STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashland Nursing and Rehabilitation	906 Thompson Street Ashland, VA 23005

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to invite residents and/or residents' representatives to attend and participate in care plan meetings for two of 27 residents in the survey sample, Residents #16, and #8. The findings include:1. For Resident #16 (R16), the facility staff failed to invite the resident and the resident's representative to attend and participate in care plan meetings in 2025. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/20/25, R16 scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. A review of R16's clinical record for 2025 failed to reveal the resident and/or the resident's representative were invited to participate in the resident's care plan meetings. On 8/19/25 at 12:10 p.m., an interview was conducted with R16 and the resident's representative. During the interview, R16's representative stated R16 or the representative had not been invited to attend care plan meetings. R16 agreed. On 8/19/25 at 4:18 p.m., an interview was conducted with OSM (other staff member) #4 (the director of social services). OSM #4 stated the MDS (minimum data set) coordinators create a list of upcoming care plan meetings and then the receptionist sends invitation letters out to the residents and/or their representatives. On 8/20/25 at 10:45 a.m., an interview was conducted with OSM #13 (the receptionist). OSM #13 stated the former MDS coordinator used to create a list of care plan meetings, and she (OSM #13) mailed out the invitation letters. OSM #13 stated the last letter she sent out was on 10/9/24 because that was the last time the MDS department told her to mail out a letter. OSM #13 stated the former MDS coordinator who used to provide the list was no longer employed at the facility. On 8/20/25 at 5:00 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern. The facility policy titled, Care Plan Invitation documented, The resident and/or the resident representative shall be invited to attend each of the Interdisciplinary Care Plan Conferences for the specified resident. No further information was presented prior to exit. (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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #8 (R8), the facility staff failed to evidence the resident and/or responsible party were given an invitation to the care plan meetings. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/10/25, the resident was coded as having both short- and long-term memory difficulties. The resident had MDS assessments completed on 1/7/25, 4/10/25 and 7/10/25. Review of the clinical record, failed to evidence an invitation to the responsible party (RP) for a care plan meeting. There was no documentation in the clinical record that the responsible party attended the care plan meetings. A request was made for the evidence of an invitation for the care plan meetings on 8/19/25. The facility provided a note dated, 1/28/25 that documented, “LATE ENTRY: Writer spoke to the RP on Tuesday, 01/2/25 about resident was returned from isolation to a different room. The family was displeased. Writer explained to RP, (R7) returned to the only bed available in Memory Care at that time. Writer explained when resident is readmitted there is no certainty that resident will get the same bed or room. Writer told her we will move him as soon as another bed becomes available. Writer set up appointment with family, Ombudsman, VA (Veteran’s affairs) and staff for Friday 2/7/25 at 11 a.m. to address concerns.” On 8/19/25 at 4:18 p.m., an interview was conducted with OSM (other staff member) #4 (the director of social services). OSM #4 stated the MDS coordinators create a list of upcoming care plan meetings and then the receptionist sends invitation letters out to the residents and/or their representatives. On 8/20/25 at 10:45 a.m., an interview was conducted with OSM #13 (the receptionist). OSM #13 stated the former MDS coordinator used to create a list of care plan meetings, and she (OSM #13) mailed out the invitation letters. OSM #13 stated the last letter she sent out was 10/9/24 because that was the last time the MDS department told her to mail out a letter. OSM #13 stated the former MDS coordinator who used to provide the list was no longer employed at the facility. ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were made aware of the above findings on 8/20/25 at 4:40 p.m. No further information was provided prior to exit.

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to promote dignity for one of 27 residents in the survey sample, Resident #14, and on one of three nursing units, the [NAME] unit.The findings include:1. For Resident #14 (R14), the facility staff failed to promote dignity by maintaining trimmed facial hair on a female resident. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/26/2025, the resident was assessed as being severely impaired for making daily decisions. Rejection of care was documented occurring 1 to 3 days during the assessment period but not daily. R14 was assessed as requiring substantial to maximal assistance with personal hygiene. On 8/18/2025 at 11:37 a.m., an observation was made of R14 in the hallway of the memory care unit that they resided on. R14 was observed walking in the hallway outside of their room engaging in pleasant conversation with staff and others. She was observed to be pleasantly confused. Observation of R14's face revealed long curled white hairs present on the chin and long white hairs on the upper lip. Additional observations of R14 on 8/19/2025 at 8:22 a.m. and 8/20/2025 at 9:42 a.m. revealed the long curled white hairs present on the chin and long white hairs on the upper lip remained. The comprehensive care plan for R14 documented in part, Focus: [Name of R14] has an ADL (activities of daily living) self-care performance deficit r/t (related to) factors that include dementia, lack of coordination, and hemiplegia and hemiparesis following cerebral infarction affecting left nondominant side. Date Initiated: 09/11/2023 . Interventions: .Personal Hygiene/Oral Care: The resident requires partial to substantial assistance by 1 staff with personal hygiene and oral care. Date Initiated: 09/11/2023 . It further documented, Focus: [Name of R14] does not cooperate with care refused medication, refuse Shower, refuse foot care Podiatry, refuses skin assessment. Resident resist care. Sometimes requires two persons assist. Removes gripper socks. refuse medications r/t Personal choice. Refuses lab at times. Date Initiated: 12/04/2023. Review of the nursing progress notes from 1/1/2025 to the present failed to evidence documentation of refusal of personal hygiene or attempts made to trim the facial hair. Review of the ADL documentation for R14 from 8/1/2025 to the present documented personal hygiene completed on 8/1/2025 twice and 8/10/2025 on night shift. The ADLs failed to evidence documentation of refusal of personal hygiene or attempts made to trim the facial hair. On 8/20/2025 at 10:57 a.m., an interview was conducted with LPN (licensed practical nurse) #4 who stated that personal hygiene was completed day to day depending on the resident’s needs. She stated that some residents were resistant to care, and they often had to call the family and were able to reapproach and redirect the resident. LPN #4 stated that each day the residents were cleaned up, dressed and brought to the day room for activities if they liked them. She stated that R14 was cooperative at times but also refused care frequently and it was all in how she was approached. On 8/20/2025 at 11:57 a.m., an observation was made with LPN #4 of R14 in her room. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/25 at 1:09 p.m., an interview was conducted with OSM (other staff member) #2, activities assistant/CNA. OSM #2 stated that she worked as a CNA on the memory care unit until recently when she started working as the activities assistant and was familiar with the residents there. She stated that the residents there were challenging and working with them required a little more attention and patience. OSM #2 stated that personal hygiene was done daily and included the staff assisting the residents to wash their faces, wash them off, apply lotion, shave them if needed and brush their teeth. She stated that when female residents had facial hair they made an attempt to shave it off or trim it with scissors. OSM #2 stated that when a resident refused they let the nurse in charge know and the nurse took over from there. She stated that it could potentially be a dignity issue because females really don’t have hair on their faces. The facility policy Grooming Activities revised 3/19/19 documented in part, Grooming activities are provided to assist the residents in meeting their physical needs as well as self-esteem needs. Procedure: 1. Grooming activities shall be offered daily. 2. Grooming activities shall include, but are not limited to: Shaving . The facility policy Activities of Daily Living effective 2/1/22 documented in part, .CNA will report any changes in ability or refusals to the nurse. CNA will document care provided in the medical record . On 8/20/2025 at 4:30 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services were made aware of the findings. No further information was provided prior to exit. 2. Observation made on 8/18/25 at 2:30 p.m. The five tables had residents at each table eating their meal. There were the domes that come on the food trays, in the center of the tables with trash in them. A second observation was made on 8/19/25 at 12:15 p.m. The five tables had residents at each table eating their meal. There were domes, again observed, in the center of the four tables with trash in them. An interview was conducted with RN (registered nurse) #1 on 8/19/25 at 12:25 p.m. RN #1 stated that the domes with the trash in them in the center of the table is not a dignified manner to eat. The facility policy, “Social Dining Program” documented in part, “Policy: The social dining program is designed to create a quiet, relaxed social atmosphere in which residents can eat in a leisurely fashion, interact with others, achieve and maintain the highest possible level of independence and consume a sufficient amount of food…All non-edible items, i.e., bread wrappers, sugar packets, cellophane, etc. shall be removed from the table.” ASM (administrative staff member) 1, the ED (executive director), and ASM #2, the DCS (director of clinical services), were made aware of the above on 8/19/25 at 5:10 p.m. No further information was provided prior to exit.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to facilitate resident council meetings for three of nine months, potentially affecting all residents, and failed to resolve grievances identified in the resident council meetings for two months reviewed.1. The facility staff failed to facilitate resident council meetings from 5/1/2025 through the present potentially affecting all residents in the facility. A review of the facility resident council meeting minutes from 10/1/2024 to the present failed to evidence any meeting minutes after 4/17/2025. On 8/20/2025 at 2:00 p.m., an interview was conducted with Resident #18 (R18) who stated that there were no activities in the building from February through June. R18 stated that he called resident council meetings himself when there was no activities director and he had independently met with some other residents and former administrative staff to discuss the need for an activities director and person to file grievances through. R18 stated that he had offered to write up the other residents grievances in the absence of the activities director because that was one of the primary concerns he had about not having resident council meetings. He stated that the social worker started taking down their grievances at that point and the former administrative staff promised him that they would fill the position. R18 stated that in the resident council meetings they discussed any concerns the residents had with staff, activities they wanted to do, grievances, and changes in leadership. He stated that there were still ongoing problems that needed to be addressed, and he was working one-on-one with the new executive director and director of clinical services who have been very receptive and helpful. R18 was assessed as cognitively intact for making daily decisions on the most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 6/29/2025. On 8/20/25 at 9:01 a.m., ASM (administrative staff member) #1, the executive director stated that the current activities director had started working at the facility at the end of June and prior to that they were challenged with days when no one was at the facility. On 8/20/2025 at 12:53 p.m., ASM #2, the director of clinical services stated that the resident council meeting minutes provided were what they had and there were none for 5/1/2025 to the present. The facility policy Resident Council Meeting dated 11/1/21 documented in part, Residents will be provided the opportunity to meet together at least monthly in an organized group setting to discuss current issues/topics of their choice. These topics may include events, activities, resident rights, care, and service and concerns. In addition, a review of old business, problem resolution, and development of action plans may be discussed. The Recreational and Community Life Department staff will serve as facilitators for the meetings and will document minutes as approved by Resident Council . On 8/20/25 at 4:30 p.m., ASM #1, the executive director and ASM #2, the director of clinical services were made aware of the concern. No further information was provided prior to exit. 2. For November and December 2024, the facility staff failed to provide evidence of resolution of resident grievances expressed during Resident Council meetings. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the 11/6/24 Resident Council meeting minutes revealed the following “new business” items of concern: CNAs (certified nursing aides) not making beds or changing bed linens, pain medications not being given in a timely fashion, and a shortage of paper towels and toilet paper in rooms. A review of the 11/12/24 Resident Council meeting minutes revealed no evidence that the new concerns raised in the 11/6/24 meeting had been resolved. Additionally, these minutes revealed the following “new” concerns: beds not being made or linens changed, smoking times needing to be reviewed, resident/staff respect, residents not being introduced to caregivers each shift, and missing clothing items. A review of the 11/18/24 Resident Council meeting minutes revealed no evidence that the new concerns raised in the 11/12/24 meeting had been resolved. Additionally, these minutes revealed the following “new” concerns: CNAs and nurses treating residents with respect, lack of housekeeping services on the weekends, snacks on each unit, residents going to the kitchen to request coffee, and more trips needed to area stores. A review of the 11/25/24 Resident Council meeting minutes revealed no evidence that the new concerns raised in the 11/18/24 meeting had been resolved. Additionally, these minutes revealed the following “new” concerns: beds not being made, staff treating residents disrespectfully, adding a smoke break after dinner, CNAs and nurses on their cell phones, call bells not working, medications being given late, and missing personal items. A review of the 12/2/24 Resident Council minutes revealed no evidence that the new concerns raised in the 11/25/24 meeting had been resolved. Additionally, these minutes revealed the following “new” concern: beds not being made. A review of the 12/26/24 Resident Council minutes revealed no evidence that the new concerns raised in the 11/25/24 meeting had been resolved. On 8/20/25 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of clinical services, were informed of these concerns. On 8/20/25 at 5:13 p.m., ASM #1 was interviewed. He stated that he started working at the facility within the last month. He could not provide evidence of resolutions for grievances expressed in November and December 2024 Resident Council meetings. It is his process to review all concerns identified as grievances during a Resident Council meeting, and to make sure these are appropriately documented so they can be tracked. He reviews each and every new concern from the past 24 hours during each day’s morning meeting with staff. He assigns responsible staff to each concern and emphasized that the resident/responsible party must be involved in the resolution process. He added that resolutions need to occur in a timely manner, must be documented, and the loop must be closed. A review of the facility policy, “Complaint/Grievance,” revealed, in part: “The Center will support each resident’s right to voice a complaint/grievance without fear of discrimination or reprisal. The center will make prompt efforts to resolve the complaint/grievance and inform the resident of the progress toward resolution.” No additional 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, facility document review, and clinical record review, the facility staff failed to notify a resident's responsible party of a change in condition for one of 27 residents in the survey sample, Resident #12The findings include:For Resident #12 (R12), the facility staff failed to notify the resident's responsible party when the resident presented with behaviors and was transferred to the hospital on 4/24/24. A review of R12's clinical record revealed a nurse's note dated 4/24/24 that documented, Pt (Patient) transferred out to ER for further eval (evaluation) related to med refusal, aggressive behaviors, combativeness with staff during ADL (activities of daily living) care, impulsiveness and inappropriate responses to eval questions. Pt eval by psych MD (Medical Doctor) and nurse advised to send to ER for psychosis. Further review of R12's clinical record failed to reveal R12's responsible party was notified regarding the resident's behaviors and hospital transfer. On 8/20/25 at 11:20 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that once the nurses identify something is wrong with a resident, they are supposed to call the representative, let him or her know what is going on, and make them aware the resident is being transferred to the hospital. On 8/20/25 at 5:00 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern. The facility policy titled, Family Notification documented, 1. The family will be notified of any resident changes . No further information was presented prior to exit.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interview and staff interview, it was determined that facility staff failed to maintain a clean, homelike environment for one of 13 current residents in the survey sample, Residents #2 (R2) and one of three units ([NAME] Unit). The findings include:1. For R2, facility staff failed to maintain the room in a clean and sanitary manner. R2 was admitted to the facility with diagnosis that included but were not limited to a stroke. On the most recent comprehensive MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 01/05/2025, R2 was coded as having both short- and long-term memory difficulties and was coded as being severely impaired of cognition for making daily decisions. On 08/18/2025 at approximately 12:45 p.m., an observation of R2 room was conducted. Observation of the floor next to left side of R2’s bed revealed two packages of unopened ketchup, two packages of unopened sugar, two packages of two packages of unopened salt and pepper, several wrappers. Further observation revealed a fall mat on the floor next to the left side of R2’s bed. Observation of the fall mat revealed it to be sticky and with food debris on several areas of the mat. Observations of the floor around R2’s bed revealed discarded wrappers and dust. On 08/18/2025 at approximately 4:25 p.m., an observation of R2 room was conducted. Observation of the floor next to left side of R2’s bed revealed a fall mat. Observation of the fall mat revealed it to be sticky and with food debris on several areas of the mat. Observations of the floor around R2’s bed revealed discarded wrappers and dust. On 08/19/2025 at approximately 8:10 a.m., an observation of R2 room was conducted. Observation of the floor next to left side of R2’s bed revealed a fall mat. Observation of the fall mat revealed it to be sticky and with food debris on several areas of the mat. Observations of the floor around R2’s bed revealed discarded wrappers and dust. On 08/19/2025 at approximately 12:15 p.m. an interview was conducted with OSM (other staff member) #1, director of housekeeping. When asked about the schedule for cleaning resident’s rooms she stated cleaned once a day every day and two rooms every day are scheduled for deep cleaning. When asked about the procedure for routine cleaning of a resident’s room she stated the housekeeper starts by emptying the trash, supplying the bathroom with paper towels and toilet paper, cleans the mirror, wipe down the walls, clean and sanitize the toilet and sink, sweep and mop the bathroom floor. She also stated that the housekeeper then moves into the resident room and dusts the windowsills, cleans the vents in the air conditioner, checks the bed, over-the-bed table, and bedside table for spills and wipes then down, sweep under the bed, and mop the room. When asked about cleaning fall mats OSM #1 stated that the housekeeper removes the fall mat, cleans underneath the mat then cleans and sanitizes the top of the fall mat. On 08/19/2025 at approximately 12:40 p.m. an observation of R2’s room was conducted with OSM #1. After observing the fall mat next to the bed, under and around R2’s bed, she agreed that the room and fall mat were not clean. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility’s policy “Cleaning and Disinfecting Residents' Rooms” documented in part, “General Guidelines. 1. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. 2. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled.” On 08/19/2025 at approximately 5:00 p.m., ASM (administrative staff member) #1, executive director, and ASM #2, director of clinical services, were made aware of the above findings. No further information was provided prior to exit. Complaint deficiency 2. For one of three facility units, the facility staff failed to provide a homelike environment free of lingering urine odors. On 8/18/2025 at 11:35 a.m., an observation was made of the locked memory care unit on the [NAME] unit. Observation at the end of the hallway between the day room and exit door revealed a strong stale urine odor. Observation on the end of the main hallway of the memory care unit revealed a strong stale urine odor present at the end of the hall near the exit door. Additional observations on 8/18/2025 at 2:14 p.m. and 4:00 p.m. and 8/19/2025 at 8:52 a.m., revealed the findings above on the [NAME] unit. On 8/19/2025 at 12:16 p.m., an interview was conducted with OSM (other staff member) #1, the director of housekeeping who stated that resident rooms were cleaned daily. She stated that to control odors on the [NAME] unit the staff scrubbed the bathrooms, used a degreaser on the floors and had a scrubbing machine that circled the floor to bring up any set in stains like urine. She stated that the goal was to do this once a week and they tried to do it twice a week. OSM #1 stated that two rooms from that unit were deep cleaned every day, and they stripped and waxed the floors depending on how they looked. She stated that the lingering urine odors on the unit seemed to come from the bathrooms, and they assigned one housekeeper dedicated to that unit and rotated them around to find who was the best fit for that unit. OSM #1 stated that lingering urine odors were not homelike. She observed the hallways of the [NAME] unit at that time and stated that all she could smell at that time were the cleaning products from the floor tech cleaning the floor today. On 8/20/2025 at 1:09 p.m., an interview was conducted with OSM (other staff member) #2, activities assistant, who stated that odors were minimized on the [NAME] unit by keeping the residents as clean and dry as they could and have housekeeping do their part to keep the unit clean. On 8/20/2025 at 4:30 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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	495362	A. Building B. Wing	08/21/2025

