 pharmacy recommendations for Resident #12, as the electronic clinical record was not accessible by the pharmacy on that date. This concern was discussed at the pre-exit meeting on 12/4/25 at 1:45 PM with the administrator, director of nursing, staff scheduler, registered nurse #1, licensed practical nurse #1, human resource director, unit manager #1, unit manager #2, unit manager #3, and the business office manager No further information regarding this concern was provided to the survey team prior to exit on 12/4/25. 3. For Resident #23 the facility staff failed to follow up on a pharmacy recommendation. Resident #23's clinical record listed diagnoses which included but not limited to vascular dementia, chronic obstructive pulmonary disease, type 2 diabetes mellitus, and asthma. Resident #23's most recent minimum data set with an assessment reference date of 10/30/25 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 N, subsection N0415, High-Risk Drug Classes, indicates that the resident receives antipsychotic, antidepressant, opioid, hypoglycemic and anticonvulsant medications. Resident #23's comprehensive care plan was reviewed and contained a plan for . uses psychotropic medications. Interventions for this plan include Consult with pharmacy, MD to consider dosage reduction when clinically appropriate at least quarterly. Resident #23's clinical record was reviewed and contained a medication regimen review dated 07/15/2025 which read in part, See report for any noted irregularities and/or recommendations. Surveyor could not locate a pharmacist recommendation in the clinical record. Surveyor spoke with the administrator and staff educator on 12/04/25 at 1:20 pm regarding Resident #23's pharmacy recommendations. Administrator stated they do not have a copy of the pharmacy recommendations, due to electronic clinical records not being accessible by the pharmacist at that time. The concern of not following up on a pharmacist recommendation was discussed with the administrator, director of nursing, staff educator, unit managers, and business office manager on 12/05/25 at 1:45 pm. No further information provided prior to exit.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on staff interviews, clinical record reviews, and facility document review, the facility staff failed to ensure a complete and/or accurate clinical record for (2) two of (24) twenty-four sampled residents. Resident #6 and Resident #10. The findings included:1 For Resident #6 the facility staff filed another resident's Durable Do Not Resuscitate form in Resident #6's clinical record. Resident #6's clinical record contained diagnoses not limited to Alzheimer's disease, unspecified. Resident #6's most recent minimum data set with an assessment reference date of 09/08/25 assigned the resident a brief interview for mental status score of 3 out 15 in section C, cognitive patterns. Resident #6's clinical record was reviewed and contained a Durable Do Not Resuscitate form belonging to another resident. The concern of another resident's information being in Resident #6's clinical record was discussed with the administrator, director of nursing, staff educator, unit managers, and business office manager on 12/04/25 at 1:45 pm. No further information was provided prior to exit. 2. For Resident #10, the facility staff failed to accurately document a right knee brace placement as ordered by a medical provider. Resident #10's diagnosis list indicated diagnoses that included, but were not limited to, Diffuse Traumatic Brain Injury, Muscle Weakness, Abnormalities of Gait and Mobility, Quadriplegia, Contracture Right Hand, Contracture Left Hand, Paraplegia, Contracture Right Knee, Contracture Left Knee, Contracture Right Ankle, Contracture Left Ankle, and Abnormal Posture. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 9/5/25, was coded in Section C (Cognitive Patterns) to indicate Resident #10 was rarely/never understood, exhibited short and long-term memory problems, and was severely impaired in decision making. This surveyor made observations of Resident #10 on 12/2/25 and 12/3/25. A right knee brace was not visible on the resident's right knee during these observations. A review of a medical provider orders included an order with a start date of 11/1/25 which read in part, .Place knee brace on right knee with wedge at hip to prevent abduction and external rotation of hip. One time a day for contracture management related to CONTRACTURE, RIGHT KNEE.aides may apply.and remove per schedule. A review of the December 2025 TAR (treatment administration record) was coded to reflect the right knee brace had been applied to Resident #10's right knee at 10:00 AM on 12/2/25 and removed at 15:59 (3:59 PM) on 12/2/25. On 12/3/25 the TAR was coded to reflect the right knee brace had been applied to Resident #10's right knee at 10:00 AM. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/3/25 at 10:40 AM, registered nurse #1 (RN#1) informed this surveyor that the restorative aides apply the right knee brace to the resident and they were probably busy and had not made it into Resident #10's room to apply the brace yet. This surveyor spoke with RN#1 and the director of nursing (DON) and asked to speak to the restorative aides and was informed by the DON that one of the aides was on FMLA (family medical leave) and the other restorative aide was not working today. A review of the person-centered comprehensive care plan disclosed a focus which read in part, .impaired physical mobility r/t (related to) traumatic brain injury with paraplegia/quadriplegia.requires staff to provide her care needs. A goal and intervention related to the focus read in part, .will receive appropriate staff support with ADLs (activities of daily living).Place knee brace on right knee with wedge at hip to prevent abduction and external rotation as ordered. This concern was discussed at the end of day meeting on 12/3/25 at 5:41 PM with the administrator, director of nursing, staff scheduler, staff educator, MDS coordinator, human resource director, social services assistant, unit manager #1, unit manager #2, and unit manager #3. Surveyor requested and received a facility policy with a revision date of 11/10/25 titled, Documentation in the Medical Record which read in part, .Each resident's medical record shall contain an accurate representation of the actual experiences of the resident.Documentation shall be completed at the time of service.Documentation shall be factual.False information shall not be documented.Record.information based on.service provided. No further information regarding this concern was presented to the survey team prior to the exit on 12/4/25.