

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER Mountain View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 107 Miller Drive Ripley, WV 25271	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation and staff interviews, the facility failed to provide a safe, clean, comfortable, and homelike environment for two (2) of 58 resident rooms, and the main dining room, observed during the long-term care survey process. Dining room doors in disrepair. Rooms #209 and #210 were in disrepair. Resident Identifiers: #52, 65, 48 and 28. Facility Census: 109. Findings include: a) Hill Valley Healthcare policy titled Homelike Environment states: Residents will be provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Environment: refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas. Homelike Environment: is one that de-emphasizes the institutional character of the setting, to the extent possible, and allows the residents to use those personal belongings that support a homelike environment. A determination of homelike should include the residents opinion of the living environment. The facility team will provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a clean, sanitary and orderly environment. b) 06/01/26 at 3:50 PM room [ROOM NUMBER] - (Resident #52 and #65) has a blank electrical outlet cover that needs to be moved over to cover the hole in the wall. The television (TV) cable going to Resident #52's TV is lying on the floor away from the wall. Resident #52 stated that Resident #65's wheelchair had gotten tangled up with this cable before, and I had to help her get unstuck. There is ceiling damage in the room near a fire sprinkler that measures approximately a 12 inch by 12 inch square. On 06/01/26 at 4:05 PM, I showed the administrator these areas of concern and he stated I will put a work order in for my maintenance department to fix these, we have a lot of things that I want to get fixed, and we will continue to work on this. c) 06/02/26 at 8:30 AM room [ROOM NUMBER] - (Resident #28 and #48) I asked Resident #48 if she had any concerns, and she stated I would like my bathroom to be fixed. The vanity has a laminate strip missing, which prevents it from being easily cleanable. The strip is approximately 24 inches long and two (2) inches wide. There is a crack in the paint above the toilet measuring approximately 30 inches long. There are three small holes located above the glove holder on the wall near the bathroom door. There are two (2) areas beside the bathroom mirror that need drywall and paint repair. They both measure approximately 12 - 14 inches long. On 06/02/26 at 11:20 AM, I showed the Administrator Resident #48's concerns with her bathroom and he stated this is unacceptable and will be fixed. I will put a work order in now. d) On 06/02/26 at 11:00 PM this surveyor noticed that the paint is chipping and falling off both doors leading into the main dining room. The Corporate Registered Nurse (RN) #131 agreed that both doors need to be sanded and painted.		

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and resident interviews, the facility failed to ensure residents knew how to file a grievance, including anonymously if desired, and failed to adequately resolve resident grievances. This deficient practice was confirmed during the Resident Council Meeting and was a random opportunity for discovery. This had the potential to affect more than a limited number of residents during the Long-Term Care Survey Process. Resident identifiers: #128, #55, #38, #129, #130, #63, #33. Facility census:109. Findings Include: a) Resident Council Meeting During the Resident Council Meeting on 06/02/26 at 2:10 PM, the Resident Council agreed that they did not know how to file a grievance in writing or anonymously. Resident #88 pointed at the wall and stated, They put that box up over there today and I guess that is what that is for, but there aren't any forms in it. During an interview on 06/02/26 at 12:55 PM, the Licensed Social Worker (LSW) #100 stated, They keep the forms behind the nurses station. Most of the residents would need help filling them out anyways. During an interview on 06/02/26 at 12:58 PM, at the A/B nurses' station, Licensed Practical Nurse (LPN) #66 stated, I thought Social Services had the forms. LPN #85 stated, I am not sure where they are at. Let me look. The Director of Nursing (DON) came out to the A/B nurses' station to help LPN #85 locate a binder in a cabinet for grievances. This process from the start of the interview until the form was found, took approximately 10 minutes. The DON further confirmed that the grievance forms were not readily available for residents and/or family members to file a grievance. b) Resolution of Missing Item Grievances During and interview with Resident #33 at 3:53 PM on 06/01/26 she stated, I don't always get my clothes back from laundry. She stated she is still missing several items and stated she does not send her clothes to the laundry no more. She then asked the surveyor if she thought it would be okay for them to take her to the laundry mat so she could wash he own clothes. Review of the grievances found the resident filed a grievance on 05/21/26 reporting she was missing (continued on next page)		