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on staff interview, facility document review, and clinical record review, the facility staff failed to protect residents from abuse for four of 27 residents in the survey sample, Residents #20, #21, #22, and #23. The findings include:1. For Resident #20 (R20), the facility staff failed to protect the resident from physical abuse from Resident #25 (R25). On 1/24/25, R25 hit R20 in the face. A review of R20's clinical record revealed a nurse's note dated 1/24/25 that documented, At about 345pm staff member observed another resident on top of resident in bed (number) hitting him in the face. Writer assessed resident small skin tear noted to resident's nose. Facial swelling and bruising noted to left side of resident's face. Vitals checked, 128/77 (blood pressure), 97.9 (temperature), 72 (pulse), 18 (respirations). NP (Nurse Practitioner) called and made aware of incident. Xray order given. (Name of power of attorney) called and made aware of incident. No concerns voiced. She stated she would be in tomorrow to see resident. An initial facility synopsis submitted to the SA (State Agency) on 1/24/25 documented, Facility staff responded to resident to resident incident on locked dementia unit. (R20) had entered into the room of (R25) and sat in vacant bed opposite (R25's). (R25) asked (R20) to leave his room. When (R20) didn't leave, (R25) got up and hit (R20) on the left side of his face. Staff responded and separated residents and brought (R20) back to his room. Minor first aid provided to cut on (R20's) face and x-ray ordered as a precaution. (R20) was placed on 1:1 supervision due to his wandering into (R25's) room. Both residents have significant dementia and were unable to be appropriately interviewed regarding the incident. A final facility synopsis submitted to the SA on 1/31/25 documented, This letter is to serve as our final report for an FRI (Facility Reported Incident) submitted to your office on 1/24/2025. On that date, staff witnessed (R20) in the room of (R25). (R25) had struck (R20) resulting in a small laceration to his face and some swelling. The residents were able to be separated and (R20) was placed on 1:1 while the investigation was initiated. Both responsible parties were notified, the Medical Director was notified and local law enforcement was notified. Both (R20) and (R25) are alert residents who are very confused related to their dementia diagnoses. Both men reside on the locked dementia unit and are poor historians. (R20) is unable to be interviewed, but (R25) indicated that (R20) entered his room without permission so he hit him when he didn't leave. The laceration to (R20's) nose required basic first aid with no other issues noted. A facial x-ray was completed due to the swelling noticed on (R20's) face and the results were unremarkable with no further intervention needed. Since this incident, there have been no further attempts by (R20) of entering (R25's) room, and there have been no further issues regarding (R25's) behaviors. Local law enforcement indicate that they would not get involved due to the cognitive status of both of the residents and no charges were intended to be filed . On 8/20/25 at 1:09 p. m., an interview was conducted with OSM (other staff member) #2 (activities assistant/certified nursing assistant). CNA #2 stated the act of a resident hitting another resident is abuse, even if the aggressive resident is confused, because it's still the act of it. On 8/20/25 at 1:20 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated abuse occurs any time a resident intentionally puts his or her hands on another resident, even if the aggressive resident is confused. On 8/20/25 at 5:00 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern. The facility policy titled, Abuse, Neglect, Exploitation & Misappropriation documented, It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property .Physical Abuse includes but is not limited to: Hitting, Slapping, Punching . Sexual Abuse is non-consensual sexual contact of any type with a resident. Sexual abuse includes but is not limited to: unwanted intimate touching of any kind especially of breast or perineal area . No further information was presented prior to exit. 2. For Resident #21 (R21), the facility staff failed to protect the resident from physical abuse from Resident #25 (R25). On 3/21/25, R25 struck R21 in the face. A review of R21's clinical record revealed a nurse's note dated 3/21/25 that documented, At about 115pm writer was informed by cna (certified nursing assistant) that resident was slapped in the face by another resident. When asked what happened resident stated he smacked me right here and pointed to the right side of her face. Resident stated her and a few more residents were taking dishes off of the table (table the aggressor was seated at) and that resident smacked her in the face. Skin checked. No areas of concern noted. Pain denied when asked. Vitals checked and were wnl (within normal limits). (Name of nurse practitioner) informed of incident. No orders given at the moment. (Name of responsible party) called and made aware. Rp

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, the facility staff failed to implement their policies for the investigation of an allegation of abuse for two of 27 residents in the survey sample, Residents #7 and #2. The findings include: 1a. For Resident #7 (R7), the facility staff failed to implement their policies and procedures for the investigation of abuse. The facility synopsis of event dated 12/20/24 and reported on 12/20/24, documented in part, “The Interim DON (director of nursing) was notified that the Nurse witnessed (R7) hit (R27). She was not able to get to them in time. The residents were separated. Skin assessments were done. No injuries. MD (medical doctor) and RP (responsible party) updated. (R7) will be placed on Q (every) 15 safety checks.” The final report from the facility dated 12/27/24, documented in part, “This letter is to serve as our final report for an FRI (facility reported incident) submitted to your office on 12/20/24. On that date, staff witnessed (R7) strike (R27). (R27) was assessed and no injuries were noted to her. (R7) is alert but confused and resides on the locked memory care unit of the family with a primary diagnosis of Vascular Dementia and Cognitive Communication Deficit. His recent BIMS (brief interview for mental status) score is a 7/15. He has been interviewed multiple times but is unable to recall the incident. Since the date of the incident, there have been no further aggressive behaviors by him. (R27) also resides on the locked memory care unit. She is alert but confused with ta primary diagnosis of Dementia with Behavioral Disturbances. Due to her diagnoses, she is not able to be interviewed. There have been no further issues or concerns noted with her. The facility medical director was notified of the incident with no new orders indicated for either resident. The Responsible Parties for both residents were notified with no further issues or concerns noted by them. Local police were notified of the incident, however no formal report was initiated based on the diagnoses of both residents and the fact that they reside on a memory care unit. While we can validate that this incident did occur in the facility, we have unsubstantiated this allegation of abuse. This was based on the cognitive status of the residents, lack of injury and their inability to recall the incident.” The folder with the facility synopsis of event failed to evidence documentation of any interviews conducted, observations or assessments of the residents involved or any other assessments or interviews with other residents on the unit, or staff members. 1b. The facility synopsis of event dated, 12/30/24 with the incident dated 12/27/24, documented in part, “The Interim DON was notified that the nurse witnessed (R7) hit (R26) in the face. She was not able to get to them in time. The residents were separated. Skin assessments were done. Note discoloration to the side of (R26)’s face. MD and RP updated. (R7) will be placed on Q 15 (minute) safety checks. The final report to the state agency documented in part, “On 12/30/24 the Interim DON was notified that the Nurse witnessed (R7) hit (R26) in the face. She was not able to get to them in time. The residents were separated. Skin assessments were done. Note discoloration to the side of (R26)’s face. MD and RP updated. (R7) will place Q 15 safety checks.” The final report to the state agency was obtained through their corporate office, it was not in the file. Review of the file folder for the investigation of the facility synopsis of event, failed to evidence any documentation of an investigation. The only documentation that was in the folder was the clinical record documents for each resident. There were no witness statements, staff or resident interviews or assessments of residents involved and any other residents, in the file folder. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1c. The facility synopsis of event dated 12/31/25, documented in part, “The Interim DON was notified that the Nurse witnessed (R7) removing his hand from around (R27)’s neck in the dining room. She heard the residents screaming and yelling and she to check and walked up on him taking his hands off her neck. The residents were separated. Skin assessments were done. MD and RP were updated. (R7) placed on 1:1.” The file failed to contain the final report to the state agency, this was obtained for the surveyor from the corporate office. Review of the file folder for the investigation of the facility synopsis of event, failed to evidence any documentation of an investigation. The only documentation that was in the folder were the clinical record documents for each resident. There were no witness statements, staff or resident interviews in the file folder. An interview was conducted with ASM (administrative staff member) #1, the executive director, on 8/20/25 at 5:30 p.m. ASM #1 stated that the investigation should include statements from the residents involved, if capable, other witnesses, staff members of family members at the time of the incident. He stated the following documents should be in the file folder: summary of investigation and all supporting documentation related to the incident. The facility policy, “Abuse, Neglect, Exploitation & Misappropriation” documented in part, “Investigation: The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation. A Social Services representative may be offered in the role of resident advocate during any questioning of or interviewing of residents. Investigations will be accomplished in the following manner: Preliminary Investigations: Immediately upon an allegation of abuse or neglect, the suspect(s) shall be segregated from residents pending the investigation of the resident allegation. The nurse or Director of Nursing/designee shall perform and document a thorough nursing evaluation and notify the attending physician.The Abuse Coordinator and/or Director of Nursing shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be prepared.” ASM #1, and ASM #2, the director of clinical services, were made aware of the above concern on 8/20/25 at 4:40 p.m. No further information was obtained prior to exit. 2. For R2, facility staff failed to implement their policy regarding an allegation of abuse. On the most recent comprehensive MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 01/05/2025, R2 was coded as having both short- and long-term memory difficulties and was coded as being severely impaired of cognition for making daily decisions. The facility’s incident report for R2 documented, Incident Date: 05/30/2025. Incident type: Allegation of abuse/mistreat (mistreatment).” (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility’s synopsis of events dated June 6, 2025, regarding the incident on 05/30/3025 documented in part, “(R3) reports that as he was attempting to exit their room, (R2) forcefully pushed the room door into him hitting him in the back of the arm. (r3) states that he forcefully pushed the door back open hitting (R2) in the face with door. Residents were immediately separated. MD (medical doctor) and RP (responsible party) notified for both residents. Law enforcement notified as well. (R2) had a laceration to lip, bloody nose and swelling to the left side of his face. (R2) was sent to ER (emergency room) for evaluation. Room change initiated for (R2) upon his return to the facility…Facility investigation included interviews with residents, staff and review of the medical record. Upon interview, (R3) stated that he was exiting his room and his roommate attempted to grab him and then his roommate forcefully pushed the door into him, hitting him in arm. (R3) then stated that [sic] used his arm/elbow to forcefully push the door back toward his roommate resulting in his roommate being struck in the face with ddor. Staff observed (R2) sitting in the doorway of his room with a laceration to lip, bloody nose and swelling to the left side of his face. Upon interview, (2) was unable to recall any details of the incident. Staff report that (R2) had to be re-directed from blocking the door to the room. (R2) returned to the facility on [DATE] with a diagnosis of left orbital fracture. (R2) re-admitted to a different room upon his return to the facility. There has been no contact between (R2) and (R3). There have been no further incidents involving either resident.” The facility’s nursing progress note for R2 dated 05/30/2025 documented, “Resident was observed sitting in doorway. When evaluating resident, resident was observed with left eye swollen, left side of lip bleeding, and left nostril bleeding. Resident said he does not recall what happened. Vitals were obtained and resident was assisted with the bleeding due to his injures. 911 was called to send resident out for evaluation of his injures. MD and RP was notified.” The facility’s nursing progress note for R2 dated 05/30/2025 documented, “Resident is at (Name of Hospital) and is admitted with right orbital fracture per (Name of Hospital) nurse. Nurse needed review of residents medications.” Review of the facility’s documents revealed one “Witness Statement” for R2 by an LPN (licensed practical nurse) dated 05/30/2025. The witness statement documented, “Resident was observed sitting at doorway of room. When approaching resident, I observed his nose was bleeding. I also observed one eye was swollen and his lip was bleeding. Resident could not recall what happened.” Review of the facility’s documents failed to evidence interviews were conducted or attempted with other facility residents, (R2), (R3), additional facility staff and evidence of review of medical record documents. On 08/20/2025 at approximately 5:33 p.m. an interview was conducted with ASM (administrative staff member) #1, executive director, regarding the procedure for an investigation related to a resident-to-resident altercation with injury. When asked what documentation constitutes a complete investigation he stated he would obtain statements from residents involved, other witnesses, staff members, summary of the investigation and other supportive documentation . ASM #1 was asked to review the investigative file for the resident-to-resident altercation dated 05/30/2025. When asked if the documentation evidenced a complete investigation he stated no. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/20/2025 at approximately 4:30 p.m., ASM #1 and ASM #2, director of clinical services, were made aware of the above findings. No further information was provided prior to exit. Complaint deficiency