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, staff interview, clinical record review, and facility document review, the facility staff failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The findings included: For the infection control program, the facility staff failed to follow the enhanced barrier precautions (EBP) process and maintain infection control interventions to help reduce the transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities for facility residents with wounds and indwelling medical devices. This surveyor requested and received a list of residents on EBP. One resident was listed on the report for a dialysis access port. A review of the complete matrix for the facility indicated three facility residents had indwelling catheters, one resident had a stage II pressure ulcer, and one resident had a feeding tube and a tracheostomy. One of the residents with a catheter was on Transition Based Precautions related to an infection. On 12/4/25 at 9:00 AM, this surveyor interviewed the infection preventionist, registered nurse #1 (RN#1) and she informed surveyor the facility staff are using EBP when there are residents at increased risk such as those residents that may have midlines, PIC lines, wound vacs, ports, catheters, etc. On 12/4/25 at 11:23 AM, RN#1 informed this surveyor she does not put long-term catheters, feeding tubes or tracheostomies on EBP if they have no adverse effects. She stated she does put new admissions on EBP if warranted and residents that have new catheters. This concern was discussed at the pre-exit meeting on 12/4/25 at 1:45 PM with the administrator, director of nursing, staff scheduler, registered nurse #1, licensed practical nurse #1, human resource director, unit manager #1, unit manager #2, unit manager #3, and the business office manager. Surveyor requested and received a facility policy titled, Enhanced Barrier Precautions with a revision date of 11/13/25, which read in part, .An order for enhanced barrier precautions will be obtained for residents with any of the following.Wounds.and/or indwelling medical devices (e.g.urinary catheters, feeding tubes, tracheostomy.midline catheters.High-contact resident care activities include: a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use.urinary catheters, feeding tubes, tracheostomy.tubes.midline catheters. No further information regarding this concern was provided to the survey team prior to exit on 12/4/25.

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F 0887 Level of Harm - Potential for minimal harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on staff interview and facility document review, the facility staff failed to provide evidence of education regarding the risks, benefits and potential side effects of the COVID-19 vaccine for facility employees and failed to provide evidence of informed consent of the COVID-19 vaccine for facility employees. The findings included:This surveyor requested evidence of a facility staff member's screening and eligibility, provision of education, risks versus benefits, offering and administration of the COVID-19 vaccine during the infection prevention review. On 12/3/25 at 9:12 AM, the facility administrator informed this surveyor if an employee wants a COVID-19 vaccine, the facility orders the vaccine from the pharmacy and administers it. If an employee does not want a COVID-19 vaccine, then the facility does not do anything. This surveyor asked the administrator for any evidence of staff education and any evidence of employee declinations of the COVID-19 vaccine. On 12/3/25 at 10:05 AM, the facility administrator provided this surveyor with a facility document titled, Staying Up to Date with COVID-19 Vaccines which contained education criteria about the COVID-19 vaccine. He informed this surveyor the facility offers the facility employees the COVID-19 vaccine, but he could not provide any evidence the employees of the facility had been educated or if they refused or accepted the COVID-19 vaccine. On 12/3/25 at 11:53 AM, the facility administrator provided this surveyor with a facility document titled, COVID-19 Vaccine Consent Form and a facility document titled, Informed Consent for COVID-19 Vaccine. The facility administrator informed this surveyor that starting today, the facility will have facility employees sign these consents and education will be provided about the vaccine and if the vaccine is declined by an employee. This concern was discussed at the pre-exit meeting on 12/4/25 at 1:45 PM with the administrator, director of nursing, staff scheduler, registered nurse #1, licensed practical nurse #1, human resource director, unit manager #1, unit manager #2, unit manager #3, and the business office manager. On 12/4/25 at 2:25 PM, a surveyor interviewed licensed practical nurse #8, certified nursing assistant #3, certified nursing assistant # 4, and certified nursing assistant #5 and they all agreed they are offered the COVID-19 vaccine and offered education about the vaccine. Surveyor requested and received the facility policy titled COVID-19 Prevention, Response and Reporting with a revision date of 10/14/25, which read in part, .The facility should offer resources and counseling to healthcare personnel.on the importance of receiving the COVID-19 vaccine and staying up to date with all recommended COVID-19 vaccine doses.14. Communication and Education 1. Educate staff.regularly. No further information regarding this concern was provided to the survey team prior to exit on 12/4/25.