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on staff interview, facility document review and clinical record review, the facility staff failed to report an allegation of abuse in a timely manner for one of 27 residents in the survey sample, Resident #7. The findings include: For Resident #7 (R7) the facility staff failed to report an allegation to the state agency in a timely manner. The incident occurred on 12/27/25 and was not reported to the state agency until 12/30/25. The facility synopsis of event dated, 12/30/24 with the incident dated 12/27/24, documented in part, The Interim DON was notified that the nurse witnessed (R7) hit (R26) in the face. She was not able to get to them in time. The residents were separated. Skin assessments were done. Note discoloration to the side of (R26)'s face. MD and RP updated. (R7) will be placed on Q 15 (minute) safety checks. The final report to the state agency documented in part, On 12/30/24 the Interim DON was notified that the Nurse witnessed (R7) hit (R26) in the face. She was not able to get to them in time. The residents were separated. Skin assessments were done. Note discoloration to the side of (R26)'s face. MD and RP updated. (R7) will place Q 15 safety checks. The final report to the state agency was obtained through their corporate office, it was not in the file. Review of the file folder for the investigation of the facility synopsis of event, failed to evidence any documentation of an investigation. The only documentation that was in the folder was the clinical record documents for each resident. There were no witness statements, staff or resident interviews or assessments of residents involved and any other residents, in the file folder. An interview was conducted with ASM (administrative staff member) #1, the executive director, on 8/20/25 at 8:30 p.m. ASM #1 stated if there is an allegation of abuse, it must be reported to the state agency within two hours. The facility policy, Abuse, Neglect, Exploitation & Misappropriation documented in part, Reporting/Response: Any employee or contracted service provider who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of Nursing is designated as an abuse coordinator. Once an allegation of abuse is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notification of Law Enforcement if a reasonable suspicion of crime has occurred. Facility staff should be aware of and comply with their individual requirements and responsibilities for reporting by law. ASM #1 and ASM #2, the director of clinical services, were made aware of the above concern on 8/20/25 at 4:40 p.m. No further information was obtained prior to exit.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, the facility staff failed to thoroughly investigate an allegation of abuse for two of 27 residents in the survey sample, Residents #7 and #2. The findings include: 1. For Resident #7 (R7), the facility staff failed to evidence a thorough investigation for an allegation of abuse. The facility synopsis of event dated 12/20/24 and reported on 12/20/24, documented in part, “The Interim DON (director of nursing) was notified that the Nurse witnessed (R7) hit (R27). She was not able to get to them in time. The residents were separated. Skin assessments were done. No injuries. MD (medical doctor) and RP (responsible party) updated. (R7) will be placed on Q (every) 15 safety checks.” The final report from the facility dated 12/27/24, documented in part, “This letter is to serve as our final report for an FRI (facility reported incident) submitted to your office on 12/20/24. On that date, staff witnessed (R7) strike (R27). (R27) was assessed and no injuries were noted to her. (R7) is alert but confused and resides on the locked memory care unit of the family with a primary diagnosis of Vascular Dementia and Cognitive Communication Deficit. His recent BIMS (brief interview for mental status) score is a 7/15. He has been interviewed multiple times but is unable to recall the incident. Since the date of the incident, there have been no further aggressive behaviors by him. (R27) also resides on the locked memory care unit. She is alert but confused with ta primary diagnosis of Dementia with Behavioral Disturbances. Due to her diagnoses, she is not able to be interviewed. There have been no further issues or concerns noted with her. The facility medical director was notified of the incident with no new orders indicated for either resident. The Responsible Parties for both residents were notified with no further issues or concerns noted by them. Local police were notified of the incident, however no formal report was initiated based on the diagnoses of both residents and the fact that they reside on a memory care unit. While we can validate that this incident did occur in the facility, we have unsubstantiated this allegation of abuse. This was based on the cognitive status of the residents, lack of injury and their inability to recall the incident.” The folder with the facility synopsis of event failed to evidence documentation of any interviews conducted, observations or assessments of the residents involved or any other assessments or interviews with other residents on the unit, or staff members. 1b. The facility synopsis of event dated, 12/30/24 with the incident dated 12/27/24, documented in part, “The Interim DON was notified that the nurse witnessed (R7) hit (R26) in the face. She was not able to get to them in time. The residents were separated. Skin assessments were done. Note discoloration to the side of (R26)’s face. MD and RP updated. (R7) will be placed on Q 15 (minute) safety checks. The final report to the state agency documented in part, “On 12/30/24 the Interim DON was notified that the Nurse witnessed (R7) hit (R26) in the face. She was not able to get to them in time. The residents were separated. Skin assessments were done. Note discoloration to the side of (R26)’s face. MD and RP updated. (R7) will place Q 15 safety checks.” The final report to the state agency was obtained through their corporate office, it was not in the file. Review of the file folder for the investigation of the facility synopsis of event, failed to evidence any documentation of an investigation. The only documentation that was in the folder was the clinical record documents for each resident. There were no witness statements, staff or resident interviews or assessments of residents involved and any other residents, in the file folder. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1c. The facility synopsis of event dated 12/31/25, documented in part, “The Interim DON was notified that the Nurse witnessed (R7) removing his hand from around (R27)’s neck in the dining room. She heard the residents screaming and yelling and she to check and walked up on him taking his hands off her neck. The residents were separated. Skin assessments were done. MD and RP were updated. (R7) placed on 1:1.” The file failed to contain the final report to the state agency, this was obtained for the surveyor from the corporate office. Review of the file folder for the investigation of the facility synopsis of event, failed to evidence any documentation of an investigation. The only documentation that was in the folder were the clinical record documents for each resident. There were no witness statements, staff or resident interviews in the file folder. An interview was conducted with ASM (administrative staff member) #1, the executive director, on 8/20/25 at 5:30 p.m. ASM #1 stated that the investigation should include statements from the residents involved, if capable, other witnesses, staff members of family members at the time of the incident. He stated the following documents should be in the file folder: summary of investigation and all supporting documentation related to the incident. The facility policy, “Abuse, Neglect, Exploitation & Misappropriation” documented in part, “Investigation: The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation. A Social Services representative may be offered in the role of resident advocate during any questioning of or interviewing of residents. Investigations will be accomplished in the following manner: Preliminary Investigations: Immediately upon an allegation of abuse or neglect, the suspect(s) shall be segregated from residents pending the investigation of the resident allegation. The nurse or Director of Nursing/designee shall perform and document a thorough nursing evaluation and notify the attending physician.The Abuse Coordinator and/or Director of Nursing shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be prepared.” ASM #1, and ASM #2, the director of clinical services, were made aware of the above concern on 8/20/25 at 4:40 p.m. No further information was obtained prior to exit. 2. For R2, facility staff failed to conduct a complete investigation for an allegation of abuse. On the most recent comprehensive MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 01/05/2025, R2 was coded as having both short- and long-term memory difficulties and was coded as being severely impaired of cognition for making daily decisions. The facility’s incident report for R2 documented, Incident Date: 05/30/2025. Incident type: Allegation of abuse/mistreat (mistreatment).” (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility’s synopsis of events dated June 6, 2025, regarding the incident on 05/30/3025 documented in part, “(R3) reports that as he was attempting to exit their room, (R2) forcefully pushed the room door into him hitting him in the back of the arm. (r3) states that he forcefully pushed the door back open hitting (R2) in the face with door. Residents were immediately separated. MD (medical doctor) and RP (responsible party) notified for both residents. Law enforcement notified as well. (R2) had a laceration to lip, bloody nose and swelling to the left side of his face. (R2) was sent to ER (emergency room) for evaluation. Room change initiated for (R2) upon his return to the facility…Facility investigation included interviews with residents, staff and review of the medical record. Upon interview, (R3) stated that he was exiting his room and his roommate attempted to grab him and then his roommate forcefully pushed the door into him, hitting him in arm. (R3) then stated that [sic] used his arm/elbow to forcefully push the door back toward his roommate resulting in his roommate being struck in the face with ddor. Staff observed (R2) sitting in the doorway of his room with a laceration to lip, bloody nose and swelling to the left side of his face. Upon interview, (2) was unable to recall any details of the incident. Staff report that (R2) had to be re-directed from blocking the door to the room. (R2) returned to the facility on [DATE] with a diagnosis of left orbital fracture. (R2) re-admitted to a different room upon his return to the facility. There has been no contact between (R2) and (R3). There have been no further incidents involving either resident.” The facility’s nursing progress note for R2 dated 05/30/2025 documented, “Resident was observed sitting in doorway. When evaluating resident, resident was observed with left eye swollen, left side of lip bleeding, and left nostril bleeding. Resident said he does not recall what happened. Vitals were obtained and resident was assisted with the bleeding due to his injures. 911 was called to send resident out for evaluation of his injures. MD and RP was notified.” The facility’s nursing progress note for R2 dated 05/30/2025 documented, “Resident is at (Name of Hospital) and is admitted with right orbital fracture per (Name of Hospital) nurse. Nurse needed review of residents medications.” Review of the facility’s documents revealed one “Witness Statement” for R2 by an LPN (licensed practical nurse) dated 05/30/2025. The witness statement documented, “Resident was observed sitting at doorway of room. When approaching resident, I observed his nose was bleeding. I also observed one eye was swollen and his lip was bleeding. Resident could not recall what happened.” Review of the facility’s documents failed to evidence interviews with other facility residents, (R2), (R3), additional facility staff and supporting documentation. On 08/20/2025 at approximately 5:33 p.m. an interview was conducted with ASM (administrative staff member) #1, executive director, regarding the procedure for an investigation related to a resident-to-resident altercation with injury. When asked what documentation constitutes a complete investigation he stated he would obtain statements from residents involved, other witnesses, staff members, summary of the investigation and other supportive documentation . ASM #1 was asked to review the investigative file for the resident-to-resident altercation dated 05/30/2025. When asked if the documentation evidenced a complete investigation he stated no. On 08/20/2025 at approximately 4:30 p.m., ASM #1 and ASM #2, director of clinical services, were made aware of the above findings. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to exit. Complaint deficiency

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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, facility document review, and clinical record review, the facility staff failed to provide a written notice of transfer, and a written notice of the bed hold policy to the resident and/or resident representative upon hospital transfer for two of 27 residents in the survey sample, Residents #12, and #8. The findings include:1. For Resident #12, the facility staff failed to provide a written notice of transfer, and a written notice of the bed hold policy when the resident transferred to the hospital on 4/24/24. A nurse's noted dated 4/24/24 documented, Pt (Patient) transferred out to ER for further eval (evaluation) related to med refusal, aggressive behaviors, combativeness with staff during ADL (activities of daily living) care, impulsiveness and inappropriate responses to eval questions. Pt eval by psych MD (Medical Doctor) and nurse advised to send to ER for psychosis. Further review of R12's clinical record failed to reveal evidence that the resident and/or responsible party were provided with a written notice of transfer and a written notice of the bed hold policy. A written notice of transfer and a written notice of the bed hold policy was provided by OSM (other staff member) #4 (the director of social services). The forms documented R12's name, the responsible party's name, and the date 4/24/24 but failed to document evidence the forms were provided to R12 or the responsible party. On 8/20/25 at 9:03 a.m., an interview was conducted with OSM #4. OSM #4 stated she mails the written notices of transfers and written notices of the bed hold policy to responsible parties and keeps the notices in her office. OSM #4 stated she could not provide evidence that R12's written notices were provided to R12 or the resident's responsible party. On 8/20/25 at 5:00 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern. The facility policy titled, Bed Hold documented, Resident or Resident Representative will be notified on admission, and at the time of transfer (to the hospital or therapeutic leave) of the bed hold policies, according to Federal and/or State requirements. No further information was presented prior to exit. 2. For Resident #8 (R8), the facility staff failed to evidence the written notice and bed hold notice were sent to the responsible party for a transfer to the hospital on 1/12/15. The nurse’s note dated 1/12/25 at 3:41 p.m. documented, “Resident tolerated AM (morning) medications well, resident was up in wheelchair after breakfast. During afternoon med (medication) pass, resident’s daughter requested for aid to obtain his temperature, resident had temp (temperature) of 102.1 orally. Blood pressure reading of 98/56, 94 pulse, 18 respirations. Mild c/o (complaint of) left side when touched but resident able to lift arms up upon writer’s request without difficulty. Resident in no apparent distress. Writer placed page for on call MD (medical doctor) for further orders, daughter updated on outgoing all to MD. Writer received call from spouse moments requesting to have resident sent to ER. ” Further review of the clinical record failed to evidence documentation of the written notice and bed hold notice sent to the responsible party. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 8/19/25 at 4:37 p.m. with OSM (other staff member) #5, the social worker. OSM #5 stated she has copies of the letter and bed hold notice but could not evidence that it was actually sent out. ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were made aware of the above findings on 8/20/25 at 4:40 p.m. No further information was provided prior to exit.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for six of 27 residents in the survey sample, Resident #6, #13, #8, #10, #25, and #1.The findings include:1. For Resident #6 (R6), the facility staff failed to implement the comprehensive care plan to provide toileting assistance on multiple dates in August 2023, September 2023 and October 2023. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/4/23, the resident was assessed as being severely impaired for making daily decisions. The resident was assessed as requiring supervision of one person for toileting and personal hygiene and being occasionally incontinent of urine and always continent of bowel. Review of the ADL documentation for R6 dated 8/1-8/31/2023 failed to evidence toileting assistance provided on day shift on 8/1/23, 8/2/23, 8/7/23, 8/10/23, 8/12/23-8/18/23, 8/20/23-8/22/23, and 8/25/23-8/31/23. On evening shift on 8/7/23, 8/11/23, 8/17/23, 8/18/23, 8/20/23, 8/24/23-8/26/23, 8/29/23, and 8/31/23 and on night shift on 8/11/23, 8/24/23, 8/26/23 and 8/31/23. Review of the ADL documentation for R6 dated 9/1-9/30/2023 failed to evidence toileting assistance provided on day shift on 9/1/23, 9/4/23, 9/7/23-9/9/23, 9/11/23, 9/16/23, 9/18/23, 9/22/23, 9/25/23, and 9/27/23. On evening shifts on 9/2/23, 9/4/23, 9/7/23, 9/16/23, 9/21/23, 9/17/23, 9/27/23 and 9/29/23 and on night shifts on 9/1/23, 9/2/23, 9/5/23, 9/7/23, 9/10/23-9/12/23, 9/20/23, 9/22/23, 9/25/23, and 9/28/23-9/30/23. The comprehensive care plan for R6 documented in part, “Focus: [Name of R6] has an ADL self-care performance deficit r/t (related to) factors that include unspecified dementia, cognitive communication deficit, and lack of coordination. Date Initiated: 08/16/2023… Interventions: …Toilet Use: The resident requires assistance by (1) staff for toileting. Date Initiated: 08/16/2023…” It further documented, “[Name of R6] has episodes of incontinence r/t factors that that include unspecified dementia, lack of coordination, and cognitive communication deficit. Date Initiated: 08/16/2023.” On 8/19/2025 at 10:21 a.m., an interview was conducted with CNA (certified nursing assistant) #1 who stated that residents were rounded on for toileting three to four times a shift and they evidenced this by documenting it in the medical record. On 8/20/2025 at 10:57 a.m., an interview was conducted with LPN (licensed practical nurse) #4 who stated that the purpose of the care plan was to show the specialized needs of the resident. She stated that the care plan was updated daily as needed by the team during the morning meetings and should be implemented. On 8/20/2025 at 1:11 p.m., an interview was conducted with OSM (other staff member) # 2, activities assistant/certified nursing assistant. OSM #2 stated the CNAs document in PCC (electronic medical records) that they have provided activities of daily living. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Plans of Care revised 9/25/2017 documented in part, . Procedure: . Develop and implement an Individualized Person-Centered baseline plan of care by the Interdisciplinary Team . On 8/20/2025 at 4:30 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services were made aware of the findings. No further information was provided prior to exit. 2. For Resident #13 (R13), the facility staff failed to implement the comprehensive care plan to provide activities. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/8/2025, the resident was assessed as being severely impaired for making daily decisions. An admission MDS with an ARD of 9/5/2024 documented music, animals, news, group activities, going outside, religious services and books, newspapers and magazines all being very important activities for R13. The comprehensive care plan for R13 documented in part, Focus: [Name of R13] is an elopement risk/wanderer r/t (related to) Dementia, Impaired safety awareness, Resident wanders aimlessly(not to safety needs). Date Initiated: 09/23/2024 . Interventions: . Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes as indicated. Date Initiated: 09/23/2024 . On 8/19/2025 at 3:35 p.m., a request was made to ASM (administrative staff member) #2, the director of clinical services, for evidence of participation in activities from 2/1/2025-6/30/2025 for R13. On 8/19/2025 at 2:14 p.m., an interview was conducted with OSM (other staff member) #2, activities assistant, who stated that they had been handling activities on the memory care unit since 6/28/25. She stated that she worked as a CNA (certified nursing assistant) on the unit prior to that date and there was someone who would come over off and on to do some activities, but it was not every day. She stated that she did some activities with residents on the memory care unit in addition to her CNA duties when there was no activities director in place to keep residents occupied. On 8/19/2025 at 4:32 p.m., an interview was conducted with OSM #4, the director of social services. OSM #4 stated that for months there were no activities going on in the memory care unit and staffing had been a challenge. She stated that things were much better now, and activities were going on every day. On 8/20/25 at 9:01 a.m., ASM #1, the executive director stated that they did not have any of the requested activity participation evidence to provide. He stated that the current activities director had started working at the facility at the end of June and prior to that they were challenged with days when no one was at the facility. ASM #1 stated that they had no ability to produce information that they could not find. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/20/2025 at 9:03 a.m., an interview was conducted with OSM #9, activities director, who stated that they determined activity preferences by developing interpersonal connections with the residents during rounding and morning breaks. She stated that she liked getting an idea of what the residents liked to do, and she offered activities of preference and one-on-one activities as well. OSM #9 stated that since she began working at the facility in June she had created a daily activity sheet that documented the activities for the day, and the attendance logs of residents. She stated that her current activities staff consisted of herself and two activities assistants with one dedicated to the memory care unit. OSM #9 stated that they offered activities such as one-on-one, spa treatments, devotionals, religious activities, arts and crafts and games. She stated that activities should be offered to residents daily to ensure that they are engaged and to give them something to do and a sense of purpose in their day-to-day living. On 8/20/2025 at 10:57 a.m., an interview was conducted with LPN (licensed practical nurse) #4, who stated that there was a time in early 2025 when there was no activities director. She stated that one of her CNA staff would play some games and take residents outside on the memory care unit to give them something to do. LPN #4 stated that the facility tried to have someone come in from the outside, but the CNA had done most everything for memory care until the new activities director and activities aide started in June 2025. She stated that the purpose of the care plan was to show the specialized needs of the resident. She stated that the care plan was updated daily as needed by the team during the morning meetings and should be implemented. On 8/20/2025 at 4:30 p.m., ASM #1, the executive director and ASM #2, the director of clinical services were made aware of the findings. No further information was provided prior to exit. 3. For Resident #8 (R8), the facility staff failed to develop a care plan for the resident residing on a memory care unit. The comprehensive care plan dated 10/1/24, documented in part, “Focus: The resident has impaired cognitive function/dementia or impaired thought processes r/t Dementia Severe Impairment. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Ask yes/no questions in order to determine the resident's needs. Cue, reorient and supervise as needed.” On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/10/25, the resident was coded as having both short- and long-term memory difficulties. An interview was conducted on 8/20/25 at 9:41 a.m. with ASM (administrative staff member) #3, regional MDS coordinator. ASM #3 reviewed the above care plan. ASM #3 stated if a resident resides in a memory care unit, it should be addressed on the care plan. ASM (administrative staff member) #1, the executive director and ASM #2 made aware of the above concern on 8/20/25 at 4:40 p.m. No further information was provided prior to exit. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. For Resident #10 (R10), the facility staff failed to develop a care plan for radiation therapy, chemotherapy, anticonvulsants, and a diagnosis of brain cancer. R10 was admitted to the facility on [DATE] with diagnoses including brain cancer and seizure disorder. He was discharged [DATE]. A review of R10’s orders and MARs (medication administration records) from admission on [DATE] through discharge on [DATE] 2024 revealed he received the following medications: Levetiracetam 250 mg tablet daily for seizures; Temozolomide 145 mg each evening for cancer; and Carbamazepine 200 mg two times a day for seizures. This review also revealed evidence that R10 was receiving regular radiation therapy to his brain. A review of R10’s care plan dated 9/26/24 failed to reveal any information related to the radiation therapy; the anticonvulsants and chemotherapy he was receiving; or his diagnosis of brain cancer. On 8/20/25 at 9:30 a.m., ASM (administrative staff member) #3, the regional MDS (minimum data set) coordinator, was interviewed. She stated a comprehensive care plan is developed from the resident’s admission MDS, physician’s orders, and other clinical documentation. She stated a resident’s comprehensive care plan should include high risk medications like anticonvulsants and chemotherapy and should contain interventions related to a resident’s diagnosis of brain cancer and radiation therapy. After reviewing R10’s comprehensive care plan, she stated: “This is not a comprehensive care plan for this resident.” On 8/20/25 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of clinical services, were informed of these concerns. No additional information was provided prior to exit. 5. For Resident #25 (R25), the facility staff failed to implement the resident's comprehensive care plan for one on one monitoring. A nurse's note dated 4/11/25 documented, Resident observed in the hallway punching another resident on the head. Resident separated from the other resident and placed on [sic] separate room for monitoring. No injuries observed. R25's comprehensive care plan reviewed and revised on 4/11/25 documented, (R25) is at risk for psychosocial well-being issues r/t (related to) the allegation of physical contact towards another resident .1:1 (one on one monitoring) for behaviors and safety. Further review of R25's clinical record failed to reveal documentation to evidence the resident received one on one monitoring on 4/14/25, 4/16/25, 4/17/25, 4/18/25, 4/20/25, 4/21/25, 4/24/25, and 4/25/25 and failed to reveal documentation that one on one monitoring was discontinued. On 8/20/25 at 11:20 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the purpose of the care plan is to specialize in the needs of the resident. LPN #4 stated nurses have access to residents' care plans to ensure they are implemented. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/20/25 at 5:00 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern. No further information was presented prior to exit. 6. For R1, the facility staff failed to follow the comprehensive care plan for personal hygiene on 02/14/2025. R1 was admitted with diagnoses that included but were not limited to quadriplegia (1). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 02/23/2025, R1 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. The facility’s personal hygiene (combing hair, brushing teeth, shaving, applying makeup, washing/drying hands and face) POC (point of care) sheet for R1 dated February 2025 documented a blank on 02/14/2025 during the day shift (7:00 a.m. to 3:00 p.m.); evening shift (3:00 p.m. to 11:00 p.m.) and on the night shift (11:00 p.m. to 7:00 a.m.). Further review of the POC failed to evidence documentation that R1 may have refused care for personal hygiene. The comprehensive care plan for R1 dated 02/26/2025 documented in part, “Focus. The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) limited mobility. Date Initiated: 02/26/2025.” Under “Interventions” it documented in part, “PERSONAL HYGIENE/ORAL CARE: The resident is totally dependent on (X) staff for personal hygiene and oral care. Date initiated: 02/26/2025.” Review of the facility’s nursing progress notes failed to evidence documentation that R1 may have refused care for personal hygiene on 02/14/2025. An interview was conducted with LPN (licensed practical nurse) #4, the unit manager, on 8/20/25 at 11:39 a. m. LPN #4 stated the purpose of the care plan is specialized for each resident and is to be updated with behaviors, refusals of care, medication changes and psychotropic medications. On 08/20/2025 at approximately 4:30 p.m., ASM #1 and ASM #2, director of clinical services, were made aware of the above findings. No further information was provided prior to exit. References: (1) The loss of muscle function in part of your body. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to review and/or revise the comprehensive care plan for four of 27 residents in the survey sample, Residents #14, #8, #20 and #25.The findings include:1. For Resident #14 (R14), the facility staff failed to revise the comprehensive care plan to reflect A) the resident no longer using a wanderguard device and B) no longer on every 15-minute checks. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/26/25, the resident was assessed as being severely impaired for making daily decisions. The assessment documented no wandering behaviors or wander/elopement alarm devices in use. On 8/18/2025 at 11:37 a.m., an observation was made of R14 who was observed in the hallway without shoes or socks on. No wanderguard device was visible at that time. Additional observation of R14 on 8/18/2025 at 1:14 p.m. and 8/19/2025 at 8:44 a.m. revealed no wanderguard observed. The comprehensive care plan for R14 documented in part, “The resident is an elopement risk/wanderer (SPECIFY) r/t (related to) Dementia, Impaired safety awareness, Resident wanders aimlessly. Removes wanderguard. Date Initiated: 09/23/2024.” Under “Interventions” it documented in part, “…Electronic monitoring device per order. Date Initiated: 09/23/2024. Q (every) 15 min safety checks. Date Initiated: 09/23/2024…” The clinical record failed to evidence current physician orders for a wanderguard device or every 15-minute checks. On 8/20/2025 at 9:35 a.m., an interview was conducted with ASM (administrative staff member) #3, regional MDS coordinator who stated that the care plan was updated daily with anything that came up and was updated by MDS staff or nursing. She stated that they reviewed orders each morning and someone should go behind and make sure the care plan was complete. ASM #3 stated that an electronic monitoring device on the care plan usually referred to a wanderguard and if it was no longer in use, it should not be on the care plan anymore. On 8/20/2025 at 10:57 a.m., an interview was conducted with LPN (licensed practical nurse) #4 who stated that when a resident was on every 15 minutes checks they had a paper document that they used to document their checks. She stated that R14 was not on every 15 minutes checks and the care plan was not accurate. LPN #4 stated that she was not sure if R14 had a wanderguard and would have to check the orders. She stated that if a resident had a wanderguard it was checked every shift for placement and every night for function and documented in the medical record. She stated that there would be a physician order for the wanderguard. LPN #4 observed R14 in her room and stated that she did not have a wanderguard and was not on every 15-minute checks and the care plan needed to be updated. She stated that the care plan was updated by MDS and nursing as there were changes in the residents care daily to specialize the needs of the resident. The facility policy “Plans of Care” revised 9/25/2017 documented in part, “…Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions after the completion of each OBRA MDS assessment (except discharge assessments), and as needed…” (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/20/2025 at 4:30 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services were made aware of the findings. No further information was provided prior to exit. 2.a. For Resident #8 (R8), the facility staff failed to review/revise the comprehensive care plan to A) reflect the resident no longer using a wanderguard device and B) reflect preferences. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/10/2025, the resident was assessed as being severely impaired for making daily decisions. The assessment documented no wandering behaviors or wander/elopement alarm devices in use. On 8/18/2025 at 11:39 a.m., an observation was made of R8 who was observed in the hallway in a wheelchair. No wanderguard device was visible at that time. Additional observation of R8 on 8/18/2025 at 1:18 p.m. and 8/19/2025 at 8:46 a.m. revealed no wanderguard observed. The comprehensive care plan for R8 documented in part, The resident is an elopement risk/wanderer r/t (related to) Dementia, Resident wanders aimlessly. Date Initiated: 10/24/2024.” Under “Interventions” it documented in part, “…Electronic monitoring device. Date Initiated: 10/24/2024.” The clinical record failed to evidence current physician orders for a wanderguard device or every 15-minute checks. On 8/20/2025 at 9:35 a.m., an interview was conducted with ASM (administrative staff member) #3, regional MDS coordinator who stated that the care plan was updated daily with anything that came up and was updated by MDS staff or nursing. She stated that they reviewed orders each morning and someone should go behind and make sure the care plan was complete. ASM #3 stated that an electronic monitoring device on the care plan usually referred to a wanderguard and if it was no longer in use, it should not be on the care plan anymore. On 8/20/2025 at 10:57 a.m., an interview was conducted with LPN (licensed practical nurse) #4 who stated that R8 no longer had a wanderguard because it caused issues when he went out to physician appointments and he resided on the locked unit and did not need it. She stated that if a resident had a wanderguard it was checked every shift for placement and every night for function and documented in the medical record. She stated that there would be a physician order for the wanderguard. LPN #4 stated that R8’s care plan needed to be updated and that normally it was updated by MDS and nursing as there were changes in the residents care daily to specialize the needs of the resident. On 8/20/2025 at 4:30 p.m., ASM #1, the executive director and ASM #2, the director of clinical services were made aware of the findings. No further information was provided prior to exit. 2.b. For Resident #8 (R8), the facility staff failed to revise the care plan to include the residents’ preferences for activities. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/10/25, the resident was coded as having both short- and long-term memory difficulties. On the admission MDS assessment, with an assessment reference date of 10/7/24, the resident was coded it being very important to have books, magazines, and newspapers; being around animals, keeping up with the news, going outside, participating in religious activities and doing things with a group of people. The comprehensive care plan dated, 11/17/24, documented in part, “Focus: (R8) is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t (if dependent) Disease process dementia, confusion, PTSD. Interventions: All staff to converse with resident while providing care. Encourage ongoing family involvement. Invite the residents’ family to attend special events, activities, meals. Introduce the resident to residents with similar background, interests and encourage/facilitate interaction. Invite the resident to scheduled activities.” An interview was conducted with ASM (administrative staff member) #3, the regional MDS coordinator on 8/20/25 at 9:41 a.m. ASM #3 stated that every resident should have an activity care plan. The current care plan was reviewed with ASM #3. ASM #3 stated, the care plan should be individualized for each resident. ASM #1, the executive director and ASM #2 made aware of the above concern on 8/20/25 at 4:40 p.m. No further information was provided prior to exit. 3. For Resident #20 (R20), the facility staff failed to review and revise the resident's care plan after the resident was hit by another resident on 1/24/25. A review of R20's clinical record revealed a nurse’s note dated 1/24/25 that documented, At about 345pm staff member observed another resident on top of resident in bed (number) hitting him in the face. Writer assessed resident small skin tear noted to resident's nose. Facial swelling and bruising noted to left side of resident's face. Vitals checked, 128/77 (blood pressure), 97.9 (temperature), 72 (pulse), 18 (respirations). NP (Nurse Practitioner) called and made aware of incident. Xray order given. (Name of power of attorney) called and made aware of incident. No concerns voiced. She stated she would be in tomorrow to see resident. Further review of R20's clinical record failed to reveal the resident's care plan (dated 1/21/25) was reviewed and revised after the 1/24/25 incident. On 8/20/25 at 11:20 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the purpose of the care plan is to specialize in the needs of the resident. LPN #4 stated a resident's care plan should be updated when a resident is hit by another resident and the update should be based on the interventions that were done. On 8/20/25 at 5:00 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern. No further information was presented prior to exit. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. For Resident #25 (R25), the facility staff failed to review and revise the resident's care plan after the resident hit another resident on 1/24/25 and 3/21/25. A review of R25's clinical record revealed the following nurses' notes: 1/24/25- At about 345pm staff member observed resident on top of another resident (in bed number) hitting him in the face. Cna (Certified nursing assistant) that observed incident immediately separated residents. Writer assessed resident. No new skin concerns noted. When asked why were you hitting him, he stated, he was in my room. NP (Nurse Practitioner) called and made aware. Sister called and made aware of incident. 3/21/25- Writer informed by cna that resident slapped another resident in the face. Writer asked resident what happened, and resident stated, 'She was trying to take my juice.' (Name of responsible party) called and made aware of incident. (Name of nurse practitioner) called and informed. No new orders given at the moment. Further review of R25's clinical record failed to reveal the resident's care plan (dated 8/14/23) was reviewed and revised after the 1/24/25 and 3/21/25 incidents. On 8/20/25 at 11:20 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the purpose of the care plan is to specialize in the needs of the resident. LPN #4 stated a resident's care plan should be updated when a resident hits another resident and should include the interventions there were put in place. On 8/20/25 at 5:00 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern. No further information was presented prior to exit.

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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. Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to provide ADL (activities of daily living) care for four of 27 residents in the survey sample, Resident #8, Resident #14, Resident #6, and Resident #1. The findings include: 1. For Resident #8 (R8), the facility staff failed evidence that showers were provided. The June 2025 ADL records documented the resident received two showers, 6/17/25 and 6/25/25. He received four partial baths on 6/7/25, 6/8/25, 6/10/25 and 6/13/25. Of the 78 opportunities for documenting baths, showers or any bathing activity, there were only 13 documented, the rest were all blank. The July 2025 ADL records documented that the resident received no showers. He received seven partial baths, 7/1/25, 7/2/25, 7/5/25, 7/6/25, 7/7/25, 7/20/25 and 7/29/25 and two bed baths 7/3/25 and 7/9/25. Of the 93 opportunities for documenting baths, showers or any bathing activity, there were only 16 documented, the rest were all blank. The August 2025 ADL records documented the resident did not receive any showers. He received one bed bath on 8/1/25. Of the 60 opportunities for documenting baths, showers or any bathing activity, there were only three documented, the rest were all blank. A request was made for documentation of showers, in the form of shower sheets, was requested on 8/20/25. The facility presented two shower sheets for the months of June, July and August 2025. One on 7/2/25 and one on 8/19/25. An interview was conducted with OSM (other staff member) # 2, activities assistant/certified nursing assistant, on 8/20/25 at 1:11 p.m. OSM #2 stated the CNAs document in PCC (electronic medical records) that they have provided activities of daily living. She stated showers are given twice a week and as needed and documented in PCC and on the shower sheets. The facility policy, “Bathing/Showering” documented in part, “Policy: The resident preferences on bathing/showering will be reviewed and identified upon admission, including frequency, and other preferences. The resident’s frequency and preferences for bathing will be reviewed during care conference…Document in the medical record.” ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services, were made aware of the above concern on 8/20/25 at 4:40 p.m. No further information was provided prior to exit. 2. For Resident #14 (R14), the facility staff failed to provide ADL (activities of daily living) care to a dependent resident. R14 was observed with untrimmed facial hair. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/26/2025, the resident was assessed as being severely impaired for making daily decisions. Rejection of care was documented occurring 1 to 3 days during the assessment period but not daily. R14 was assessed as requiring substantial to maximal assistance with personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/18/2025 at 11:37 a.m., an observation was made of R14 in the hallway of the memory care unit that they resided on. R14 was observed walking in the hallway outside of their room engaging in pleasant conversation with staff and others. She was observed to be pleasantly confused. Observation of R14's face revealed long curled white hairs present on the chin and long white hairs on the upper lip. Additional observations of R14 on 8/19/2025 at 8:22 a.m. and 8/20/2025 at 9:42 a.m. revealed the long curled white hairs present on the chin and long white hairs on the upper lip remained. The comprehensive care plan for R14 documented in part, Focus: [Name of R14] has an ADL (activities of daily living) self-care performance deficit r/t (related to) factors that include dementia, lack of coordination, and hemiplegia and hemiparesis following cerebral infarction affecting left nondominant side. Date Initiated: 09/11/2023 . Interventions: .Personal Hygiene/Oral Care: The resident requires partial to substantial assistance by 1 staff with personal hygiene and oral care. Date Initiated: 09/11/2023 . It further documented, Focus: [Name of R14] does not cooperate with care refused medication, refuse Shower, refuse foot care Podiatry, refuses skin assessment. Resident resist care. Sometimes requires two persons assist. Removes gripper socks. refuse medications r/t Personal choice. Refuses lab at times. Date Initiated: 12/04/2023. Review of the nursing progress notes from 1/1/2025 to the present failed to evidence documentation of refusal of personal hygiene or attempts made to trim the facial hair. Review of the ADL documentation for R14 from 8/1/2025 to the present documented personal hygiene completed on 8/1/2025 twice and 8/10/2025 on night shift. The ADLs failed to evidence documentation of refusal of personal hygiene or attempts made to trim the facial hair. On 8/20/2025 at 10:57 a.m., an interview was conducted with LPN (licensed practical nurse) #4 who stated that personal hygiene was completed day to day depending on the resident’s needs. She stated that some residents were resistant to care, and they often had to call the family and were able to reapproach and redirect the resident. LPN #4 stated that each day the residents were cleaned up, dressed and brought to the day room for activities if they liked them. She stated that R14 was cooperative at times but also refused care frequently and it was all in how she was approached. On 8/20/2025 at 11:57 a.m., an observation was made with LPN #4 of R14 in her room. On 8/20/25 at 1:09 p.m., an interview was conducted with OSM (other staff member) #2, activities assistant/CNA. OSM #2 stated that she worked as a CNA on the memory care unit until recently when she started working as the activities assistant and was familiar with the residents there. She stated that the residents there were challenging and working with them required a little more attention and patience. OSM #2 stated that personal hygiene was done daily and included the staff assisting the residents to wash their faces, wash them off, apply lotion, shave them if needed and brush their teeth. She stated that when female residents had facial hair they made an attempt to shave it off or trim it with scissors. OSM #2 stated that when a resident refused they let the nurse in charge know and the nurse took over from there. She stated that it could potentially be a dignity issue because females really don’t have hair on their faces. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Grooming Activities revised 3/19/19 documented in part, Grooming activities are provided to assist the residents in meeting their physical needs as well as self-esteem needs. Procedure: 1. Grooming activities shall be offered daily. 2. Grooming activities shall include, but are not limited to: Shaving . The facility policy Activities of Daily Living effective 2/1/22 documented in part, .CNA will report any changes in ability or refusals to the nurse. CNA will document care provided in the medical record . On 8/20/2025 at 4:30 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services were made aware of the findings. No further information was provided prior to exit. 3. For Resident #6 (R6), the facility staff failed to provide toileting assistance on multiple dates in August 2023, September 2023 and October 2023. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/4/23, the resident was assessed as being severely impaired for making daily decisions. The resident was assessed as requiring supervision of one person for toileting and personal hygiene and being occasionally incontinent of urine and always continent of bowel. Review of the ADL documentation for R6 dated 8/1-8/31/2023 failed to evidence toileting assistance provided on day shift on 8/1/23, 8/2/23, 8/7/23, 8/10/23, 8/12/23-8/18/23, 8/20/23-8/22/23, and 8/25/23-8/31/23. On evening shift on 8/7/23, 8/11/23, 8/17/23, 8/18/23, 8/20/23, 8/24/23-8/26/23, 8/29/23, and 8/31/23. On night shift on 8/11/23, 8/24/23, 8/26/23 and 8/31/23. Review of the ADL documentation for R6 dated 9/1-9/30/2023 failed to evidence toileting assistance provided on day shift on 9/1/23, 9/4/23, 9/7/23-9/9/23, 9/11/23, 9/16/23, 9/18/23, 9/22/23, 9/25/23, and 9/27/23. On evening shifts on 9/2/23, 9/4/23, 9/7/23, 9/16/23, 9/21/23, 9/17/23, 9/27/23 and 9/29/23. On night shifts on 9/1/23, 9/2/23, 9/5/23, 9/7/23, 9/10/23-9/12/23, 9/20/23, 9/22/23, 9/25/23, and 9/28/23-9/30/23. The comprehensive care plan for R6 documented in part, “Focus: [Name of R6] has an ADL self-care performance deficit r/t (related to) factors that include unspecified dementia, cognitive communication deficit, and lack of coordination. Date Initiated: 08/16/2023… Interventions: …Toilet Use: The resident requires assistance by (1) staff for toileting. Date Initiated: 08/16/2023…” It further documented, “[Name of R6] has episodes of incontinence r/t factors that that include unspecified dementia, lack of coordination, and cognitive communication deficit. Date Initiated: 08/16/2023.” On 8/19/2025 at 10:21 a.m., an interview was conducted with CNA (certified nursing assistant) #1 who stated that residents were rounded on for toileting three to four times a shift and they evidenced this by documenting it in the medical record. On 8/20/2025 at 1:11 p.m., an interview was conducted with OSM (other staff member) # 2, activities assistant/certified nursing assistant. OSM #2 stated the CNAs document in PCC (electronic medical records) that they have provided activities of daily living. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/20/2025 at 4:30 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services were made aware of the findings. No further information was provided prior to exit. 4. For R1, the facility staff failed to follow the comprehensive care plan for personal hygiene on 02/14/2025. R1 was admitted with diagnoses that included but were not limited to quadriplegia (1). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 02/23/2025, R1 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. The facility’s personal hygiene (combing hair, brushing teeth, shaving, applying makeup, washing/drying hands and face) POC (point of care) sheet for R1 dated February 2025 documented a blank on 02/14/2025 during the day shift (7:00 a.m. to 3:00 p.m.); evening shift (3:00 p.m. to 11:00 p.m.) and on the night shift (11:00 p.m. to 7:00 a.m.). Further review of the POC failed to evidence documentation that R1 may have refused care for personal hygiene. The comprehensive care plan for R1 dated 02/26/2025 documented in part, “Focus. The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) limited mobility. Date Initiated: 02/26/2025.” Under “Interventions” it documented in part, “PERSONAL HYGIENE/ORAL CARE: The resident is totally dependent on (X) staff for personal hygiene and oral care. Date initiated: 02/26/2025.” Review of the facility’s nursing progress notes failed to evidence documentation that R1 may have refused care for personal hygiene on 02/14/2025. On 08/21/2025 at approximately 9:05 a.m. an interview was conducted with ASM (administrative staff member) #2, director of clinical services. When asked how often a resident receives personal hygiene she stated that it should be done daily and documented if the resident refuses. After reviewing the personal hygiene point of care dated 02/14/2025 for R1, ASM #2 stated that it could not be determined that R1 received personal care on 02/14/2025. On 08/20/2025 at approximately 4:30 p.m., ASM #1 and ASM #2, director of clinical services, were made aware of the above findings. No further information was provided prior to exit. Complaint deficiency References: (1) The loss of muscle function in part of your body. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide activities for five of 27 residents in the survey sample, Residents #17, #13, #14, #2, and #8.The findings include:1. For Resident #17 (R17), the facility staff failed to provide activities according to the resident’s preferences from February through June 2025. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 5/26/25, R17 was coded as having no cognitive impairment. R17 was coded as prioritizing the following activities as “very important:” listening to music, keeping up with the news, doing things with groups of people, doing his favorite activities, and going outside to get fresh air when the weather is good. On 8/20/25 at 9:01 a.m., ASM (administrative staff member) #1, the executive director, stated the facility did not have evidence of activities for R17 or other residents between February and June 2025. He stated that the current activities director had started working at the facility at the end of June 2025 and prior to that, they were challenged with days when there was no facility activities director On 8/20/25 at 9:03 a.m., OSM (other staff member) #9, the activities director, was interviewed. She stated she determined activity preferences by developing interpersonal connections with the residents during rounding and morning breaks. She stated that she liked getting an idea of what the residents liked to do and she offered activities of preference and one-on-one activities as well. OSM #9 stated that since she began working at the facility in June she had created a daily activity sheet that documented the activities for the day, and the attendance logs of residents. She stated that her current activities staff consisted of herself and two activities assistants, with one dedicated to the memory care unit. OSM #9 stated the staff currently offered activities such as one on one, spa treatments, devotionals, religious activities, arts and crafts and games. She stated that activities should be offered to residents daily to ensure that they are engaged and to give them something to do and a sense of purpose in their day-to-day living. On 8/20/25 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of clinical services, were informed of these concerns. A review of the facility policy, “Group Activities,” revealed, in part, “Group activities are scheduled to enhance the resident’s well-being and self-esteem. The activities are planned and organized to meet a specific purpose…Document participation in the point of care in the EHR (electronic health record). Document a summary of the resident’s interest, motivation, and progress at least quarterly.” No additional information was provided prior to exit. 2. For Resident #13 (R13), the facility staff failed to provide activities between 2/1/2025-6/30/2025. (continued on next page)

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/8/2025, the resident was assessed as being severely impaired for making daily decisions. An admission MDS with an ARD of 9/5/2024 documented music, animals, news, group activities, going outside, religious services and books, newspapers and magazines all being very important activities for R13. The comprehensive care plan for R13 documented in part, Focus: [Name of R13] is an elopement risk/wanderer r/t (related to) Dementia, Impaired safety awareness, Resident wanders aimlessly(not to safety needs). Date Initiated: 09/23/2024 . Interventions: . Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes as indicated. Date Initiated: 09/23/2024 . On 8/19/2025 at 3:35 p.m., a request was made to ASM (administrative staff member) #2, the director of clinical services, for evidence of participation in activities from 2/1/2025-6/30/2025 for R13. On 8/19/2025 at 2:14 p.m., an interview was conducted with OSM (other staff member) #2, activities assistant, who stated that they had been handling activities on the memory care unit since 6/28/25. She stated that she worked as a CNA (certified nursing assistant) on the unit prior to that date and there was someone who would come over off and on to do some activities, but it was not every day. She stated that she did some activities with residents on the memory care unit in addition to her CNA duties when there was no activities director in place to keep residents occupied. On 8/19/2025 at 4:32 p.m., an interview was conducted with OSM #4, the director of social services. OSM #4 stated that for months there were no activities going on in the memory care unit and staffing had been a challenge. She stated that things were much better now, and activities were going on every day. On 8/20/25 at 9:01 a.m., ASM #1, the executive director stated that they did not have any of the requested activity participation evidence to provide. He stated that the current activities director had started working at the facility at the end of June and prior to that they were challenged with days when no one was at the facility. ASM #1 stated that they had no ability to produce information that they could not find. On 8/20/2025 at 9:03 a.m., an interview was conducted with OSM #9, activities director, who stated that they determined activity preferences by developing interpersonal connections with the residents during rounding and morning breaks. She stated that she liked getting an idea of what the residents liked to do, and she offered activities of preference and one-on-one activities as well. OSM #9 stated that since she began working at the facility in June she had created a daily activity sheet that documented the activities for the day, and the attendance logs of residents. She stated that her current activities staff consisted of herself and two activities assistants with one dedicated to the memory care unit. OSM #9 stated that they offered activities such as one-on-one, spa treatments, devotionals, religious activities, arts and crafts and games. She stated that activities should be offered to residents daily to ensure that they are engaged and to give them something to do and a sense of purpose in their day-to-day living. (continued on next page)

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/20/2025 at 10:57 a.m., an interview was conducted with LPN (licensed practical nurse) #4, who stated that there was a time in early 2025 when there was no activities director. She stated that one of her CNA staff would play some games and take residents outside on the memory care unit to give them something to do. LPN #4 stated that the facility tried to have someone come in from the outside, but the CNA had done most everything for memory care until the new activities director and activities aide started in June 2025. On 8/20/2025 at 4:30 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services were made aware of the findings. No further information was provided prior to exit. 3. For Resident #14 (R14), the facility staff failed to provide activities between 2/1/2025-6/30/2025. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/26/2025, the resident was assessed as being severely impaired for making daily decisions. An annual MDS with an ARD of 8/23/2024 documented music, religious services and their favorite activities as very important, going outside as somewhat important activities for R13. The comprehensive care plan for R14 documented in part, Focus: [Name of R14] is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t (related to) Cognitive deficits, Disease process of dementia which also causes her to have verbal/aggressive behaviors. Resident enjoys oldies and rock and roll music. Date Initiated: 03/04/2024 . Interventions: .Provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression and responsibility. Date Initiated: 08/22/2024. On 8/19/2025 at 3:35 p.m., a request was made to ASM (administrative staff member) #2, the director of clinical services, for evidence of participation in activities from 2/1/2025-6/30/2025 for R14. On 8/19/2025 at 2:14 p.m., an interview was conducted with OSM (other staff member) #2, activities assistant, who stated that they had been handling activities on the memory care unit since 6/28/25. She stated that she worked as a CNA (certified nursing assistant) on the unit prior to that date and there was someone who would come over off and on to do some activities, but it was not every day. She stated that she did some activities with residents on the memory care unit in addition to her CNA duties when there was no activities director in place to keep residents occupied. On 8/19/2025 at 4:32 p.m., an interview was conducted with OSM #4, the director of social services. OSM #4 stated that for months there were no activities going on in the memory care unit and staffing had been a challenge. She stated that things were much better now, and activities were going on every day. On 8/20/25 at 9:01 a.m., ASM #1, the executive director stated that they did not have any of the requested activity participation evidence to provide. He stated that the current activities director had started working at the facility at the end of June and prior to that they were challenged with days when no one was at the facility. ASM #1 stated that they had no ability to produce information that they could not find. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/20/2025 at 9:03 a.m., an interview was conducted with OSM #9, activities director, who stated that they determined activity preferences by developing interpersonal connections with the residents during rounding and morning breaks. She stated that she liked getting an idea of what the residents liked to do, and she offered activities of preference and one-on-one activities as well. OSM #9 stated that since she began working at the facility in June she had created a daily activity sheet that documented the activities for the day, and the attendance logs of residents. She stated that her current activities staff consisted of herself and two activities assistants with one dedicated to the memory care unit. OSM #9 stated that they offered activities such as one-on-one, spa treatments, devotionals, religious activities, arts and crafts and games. She stated that activities should be offered to residents daily to ensure that they are engaged and to give them something to do and a sense of purpose in their day-to-day living. On 8/20/2025 at 10:57 a.m., an interview was conducted with LPN (licensed practical nurse) #4, who stated that there was a time in early 2025 when there was no activities director. She stated that one of her CNA staff would play some games and take residents outside on the memory care unit to give them something to do. LPN #4 stated that the facility tried to have someone come in from the outside, but the CNA had done most everything for memory care until the new activities director and activities aide started in June 2025. On 8/20/2025 at 4:30 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services were made aware of the findings. No further information was provided prior to exit. 4. For R2, facility staff failed to provide from 02/01/2025 through 06/27/2025. R2 was admitted to the facility with diagnosis that included but were not limited to a stroke. On the most recent comprehensive MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 01/05/2025, R2 was coded as having both short- and long-term memory difficulties and was coded as being severely impaired of cognition for making daily decisions. Section F0800 “Staff Assessment of Daily and Activity Preferences” documented in part, “Listening to music, participating in favorite activities, and Spending time outdoors.” Review of R2’s clinical record failed to evidence documentation of facility activities being offered and R2 attending facility-initiated activities. On 8/19/25 at 2:14 p.m., an interview was conducted with OSM (other staff member) #2, activities assistant who stated that they had been handling activities on the memory care unit since 06/28/2025. She stated that she worked as a CNA (certified nursing assistant) on the unit prior to that date and there was someone who would come over off and on to do some activities, but it was not every day. On 8/20/25 at 9:01 a.m., ASM (administrative staff member) #1, the executive director stated that they did not have any of the requested activity participation evidence to provide. He stated that the current activities director had started working at the facility at the end of June and prior to that they were challenged with days when no one was at the facility. ASM #1 stated that they had no ability to produce information that they could not find. (continued on next page)

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/20/25 at 9:03 a.m., an interview was conducted with OSM #9, activities director who stated that they determined activity preferences by developing interpersonal connections with the residents during rounding and morning breaks. She stated that she liked getting an idea of what the residents liked to do, and she offered activities of preference and one-on-one activities as well. OSM #9 stated that since she began working at the facility in June she had created a daily activity sheet that documented the activities for the day, and the attendance logs of residents. She stated that her current activities staff consisted of herself and two activities assistants with one dedicated to the memory care unit. OSM #9 stated that they offered activities such as one on one, spa treatments, devotionals, religious activities, arts and crafts and games. She stated that activities should be offered to residents daily to ensure that they are engaged and to give them something to do and a sense of purpose in their day-to-day living. On 08/20/2025 at approximately 4:30 p.m., ASM #1 and ASM #2, director of clinical services, were made aware of the above findings. No further information was provided prior to exit. 5. For Resident #8 (R8), the facility staff failed to evidence the resident had participated in activities from February 2025 through June 2025. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/10/25, the resident was coded as having both short- and long-term memory difficulties. On the admission MDS assessment, with an assessment reference date of 10/7/24, the resident was coded it being very important to have books, magazines, and newspapers; being around animals, keeping up with the news, going outside, participating in religious activities and doing things with a group of people. The comprehensive care plan dated, 11/17/24, documented in part, “Focus: (R8) is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t (if dependent) Disease process dementia, confusion, PTSD. Interventions: All staff to converse with resident while providing care. Encourage ongoing family involvement. Invite the residents’ family to attend special events, activities, meals. Introduce the resident to residents with similar background, interests and encourage/facilitate interaction. Invite the resident to scheduled activities.” On 8/19/2025 at 3:35 p.m., a request was made to ASM (administrative staff member) #2, the director of clinical services, for evidence of participation in activities from 2/1/2025-6/30/2025 for R8. On 8/19/2025 at 2:14 p.m., an interview was conducted with OSM (other staff member) #2, the activities assistant, who stated that they had been handling activities on the memory care unit since 6/28/25. She stated that she worked as a CNA (certified nursing assistant) on the unit prior to that date and there was someone who would come over off and on to do some activities, but it was not every day. She stated that she did some activities with residents on the memory care unit in addition to her CNA duties when there was no activities director in place to keep residents occupied. OSM #2 stated R8 likes conversation, telling stories, likes to color, participate in reminiscing, doing word games and balloon toss. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ASM #1, the executive director and ASM #2 made aware of the above concern on 8/20/25 at 4:40 p.m. No further information was provided prior to exit.

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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 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. (continued on next page)

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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 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on resident interview, staff interview, clinical record review and facility document review, the facility staff failed to ensure the activities program was directed by a qualified professional between 1/29/2025 and 6/27/2025 potentially affecting all residents in the facility.The findings include:The facility staff failed to ensure a director of activities was in place between 1/29/2025 and 6/27/2025.On 8/19/2025 at 2:09 p.m., an interview was conducted with Resident #17 (R17) who stated that they could remember a time this year when there were no activities. R17 stated that he liked to go to various activities, but there were none being done that he knew of. He stated he thought there should have been someone to do them for him and other residents. R17 was assessed as being cognitively intact for making daily decisions on the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 5/26/2025.On 8/20/2025 at 2:00 p.m., an interview was conducted with Resident #18 (R18) who stated that there were no activities in the building from February through June. R18 stated that a person came back but left shortly thereafter and that activities are a must for residents in a nursing home. R18 was assessed as being cognitively intact for making daily decisions on the most recent MDS, a quarterly assessment with an ARD of 6/29/2025.On 8/18/2025 at 4:03 p.m., a request was made to ASM (administrative staff member) #2, the director of clinical services, for evidence of an activities director in place from 1/1/2025 to the present with evidence of their qualifications.A review of employment documentation provided by ASM #2, the director of clinical services, documented the previous activities director terminated on 1/29/2025 and the current activities director (OSM (other staff member) #9) hired on 6/27/2025.On 8/19/2025 at 2:00 pm, ASM #2 stated that there was an employee from a contacted managed care company who came to the facility once a week to do activities in the absence of the activities director. She stated that the person did not single out certain residents and did activities for the whole building but were not employed by the facility as the activities director. ASM #2 stated that they also had an activities assistant who was a CNA, but they did not have the credentials to be the activities director. She stated that they had a regional activities director come to the facility for a couple of weeks to do activities during the time also and provided timesheets to evidence the time spent at the facility. Review of the timesheets provided documented the regional staff member working 24 hours between 6/5-6/18/25 and 8 hours between 6/19-7/2/25.On 8/19/2025 at 2:14 p.m., an interview was conducted with OSM #2, activities assistant, who stated that they had been handling activities on the memory care unit since 6/28/25. She stated that she worked as a CNA (certified nursing assistant) on the unit prior to that date and there was someone who would come over off and on to do some activities, but it was not every day. She stated that she did some activities with residents on the memory care unit in addition to her CNA duties when there was no activities director in place to keep residents occupied.On 8/19/2025 at 4:32 p.m., an interview was conducted with OSM #4, the director of social services. OSM #4 stated that for months there were no activities going on in the memory care unit and staffing had been a challenge. She stated that things were much better now, and activities were going on every day.On 8/20/2025 at 9:01 a.m., ASM #1, the executive director, stated that the current activities director had started working at the facility at the end of June and prior to that they were challenged with days when no one was at the facility. On 8/20/2025 at 9:03 a.m., an interview was conducted with OSM #9, activities director, who stated that they determined activity preferences by developing interpersonal connections with the residents during rounding and morning breaks. She stated that she liked getting an idea of what the residents liked to do, and she offered activities of preference and one-on-one activities as well. OSM #9 stated that since she began working at the facility in June she had created a daily activity sheet that documented the activities for the day, and the attendance logs of residents. She stated that her current activities staff consisted of herself and two activities assistants with one dedicated to the memory care unit. OSM #9 stated that they offered activities such as one-on-one, spa treatments, devotionals, religious activities, arts and crafts and games. She stated that activities should be offered to residents daily to ensure that they are engaged and to give them something to do and a sense of purpose in their day-to-day living.On 8/20/2025 at 10:57 a.m., an interview was conducted with LPN (licensed practical nurse) #4, who stated that there was a time in early 2025 when there was no activities director. She stated that one of her CNA staff would play some games and take residents outside on the memory care unit to give them something to do. LPN #4 stated that the facility tried to have someone come in from the outside, but the CNA had done most everything for memory care until the new activities director and activities aide started in June 2025.The facility policy Group Activities

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide foot care for one of 27 residents in the survey sample, Resident #14.The findings include:For Resident #14 (R14), the facility staff failed to provide foot care to maintain trimmed toenails.On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/26/2025, the resident was assessed as being severely impaired for making daily decisions. Rejection of care was documented occurring 1 to 3 days during the assessment period but not daily. R14 was assessed as requiring substantial to maximal assistance with personal hygiene and bathing. R14 was not documented as being diabetic.On 8/18/2025 at 11:37 a.m., an observation was made of R14 in the hallway of the memory care unit that they resided on. R14 was observed walking in the hallway outside of their room in bare feet. R14's feet were observed with long untrimmed toenails that were uneven and approximately 1/8 inch from the nailbed. The comprehensive care plan for R14 documented in part, Focus: [Name of R14] has an ADL (activities of daily living) self-care performance deficit r/t (related to) factors that include dementia, lack of coordination, and hemiplegia and hemiparesis following cerebral infarction affecting left nondominant side. Date Initiated: 09/11/2023 . It further documented, Focus: [Name of R14] does not cooperate with care refused medication, refuse Shower, refuse foot care Podiatry, refuses skin assessment. Resident resist care. Sometimes requires two persons assist. Removes gripper socks. refuse medications r/t Personal choice. Refuses lab at times. Date Initiated: 12/04/2023.Review of the nursing progress notes from 5/1/2025 to the present failed to evidence documentation of refusal of personal hygiene or attempts made to trim the toenails.A podiatry note for R14 dated 4/18/2025 documented the toenails trimmed by the podiatrist on that day. The clinical record failed to evidence R14's toenails trimmed after 4/18/2025.On 8/20/2025 at 10:57 a.m., an interview was conducted with LPN (licensed practical nurse) #4 who stated that R14 was cooperative at times but also refused care frequently and it was all in how she was approached. She stated that the nurses were allowed to trim toenails if the resident was not diabetic. She stated that they tried to have the podiatrist trim the nails of the residents that resided in the memory care unit when he came in monthly, but there were times when they refused. LPN #4 stated that when the resident refused, the nurse should notify the physician and the responsible party and document it in the medical record. On 8/20/2025 at 11:57 a.m., an observation was made with LPN #4 of R14 in her room however she refused to allow LPN #4 to see her feet at that time. On 8/20/25 at 1:09 p.m., an interview was conducted with OSM (other staff member) #2, activities assistant/CNA. OSM #2 stated that she worked as a CNA on the memory care unit until recently when she started working as the activities assistant and was familiar with the residents there. She stated that the podiatrist trimmed the residents toenails, but she was not sure of how often he came in or who he saw when he came in because he saw the residents that the nurse put on the list.The facility policy Grooming Activities revised 3/19/19 documented in part, Grooming activities are provided to assist the residents in meeting their physical needs as well as self-esteem needs. Procedure: 1. Grooming activities shall be offered daily. 2. Grooming activities shall include, but are not limited to: .Nail Care. The facility policy Activities of Daily Living effective 2/1/22 documented in part, .CNA will report any changes in ability or refusals to the nurse. CNA will document care provided in the medical record .On 8/20/2025 at 4:30 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of clinical services were made aware of the findings.No further information was provided prior to exit.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide adequate supervision for one of 27 residents in the survey sample, Resident #25. The findings include:For Resident #25 (R25), the facility staff failed to provide adequate and consistent monitoring, resulting in multiple incidents of the resident hitting and inappropriately touching other residents. A review of R25's clinical record revealed a nurse's note dated 1/24/25 that documented, At about 345pm staff member observed resident on top of another resident (in bed number) hitting him in the face. Cna (Certified nursing assistant) that observed incident immediately separated residents. Writer assessed resident. No new skin concerns noted. When asked why were you hitting him, he stated, he was in my room. NP (Nurse Practitioner) called and made aware. Sister called and made aware of incident.An initial facility synopsis submitted to the SA (State Agency) on 1/24/25 documented, Facility staff responded to resident to resident incident on locked dementia unit. (R20) had entered into the room of (R25) and sat in vacant bed opposite (R25's). (R25) asked (R20) to leave his room. When (R20) didn't leave, (R25) got up and hit (R20) on the left side of his face. Staff responded and separated residents and brought (R20) back to his room. Minor first aid provided to cut on (R20's) face and x-ray ordered as a precaution. (R20) was placed on 1:1 (one on one) supervision due to his wandering into (R25's) room. Both residents have significant dementia and were unable to be appropriately interviewed regarding the incident.Further review of R25's clinical record failed to reveal documentation to evidence the resident received one on one monitoring (until 3/22/25) and failed to reveal documentation that the interdisciplinary team discussed discontinuation of one on one monitoring. A nurse's note dated 3/21/25 documented, Writer informed by cna that resident slapped another resident in the face. Writer asked resident what happened, and resident stated, 'She was trying to take my juice.' (Name of responsible party) called and made aware of incident. (Name of nurse practitioner) called and informed. No new orders given at the moment.An initial facility synopsis submitted to the SA (state agency) on 3/21/25 documented, (R25) and (R21) were sitting in the dining room during the afternoon meal. (R25) thought (R21) was reaching to take his cup of tea and he struck her in the face with an open hand. Residents were immediately separated. Both residents assessed with no injury noted for either resident. MD (Medical Doctor) and responsible parties for both residents notified. 1:1 monitoring initiated for (R25).Further review of R25's clinical record failed to reveal documentation to evidence the resident received one on one monitoring on 3/24/25, 3/27/25, 3/28/25, 3/30/25, 4/2/25, 4/3/25, and 4/10/25 and 4/11/25 (until 12:12 p.m.), and failed to reveal documentation that the interdisciplinary team discussed discontinuation of one on one monitoring. A nurse's note dated 4/11/25 (3:05 a.m.) documented, Resident observed in the hallway punching another resident on the head. Resident separated from the other resident and placed on separate room for monitoring. No injuries observed.An initial facility synopsis submitted to the SA (state agency) on 4/11/25 documented, It was reported that while in the hallway, (R25) struck (R22) in the head with a closed hand. Residents were immediately separated. Both residents assessed with no injury noted for either resident. Neuro checks initiated for (R22). MD and responsible parties for both residents notified. 1:1 monitoring provided for (R25). Law Enforcement Notified.R25's comprehensive care plan reviewed and revised on 4/11/25 documented, 1:1 for behaviors and safety.Further review of R25's clinical record failed to reveal documentation to evidence the resident received one on one monitoring on 4/14/25, 4/16/25, 4/17/25, 4/18/25, 4/20/25, 4/21/25, 4/24/25, 4/25/25, and 4/27/25 (after 1:27 p.m.), and failed to reveal documentation that the interdisciplinary team discussed discontinuation of one on one monitoring. A nurse's note dated 4/27/25 (9:05 p.m.) documented, Residents were separated immediately after incident involving resident A slapping Resident B with an open hand to the right face. Resident A relocated back to his room with the 1:1 CNA (Certified Nursing Assistant). DON (Director of Nursing), Administrator, NP/MD (Nurse Practitioner/Medical Doctor), Non-emergent police station and RPs are [sic] both parties called and notified. An initial facility synopsis submitted to the SA (state agency) on 4/27/25 documented, It was reported that (R25) touched a female resident, (another resident-R23) on the breast open hand on top of her clothes. Staff immediately separated them. While staff was separating the residents, (R25) struck (R22) in the face with an open hand. The residents were assessed, no injuries noted. On 8/20/25 at 11:20 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated one on one monitoring consists of a nurse, CNA, or residential aide monitoring the resident at arm's length and keeping the resident in sight at all times. LPN #4 stated the psychiatric nurse practitioner, doctor, and administrative staff are responsible for

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide sufficient nursing staff for one of 27 residents in the survey sample, Resident #25. The findings include:For Resident #25 (R25), the facility staff failed to provide sufficient nursing staff to ensure adequate monitoring, resulting in multiple incidents of the resident hitting and inappropriately touching other residents. A review of R25's clinical record revealed a nurse's note dated 1/24/25 that documented, At about 345pm staff member observed resident on top of another resident (in bed number) hitting him in the face. Cna (Certified nursing assistant) that observed incident immediately separated residents. Writer assessed resident. No new skin concerns noted. When asked why were you hitting him, he stated, he was in my room. NP (Nurse Practitioner) called and made aware. Sister called and made aware of incident.An initial facility synopsis submitted to the SA (State Agency) on 1/24/25 documented, Facility staff responded to resident to resident incident on locked dementia unit. (R20) had entered into the room of (R25) and sat in vacant bed opposite (R25's). (R25) asked (R20) to leave his room. When (R20) didn't leave, (R25) got up and hit (R20) on the left side of his face. Staff responded and separated residents and brought (R20) back to his room. Minor first aid provided to cut on (R20's) face and x-ray ordered as a precaution. (R20) was placed on 1:1 (one on one) supervision due to his wandering into (R25's) room. Both residents have significant dementia and were unable to be appropriately interviewed regarding the incident.Further review of R25's clinical record failed to reveal documentation to evidence the resident received one on one monitoring (until 3/22/25) and failed to reveal documentation that the interdisciplinary team discussed discontinuation of one on one monitoring. A nurse's note dated 3/21/25 documented, Writer informed by cna that resident slapped another resident in the face. Writer asked resident what happened, and resident stated, 'She was trying to take my juice.' (Name of responsible party) called and made aware of incident. (Name of nurse practitioner) called and informed. No new orders given at the moment.An initial facility synopsis submitted to the SA (state agency) on 3/21/25 documented, (R25) and (R21) were sitting in the dining room during the afternoon meal. (R25) thought (R21) was reaching to take his cup of tea and he struck her in the face with an open hand. Residents were immediately separated. Both residents assessed with no injury noted for either resident. MD (Medical Doctor) and responsible parties for both residents notified. 1:1 monitoring initiated for (R25).Further review of R25's clinical record failed to reveal documentation to evidence the resident received one on one monitoring on 3/24/25, 3/27/25, 3/28/25, 3/30/25, 4/2/25, 4/3/25, and 4/10/25 and 4/11/25 (until 12:12 p.m.), and failed to reveal documentation that the interdisciplinary team discussed discontinuation of one on one monitoring. A nurse's note dated 4/11/25 (3:05 a.m.) documented, Resident observed in the hallway punching another resident on the head. Resident separated from the other resident and placed on separate room for monitoring. No injuries observed.An initial facility synopsis submitted to the SA (state agency) on 4/11/25 documented, It was reported that while in the hallway, (R25) struck (R22) in the head with a closed hand. Residents were immediately separated. Both residents assessed with no injury noted for either resident. Neuro checks initiated for (R22). MD and responsible parties for both residents notified. 1:1 monitoring provided for (R25). Law Enforcement Notified.R25's comprehensive care plan reviewed and revised on 4/11/25 documented, 1:1 for behaviors and safety.Further review of R25's clinical record failed to reveal documentation to evidence the resident received one on one monitoring on 4/14/25, 4/16/25, 4/17/25, 4/18/25, 4/20/25, 4/21/25, 4/24/25, 4/25/25, and 4/27/25 (after 1:27 p.m.), and failed to reveal documentation that the interdisciplinary team discussed discontinuation of one on one monitoring. A nurse's note dated 4/27/25 (9:05 p.m.) documented, Residents were separated immediately after incident involving resident A slapping Resident B with an open hand to the right face. Resident A relocated back to his room with the 1:1 CNA. DON (Director of Nursing), Administrator, NP/MD (Nurse Practitioner/Medical Doctor), Non-emergent police station and RPs are [sic] both parties called and notified.An initial facility synopsis submitted to the SA (state agency) on 4/27/25 documented, It was reported that (R25) touched a female resident, (another resident-R23) on the breast open hand on top of her clothes. Staff immediately separated them. While staff was separating the residents, (R25) struck (R22) in the face with an open hand. The residents were assessed, no injuries noted. The facility staff could not provide nursing schedules that documented how many nurses and CNAs were staffed on each unit for each shift from January 2025 through April 2025. On 8/20/25 at 10:17 a.m., an interview was conducted with OSM (other staff member) #10 (the interim staffing coordinator). OSM #10 stated wing three (which included the dementia unit where R25 resided and a

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on staff interview and facility document review, the facility staff failed to complete an annual performance evaluation for one of five CNA (certified nursing assistant) records reviewed, CNA #5.The findings include:For CNA #5, the facility staff failed to provide evidence of the required annual performance evaluation in the past 12 months.On 8/20/25 at 5:13 p.m., CNA #5's most recent performance evaluation was requested. ASM (administrative staff members) #1, the executive director, and #2, the director of clinical services, were present at this meeting. ASM #1 stated the facility staff may not be able to provide the survey team with the requested information because of the recent sale of the facility and the current staff's lack of access to old personnel records.On 8/21/25 at 9:04 a.m., ASM #5, the assistant director of clinical services, was interviewed. She stated she is very new to this role and will be taking over staff performance evaluations from this point forward. She stated she could not speak to why the evaluation had not been done in a timely manner in the past, but in the future, she will be taking care of these.On 8/21/25 at 11:10 a.m., ASM #1 and ASM #2 were informed of these concerns.No additional information was provided prior to exit.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide medically related social services for one of 27 residents in the survey sample, Resident #20. The findings include:For Resident #20 (R20), the facility staff failed to assess the resident's psychosocial status and implement psychosocial interventions to address physical abuse on 1/24/25. A review of R20's clinical record revealed a nurse's note dated 1/24/25 that documented, At about 345pm staff member observed another resident on top of resident in bed (number) hitting him in the face. Writer assessed resident small skin tear noted to resident's nose. Facial swelling and bruising noted to left side of resident's face. Vitals checked, 128/77 (blood pressure), 97.9 (temperature), 72 (pulse), 18 (respirations). NP (Nurse Practitioner) called and made aware of incident. Xray order given. (Name of power of attorney) called and made aware of incident. No concerns voiced. She stated she would be in tomorrow to see resident. Further review of R20's clinical record failed to reveal the resident's psychosocial status related to the physical abuse was assessed or psychosocial interventions were implemented. On 8/19/25 at 4:42 p.m., an interview was conducted with OSM (other staff member) #5 (the social services coordinator). OSM #5 stated that after a resident is hit by another resident, the social services staff interviews the resident who was hit and completes a psychosocial assessment of the resident. OSM #5 stated the staff also monitors the resident to make sure he or she is okay, and to see how he or she is coping every week for at least four weeks. OSM #5 stated this should be documented in the clinical record. On 8/20/25 at 5:00 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern. The facility policy titled, Assessments-Social History and Psychosocial Assessment documented, It is the policy of The Company to: Assess resident's psychosocial needs .4. Social Services will complete the Social Services Progress Review quarterly, with significant changes and as needed. No further information was presented prior to exit.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation and staff interview, it was determined that the facility staff failed to provide sufficient staff in one of one facility kitchens. The findings include:On 08/18/2025 at approximately 3:50 p.m., an observation of the last food cart for the resident's lunch revealed it arrived on Unit One at 3:50 p.m. Further observations revealed the last lunch tray was served to a resident on Unit one at 4:10 p.m. On 08/19/2025 at approximately 11:15 a.m. an interview was conducted with OSM (other staff member) #7 and OSM #6, account manager for dietary. OSM #6 stated the first breakfast food carts are sent to the floor between 7:35 a.m. and 7:40 a.m., the first lunch food carts are sent to the floor at 11:45 a.m., and the first dinner food carts are sent to the floor at 4:30 p.m. When informed of the observation of the resident's first lunch cart arriving on Unit Three at 2:00 p.m. and the last lunch cart arriving on Unit One at 3:50 p.m. she stated that it was not acceptable for the residents and the residents should not have to wait for the meals. When asked to describe the procedure to make sure the resident's meals are served in a timely manner OSM #6 stated that she makes sure all the assigned dietary staff are in the building, if short staffed she will call staff in to work, use facility staff to help out and jump in to help get the meals to the residents on time. OSM#7 stated the kitchen did not have enough staff to get the meal out on time on 08/18/2025. The facility's policy Frequency of Meals documented in part, Policy Statement. At least three daily meals will be provided, at regular times comparable to normal mealtimes in the community.Procedures. 1. The Dining Service Director coordinates with the residents, administrator and/or Director of Nursing Services to establish the meal and snack times that are comparable with the normal times in the community. On 08/19/2025 at approximately 5:00 p.m., ASM (administrative staff member) #1, executive director, and ASM #2, director of clinical services, were made aware of the above findings. No further information was provided prior to exit. Complaint deficiency

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and staff interview, it was determined that the facility staff failed to serve palatable food on one of three facility units, Unit One. The findings include:On 08/18/2025 at approximately 3:50 p.m., a test tray consisting of chicken stir-fry, chopped spinach, enhanced potatoes was placed on a food cart in the facility's kitchen, sent to Unit One of the facility. The cart was followed by the surveyor, OSM (other staff member) #7, district manager for dietary. At approximately 4:10 p.m., the last lunch tray was served to a resident on Unit One and OSM # 7 was asked to remove cover from the test plate then proceeded to take the temperatures of the food. Two surveyors observed OSM #7 obtaining the food temperatures of the test tray. The chopped spinach was 118 degrees F (Fahrenheit), the stir-fry was 111 degrees F, and the potatoes were 115 degrees F. The test tray was sampled by two surveyors, OSM #7 for appropriate holding temperatures and palatable taste. When asked to describe the taste of the food OSM #7 stated the food was lukewarm. After tasting all the food on the test tray OSM #7 was asked if the food was palatable OSM #7 did not provide an answer. On 08/19/2025 at approximately 11:15 a.m. an interview was conducted with OSM #7 and OSM #6, account manager for dietary. When informed of the food temperatures obtained on the test tray for lunch on 08/18/2025 as stated above, OSM #6 stated the food temperatures should have been 140 degrees F or greater. When asked about the food being palatable at the temperatures obtained on the test tray she stated it would not taste good because it was cold and the temperature dropped too much. The facility's policy Food: Quality and Palatability documented in part, Policy Statement. Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature. Definitions. Food palatability refers to the taste and/or flavor of the food. Proper (safe and appetizing) temperature Food should be at the appropriate temperature as determined by the type of food to ensure resident's satisfaction and minimizes the risk for scalding and burns. Procedures. 2. The Cook(s) prepare food in a sanitary manner utilizing the principles of Hazard Analysis Critical Control Point (HACCP) and time and temperature guidelines as outlined in the Federal Food Code. On 08/19/2025 at approximately 5:00 p.m., ASM (administrative staff member) #1, executive director, and ASM #2, director of clinical services, were made aware of the above findings. No further information was provided prior to exit. Complaint deficiency

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation and staff interview, it was determined that the facility staff failed to serve lunch in a timely manner on one of three facility units, Unit One. The findings include:On 08/18/2025 at approximately 3:50 p.m., an observation of the last food cart for the resident's lunch revealed it arrived on Unit One at 3:50 p.m. Further observations revealed the last lunch tray was served to a resident on Unit one at 4:10 p.m. On 08/19/2025 at approximately 11:15 a.m. an interview was conducted with OSM (other staff member) #7 and OSM #6, account manager for dietary. OSM #6 stated the first breakfast food carts are sent to the floor between 7:35 a.m. and 7:40 a.m., the first lunch food carts are sent to the floor at 11:45 a.m., and the first dinner food carts are sent to the floor at 4:30 p.m. When informed of the observation of the resident's first lunch cart arriving on Unit Three at 2:00 p.m. and the last lunch cart arriving on Unit One at 3:50 p.m. she stated that it was not acceptable for the residents and the residents should not have to wait for the meals. When asked to describe the procedure to make sure the resident's meals are served in a timely manner OSM #6 stated that she makes sure all the assigned dietary staff are in the building, if short staffed she will call staff in to work, use facility staff to help out and jump in to help get the meals to the residents on time. OSM#7 stated the kitchen did not have enough staff to get the meal out on time on 08/18/2025. The facility's policy Frequency of Meals documented in part, Policy Statement. At least three daily meals will be provided, at regular times comparable to normal mealtimes in the community.Procedures. 1. The Dining Service Director coordinates with the residents, administrator and/or Director of Nursing Services to establish the meal and snack times that are comparable with the normal times in the community. On 08/19/2025 at approximately 5:00 p.m., ASM (administrative staff member) #1, executive director, and ASM #2, director of clinical services, were made aware of the above findings. No further information was provided prior to exit. Complaint deficiency

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on staff interview and facility document review, it was determined that the facility staff failed to review and revise the facility assessment after a change of ownership effective 6/1/2025.The findings include:Review of the provided facility assessment documented a date of 7/18/2024. The facility assessment documented the former executive director and director of clinical services at the facility. It further documented information under the staff training/education and competencies that reflected the previous owner.On 8/20/2025 at 5:08 p.m., an interview was conducted with ASM (administrative staff member) #1, the executive director, who stated that the facility assessment provided was from 2024 prior to the change of ownership. He stated that they had planned to update the assessment in a QAPI (Quality Assurance Performance Improvement) meeting that they had scheduled for 8/20/2025. ASM #1 stated that the change of ownership sale was completed effective 6/1/2025 when the former owner ceased to exist and the new owner took over. He stated that they had to renew all their contracts and change the names on everything. When asked if the facility assessment should have been updated, ASM #1 stated that he did not think that the patient aspect much would change but there would be some things that would need to be reviewed and revised, same as the contracts. On 8/21/2025 at 9:03 a.m., ASM #1, the executive director was made aware of the concern.No further information was provided prior to exit.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. Based on staff interview and facility document review, the facility staff failed to provide evidence of updated contracts with outside providers for three of three contracts reviewed, potentially affecting all residents.The findings include:The facility staff failed to provide updated contracts for mobile imaging services, mobile imaging equipment, and an agreement for contract dialysis services.On 8/20/25 at 5:13 p.m., copies of current facility contracts were requested as part of the extended survey process. ASM (administrative staff member) #1, the executive director, stated he may not be able to provide the survey team with contracts that meet the regulation. He stated that due to the facility sale in June of 2024, the former company ceased to exist, and a new company took over as owner. He added: We had to go back in and negotiate contracts with all of our venders.On 8/21/25 at 8:36 a.m., ASM #1 provided a book of contracts for outside service providers to the facility. A review of three of these contracts revealed there was no contractual agreement between the providers of mobile imaging, the mobile imaging equipment company, and the facility's dialysis providers. All of these contracts were between the outside provider and the name of the previous owner of the facility, a company no longer in existence.On 8/21/25 at 11:06 a.m., ASM #1 was interviewed. He stated the former owner of the facility filed for bankruptcy protection and was sold on 6/1/25. He explained that on that day, the bankrupt company ceased to exist. He stated he and the corporate staff had attempted to contact the facility's attorneys. He said that they had not yet been able to secure the legal documents needed to satisfy the regulation. ASM #1 did not provide the survey team with a policy related to updated contracts with outside providers.No further information was 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 interview and clinical record review it was determined that the facility staff failed to maintain a completed and accurate clinical record for two of 27 residents in the survey sample, Resident #2 (R2) and R23. The findings include:1. For R2, the facility staff failed to accurately document when showers were provided. R2 was admitted to the facility with diagnosis that included but were not limited to a stroke. On the most recent comprehensive MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 01/05/2025, R2 was coded as having both short- and long-term memory difficulties and was coded as being severely impaired of cognition for making daily decisions. The facility’s resident shower schedule dated 01/03/2025 documented in R2’s room number for showers on every Monday and Thursday evening. The facility’s shower sheets dated 07/07/2025 through 08/18/2025 documented R2 received showers every Monday and Thursday. The facility’s ADL (activities of daily living) tracking sheets dated 07/07/2025 through 08/18/2025 failed to document that R2 received showers every Monday and Thursday. On 08/20/2025 at approximately 5:25 p.m. an interview was conducted with ASM (administrative staff member) #2, director of clinical services regarding R2’s shower sheets as part of the clinical record. When asked where R2’s shower sheets are kept she stated kept in a separate binder on each unit. When asked if the shower sheets for R2 were part of the clinical record she stated no. After reviewing the ADL sheets for R2 and the shower sheets ASM #2 agreed the clinical record for R2 was not complete or accurate. The facility’s policy “Clinical/Medical Records” it documented in part, “Policy. Clinical Records are maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care. ” On 08/20/2025 at approximately 4:30 p.m., ASM #1 and ASM #2, director of clinical services, were made aware of the above findings. No further information was provided prior to exit. Complaint deficiency 2. For Resident #23 (R23), the facility staff failed to document in the clinical record, an incident of Resident #25 (R25) touching R23's breast on 4/27/25. An initial facility synopsis submitted to the SA (state agency) on 4/27/25 documented, It was reported that (R25) touched a female resident, (R23) on the breast open hand on top of her clothes. Staff immediately separated them . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R23's clinical record failed to reveal documentation regarding this incident. On 8/21/25 at 7:16 a.m., an interview was conducted with ASM (administrative staff member) #2 (the director of clinical services). ASM #2 stated the above incident should have been documented in R23's clinical record. On 8/21/25 at 8:56 a.m., ASM #1 (the executive director) was made aware of the above concern. No further information was presented prior to exit.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on staff interview, facility documentation, and clinical record review, it was determined the facility staff failed to evidence communication between the hospice company and the facility for one of 27 residents in the survey sample, Resident #19 (R19). The findings include: For Resident #19, the facility staff failed to evidence communication between the hospice company and the facility. The physician order dated, 6/12/25, documented, Resident admitted to (Name of Hospice).A request was made for communication between the facility and the hospice company. On 8/20/25 at 1:27 p.m. ASM (administrative staff member) #2, the director of clinical services, presented information related to hospice communication. The documents had been faxed to the facility on 8/20/25. The documents contained notes from visits from the hospice company on 6/12/25, 6/13/25, 6/27/25 and 7/1/25. When asked the process for having the information from the hospice company available to the staff caring for the residents, ASM #2 stated, when the facility receives information, it is given to the medical records department and uploaded in the miscellaneous file in PCC (initials of electronic medical records system). When asked the expectation when the information is to be in the record, she stated she would have to check on that. ASM #2 stated she had checked on the unit to see if there was a hospice communication book, there was none. She stated she spoke with the nurse down on the unit and stated she speaks with the hospice staff members, and they share information. When asked if this information should be available to all staff including the physicians, ASM #2 stated yes. The facility policy, Hospice Care, documented in part, Communication with hospice representatives, hospice medical director and the patient/resident's attending physician to ensure coordination of care. Ensure the following information is obtained from hospice: Most recent hospice plan of care, hospice election form, physician certification and recertification of the terminal illness, Names and contact information for hospice personnel involved in the care of the patient/resident, how to access hospice's 24 hour on call system, medication information for the patient/resident, hospice physician and attending physician orders for the patient/resident and provide education to the hospice staff on center policies and procedures, including: resident rights, documentation and forms. ASM #1, the executive director and ASM #2 made aware of the above concern on 8/20/25 at 4:40 p.m. No further information was provided prior to exit.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on staff interview and facility document review, it was determined that the facility staff failed to ensure attendance of the infection preventionist at one of five QAPI (quality assurance performance improvement) meetings reviewed, Q4 (quarter four) 2024 potentially affecting all residents in the facility.The findings include:Review of the provided facility QAPI meeting sign-in attendance sheets failed to evidence the infection preventionist present at the Q4 2024 meeting.On 8/21/2025 at 9:28 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of clinical services, who stated that the infection preventionist had resigned in November of 2024 and the assistant director of nursing was covering the role at the time of the QAPI meeting and was not present at the meeting. On 8/21/2025 at 10:01 a.m., an interview was conducted with ASM #1, the executive director who stated that QAPI meetings were held quarterly at a minimum and attended by the interdisciplinary team which included the administrator, director of nursing, medical director, infection preventionist, social services, unit managers, maintenance and other staff.The facility policy Quality Assurance Performance Improvement Program (QAPI) revised 10/24/2022 documented in part, Policy: The center and organization has a comprehensive, data-drive Quality Assurance Performance Improvement Program that focuses on indicators of the outcomes of care and quality of life. QAA (Quality Assessment and Assurance Committee) members include but are not limited to: a) Executive Director, b) Medical Director/designee, c) Director of Nursing/designee, d) Infection Preventionist.On 8/21/2025 at 10:03 a.m., ASM #1, the executive director was made aware of the concern.No further information was provided prior to exit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on staff interview and facility document review, the facility staff failed to implement a complete infection control program for two of two months reviewed, November and December 2024. The findings include:For November and December 2024, the facility staff failed to provide evidence of a surveillance system to identify possible communicable diseases before they can spread to other persons in the facility.On 8/18/25 at 4:30 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of clinical services, were asked to provide evidence of the facility's infection surveillance system for November and December 2024.On 8/19/25 at 1:18 p.m., ASM #2 stated the infection surveillance logs for November and December 2024 could not be located. She stated she and the current infection preventionist had only been working at the facility since January 2025. She stated she had searched for the logs and could not find them.On 8/19/25 at 3:56 p.m., LPN (licensed practical nurse) #1, the infection preventionist, was interviewed. She stated she had started work at the facility in this role in mid-December 2025. She recalled a GI (gastrointestinal) issue on Wing 2, but stated it was not Norovirus. She stated a few people (two or three) had nausea and a little vomiting, but Norovirus was not identified and there were no overarching trends. She said there were no concerns about PPE availability during that time or at any time since. She stated she is now responsible for the infection surveillance system for the entire facility. She pulls the 24 hour reports and new orders for each day, updating the line list and antibiotic usage sheet each weekday. She is responsible for tracking all infections and antibiotic usage. She stated it is important to track infections so facility staff can track and trend, determine where problems lie with staff practice, and make changes as necessary to prevent infections from spreading.On 8/20/25 at 4:45 p.m., ASM #1, and ASM #2, the director of clinical services, were informed of these concerns.A review of the facility policy, Surveillance for Infections, revealed, in part: The Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcomes and that may require transmission-based precautions and other preventative interventions.The purpose of surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and Healthcare-Associated infections, to guide appropriate interventions, and to prevent future infections.The Infection Preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data.No additional information was provided prior to exit.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on staff interview and facility document review, the facility staff failed to provide communications training for one of ten staff records reviewed, CNA (certified nursing assistant) #5.The findings include:For CNA #5, the facility staff failed to provide required communications training.On 8/20/25 at 5:13 p.m., CNA #5's education records were requested. ASM (administrative staff members) #1, the executive director, and #2, the director of clinical services, were present at this meeting. ASM #1 stated the facility staff may not be able to provide the survey team with the requested information because of the recent sale of the facility and the current staff's lack of access to old personnel records.On 8/21/25 at 9:04 a.m., ASM #5, the assistant director of clinical services, was interviewed. She stated she is very new to this role and will be taking over staff training. She stated she could not speak to why the required trainings were not done in the past, but in the future, she will be taking care of these. She stated she will be keeping up with the required training content and tracking the training for each staff member. She explained that staff training is one way to meet residents' needs. She added that managers are responsible for making sure staff are trained in order to provide the highest level of care possible for residents. On 8/21/25 at 11:10 a.m., ASM #1 and ASM #2 were informed of these concerns.A review of the policy, In-Service Training-General, revealed, in part: Employees will be provided training on required topics on an annual basis. Additional training may be provided based on the center Facility Assessment, areas of deficiency identified and to improve the overall knowledge of the staff.Required education and in-services may include a combination of requirements based on Federal, State, and/or local regulations, company required in-service education topics and the and the center Facility Assessment. Each center is responsible to ensure that required Federal, State, and/or Local regulations are followed accordingly.No additional information was provided prior to exit.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. For RN #2 and OSM #15, the facility staff failed to provide required resident rights training.On 8/20/25 at 5:13 p.m., RN #2's and OSM #15's education records were requested. ASM (administrative staff members) #1, the executive director, and #2, the director of clinical services, were present at this meeting. ASM #1 stated the facility staff may not be able to provide the survey team with the requested information because of the recent sale of the facility and the current staff's lack of access to old personnel records.On 8/21/25 at 9:04 a. m., ASM #5, the assistant director of clinical services, was interviewed. She stated she is very new to this role and will be taking over staff training. She stated she could not speak to why the required trainings were not done in the past, but in the future, she will be taking care of these. She stated she will be keeping up with the required training content and tracking the training for each staff member. She explained that staff training is one way to meet residents' needs. She added that managers are responsible for making sure staff are trained in order to provide the highest level of care possible for residents.On 8/21/25 at 11:10 a.m., ASM #1 and ASM #2 were informed of these concerns.A review of the policy, In-Service Training-General, revealed, in part: Employees will be provided training on required topics on an annual basis. Additional training may be provided based on the center Facility Assessment, areas of deficiency identified and to improve the overall knowledge of the staff.Required education and in-services may include a combination of requirements based on Federal, State, and/or local regulations, company required in-service education topics and the and the center Facility Assessment. Each center is responsible to ensure that required Federal, State, and/or Local regulations are followed accordingly.No additional information was provided prior to exit.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on staff interview and facility document review, the facility staff failed to provide training in prevention of resident abuse, neglect, and exploitation for one of ten staff records reviewed, RN (registered nurse) #2. The findings include:For RN #2, the facility staff failed to provide required training in the prevention or resident abuse, neglect, and exploitation.On 8/20/25 at 5:13 p.m., RN #2's education records were requested. ASM (administrative staff members) #1, the executive director, and #2, the director of clinical services, were present at this meeting. ASM #1 stated the facility staff may not be able to provide the survey team with the requested information because of the recent sale of the facility and the current staff's lack of access to old personnel records.On 8/21/25 at 9:04 a.m., ASM #5, the assistant director of clinical services, was interviewed. She stated she is very new to this role and will be taking over staff training. She stated she could not speak to why the required trainings were not done in the past, but in the future, she will be taking care of these. She stated she will be keeping up with the required training content and tracking the training for each staff member. She explained that staff training is one way to meet residents' needs. She added that managers are responsible for making sure staff are trained in order to provide the highest level of care possible for residents.On 8/21/25 at 11:10 a.m., ASM #1 and ASM #2 were informed of these concerns.A review of the policy, In-Service Training-General, revealed, in part: Employees will be provided training on required topics on an annual basis. Additional training may be provided based on the center Facility Assessment, areas of deficiency identified and to improve the overall knowledge of the staff.Required education and in-services may include a combination of requirements based on Federal, State, and/or local regulations, company required in-service education topics and the and the center Facility Assessment. Each center is responsible to ensure that required Federal, State, and/or Local regulations are followed accordingly.No additional information was provided prior to exit.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on staff interview and facility document review, the facility staff failed to provide QAPI (quality assurance and performance improvement) training for two of ten staff records reviewed, RN (registered nurse) #2 and OSM (other staff member) #15, a member of the dietary staff.The findings include:For RN #2 and OSM #15, the facility staff failed to provide required QAPI training.On 8/20/25 at 5:13 p.m., RN #2's and OSM #15's education records were requested. ASM (administrative staff members) #1, the executive director, and #2, the director of clinical services, were present at this meeting. ASM #1 stated the facility staff may not be able to provide the survey team with the requested information because of the recent sale of the facility and the current staff's lack of access to old personnel records.On 8/21/25 at 9:04 a.m., ASM #5, the assistant director of clinical services, was interviewed. She stated she is very new to this role and will be taking over staff training. She stated she could not speak to why the required trainings were not done in the past, but in the future, she will be taking care of these. She stated she will be keeping up with the required training content and tracking the training for each staff member. She explained that staff training is one way to meet residents' needs. She added that managers are responsible for making sure staff are trained in order to provide the highest level of care possible for residents. On 8/21/25 at 11:10 a.m., ASM #1 and ASM #2 were informed of these concerns.A review of the policy, In-Service Training-General, revealed, in part: Employees will be provided training on required topics on an annual basis. Additional training may be provided based on the center Facility Assessment, areas of deficiency identified and to improve the overall knowledge of the staff.Required education and in-services may include a combination of requirements based on Federal, State, and/or local regulations, company required in-service education topics and the and the center Facility Assessment. Each center is responsible to ensure that required Federal, State, and/or Local regulations are followed accordingly.No additional information was provided prior to exit.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on staff interview and facility document review, the facility staff failed to provide infection control training for one of ten staff records reviewed, RN (registered nurse) #2.The findings include:For RN #2, the facility staff failed to provide required infection control training.On 8/20/25 at 5:13 p.m., RN #2's education records were requested. ASM (administrative staff members) #1, the executive director, and #2, the director of clinical services, were present at this meeting. ASM #1 stated the facility staff may not be able to provide the survey team with the requested information because of the recent sale of the facility and the current staff's lack of access to old personnel records.On 8/21/25 at 9:04 a.m., ASM #5, the assistant director of clinical services, was interviewed. She stated she is very new to this role and will be taking over staff training. She stated she could not speak to why the required trainings were not done in the past, but in the future, she will be taking care of these. She stated she will be keeping up with the required training content and tracking the training for each staff member. She explained that staff training is one way to meet residents' needs. She added that managers are responsible for making sure staff are trained in order to provide the highest level of care possible for residents.On 8/21/25 at 11:10 a.m., ASM #1 and ASM #2 were informed of these concerns. A review of the policy, In-Service Training-General, revealed, in part: Employees will be provided training on required topics on an annual basis. Additional training may be provided based on the center Facility Assessment, areas of deficiency identified and to improve the overall knowledge of the staff.Required education and in-services may include a combination of requirements based on Federal, State, and/or local regulations, company required in-service education topics and the and the center Facility Assessment. Each center is responsible to ensure that required Federal, State, and/or Local regulations are followed accordingly.No additional information was provided prior to exit.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on staff interview and facility document review, the facility staff failed to provide compliance and ethics training for one of ten staff records reviewed, RN (registered nurse) #2. The findings include:For RN #2, the facility staff failed to provide required compliance and ethics training.On 8/20/25 at 5:13 p.m., RN #2's education records were requested. ASM (administrative staff members) #1, the executive director, and #2, the director of clinical services, were present at this meeting. ASM #1 stated the facility staff may not be able to provide the survey team with the requested information because of the recent sale of the facility and the current staff's lack of access to old personnel records.On 8/21/25 at 9:04 a.m., ASM #5, the assistant director of clinical services, was interviewed. She stated she is very new to this role and will be taking over staff training. She stated she could not speak to why the required trainings were not done in the past, but in the future, she will be taking care of these. She stated she will be keeping up with the required training content and tracking the training for each staff member. She explained that staff training is one way to meet residents' needs. She added that managers are responsible for making sure staff are trained in order to provide the highest level of care possible for residents.On 8/21/25 at 11:10 a.m., ASM #1 and ASM #2 were informed of these concerns.A review of the policy, In-Service Training-General, revealed, in part: Employees will be provided training on required topics on an annual basis. Additional training may be provided based on the center Facility Assessment, areas of deficiency identified and to improve the overall knowledge of the staff.Required education and in-services may include a combination of requirements based on Federal, State, and/or local regulations, company required in-service education topics and the and the center Facility Assessment. Each center is responsible to ensure that required Federal, State, and/or Local regulations are followed accordingly.No additional information was provided prior to exit.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. For CNA #5 and CNA #8, the facility staff failed to provide at least 12 hours of education annually for the past 12 months.On 8/20/25 at 5:13 p.m., CNA #5's and CNA #8's education records were requested. ASM (administrative staff members) #1, the executive director, and #2, the director of clinical services, were present at this meeting. ASM #1 stated the facility staff may not be able to provide the survey team with the requested information because of the recent sale of the facility and the current staff's lack of access to old personnel records.On 8/21/25 at 9:04 a.m., ASM #5, the assistant director of clinical services, was interviewed. She stated she is very new to this role and will be taking over staff training from this point forward. She stated she could not speak to why the required hours were not done in the past, but in the future, she will be taking care of these. On 8/21/25 at 11:10 a.m., ASM #1 and ASM #2 were informed of these concerns.No additional information was provided prior to exit.

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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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on staff interview and facility document review, the facility staff failed to provide behavioral health training for two of ten staff records reviewed, RN (registered nurse) #2 and OSM (other staff member) #15, a member of the dietary staff. The findings include:For RN #2 and OSM #15, the facility staff failed to provide required behavioral health training.On 8/20/25 at 5:13 p.m., RN #2's and OSM #15's education records were requested. ASM (administrative staff members) #1, the executive director, and #2, the director of clinical services, were present at this meeting. ASM #1 stated the facility staff may not be able to provide the survey team with the requested information because of the recent sale of the facility and the current staff's lack of access to old personnel records.On 8/21/25 at 9:04 a.m., ASM #5, the assistant director of clinical services, was interviewed. She stated she is very new to this role and will be taking over staff training. She stated she could not speak to why the required trainings were not done in the past, but in the future, she will be taking care of these. She stated she will be keeping up with the required training content and tracking the training for each staff member. She explained that staff training is one way to meet residents' needs. She added that managers are responsible for making sure staff are trained in order to provide the highest level of care possible for residents. On 8/21/25 at 11:10 a.m., ASM #1 and ASM #2 were informed of these concerns.A review of the policy, In-Service Training-General, revealed, in part: Employees will be provided training on required topics on an annual basis. Additional training may be provided based on the center Facility Assessment, areas of deficiency identified and to improve the overall knowledge of the staff.Required education and in-services may include a combination of requirements based on Federal, State, and/or local regulations, company required in-service education topics and the and the center Facility Assessment. Each center is responsible to ensure that required Federal, State, and/or Local regulations are followed accordingly.No additional information was provided prior to exit.