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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 record review and resident and staff interviews, the facility failed to correctly interpret the results of abuse allegation investigations and prevent further potential abuse while an investigation was in progress. This was true for five (5) of six (6) residents sampled for abuse during the Long-Term Care survey process. Facility census: 109. Resident identifiers: #21, #8, #49, #74, and #70. a) Resident #21, #8, #49 A policy titled, Abuse reads, in the event of an allegation or observation of abuse, the facility will immediately assess the resident, notify the physician and resident representative, and protect the resident and other residents from further harm or incident. In a nurse note dated 02/17/26 at 5:58 PM it is documented, It was reported to this nurse that resident 94036643 and resident 94036696 was sitting in the hallway holding hands and resident 94036643 had resident 94036696 hands in between resident 94036643 legs. Resident's were separated and resident 94036643 was put on [one-on-one] 1:1 and [every fifteen] q15 minute checks. PCP [Primary Care Physician] and RP [Responsible party] notified. According to the witness statements, this incident occurred at approximately 2:30 PM between Resident #8 and Resident #21. The intervention was to place Resident #8 on one-on-one (1:1) observations immediately pending investigation. Resident #21 was listed as non-verbal with a Brief Interview of Mental Status (BIMS) score on the Minimum Data Set, dated [DATE] of 00 indicating Resident #21 was not capable of making decisions regarding daily living activities and has no recall ability. During an interview with Resident #49 on 06/03/26 at 3:40 PM, she stated she was Yelled at and called names over a man and it made me feel degraded. Upon further investigation, a nursing note dated 02/17/26 at 6:27 PM reads, It was reported to this nurse that resident 94036643 verbally threatened to kick resident 94036540's but. Resident 94036540 reported that she didn't want resident 94036643 to kick her but. Resident 94036643 put on 1:1 [one-on-one]. PCP [primary care physician] and RP [responsible party] notified. According to witness statements, this incident occurred at approximately 4:00 PM between Resident #49 and Resident #8. Another incident occurred on 02/17/26 at 4:31 PM per documentation involving Resident #8 in which Resident[#8] called this nurse in resident's room demanding to speak to the administrator now. Resident stated that unit manager had hit her. Resident pointed to her wrist and lower arm and stated She hit me right here. This nurse reported incident to risk nurse. This nurse assessed resident's skin and there was no marks or redness on resident's skin. According to witness statements and facility reported incident investigation, this incident occurred due to unit manager attempting to separate Resident #8 and Resident #21. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Social Services #100 on 06/03/26 at 3:00 PM, she confirmed Resident #8 was not on one-on-one (1:1) at the time of these incidents. During an interview with Corporate Registered Nurse #131 on 06/03/26 at 3:50 PM, she confirmed, per documentation, Resident #8 was supposed to be on one-on-one (1:1) observations from the 2:30 PM incident. According to the Medication Administration Record, the one-on-ones did not start until 7:00 PM on 02/17/26. b) Resident #74 A review of a reportable incident with an incident date of 01/19/26 involving Resident #74 as the victim and Resident #90 as the alleged perpetrator found the following description of the incident, (First and Last Name of Resident #74) was sitting by the nurses station, (First name of Resident #90), he rolled by and reached between (First Name of Resident)' s legs. and (First name of Resident #74) smacked his hands away/CNA redirected the residents. A review of the five day follow up found the following listed under conclusion: Due to the incident being witnessed by center staff, the incident has been verified. The investigation confirms that the event did occur due to staff witness account. However the investigation is inconclusive for abuse due to not indication of physical or psychosocial harm, unknown if intentional due to incapacity of alleged perpetrator and BIMS of 3.0 and no recollection of incident by either resident. During an interview with the Nursing Home Administrator (NHA), Nurse Consultant #131 and Social Worker #100 on 06/04/26 at 1:44 PM they agreed abuse should have been verified and the investigation was not inconclusive. c) Resident #70 A review of a reportable incident with an incident date of 03/19/26 found the following description of the incident: Resident made contact with other resident. The alleged victim was identified as Resident #70 and the alleged perpetrator was Resident #63. A review of the investigation found a statement from Nurse Aide #72 who the assigned 1:1 aide for Resident #63 at the time of the incident. The statement read as follows, I was following the 1:1 (resident #63's assigned Medical record number) when I saw (First Name of Resident #70) coming out of (Resident #63's assigned Medical record number) room. I immediately approached (First Name of Resident #70) to guide him out of the room and back into his room which is next) door. Resident (resident #63's assigned Medical record number) became irate as soon as she saw someone in her room, they propelled self suddenly forward in the wheelchair and kicked (first name of Resident #70) in the lower legs. Resident (resident #63's assigned Medical record number) attempted to punch (First name of Resident #70) again. I continued to separate and redirect. Other staff came and assisted. (First Name of Resident #70) presented to be unaware of the situation. A review of the Five day follow up related to this incident found the following conclusion, The facility has unsubstantiated abuse due to diagnosis and low BIMS score related to intent. Facility did interview like residents on hall with no variances regarding safety. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Nursing Home Administrator (NHA), Nurse Consultant #131 and Social Worker #100 on 06/04/26 at 1:44 PM they agreed abuse should have been verified. The NHA indicated he thought because Resident #63 had a diagnosis of dementia and a low BIMS he could not find intent. When asked if the resident kicked the other resident voluntarily he stated, yes. He agreed it was not an accident she did it on purpose but she did not know what she was doing cognitively. He stated, I understand now what that means.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to notify the resident in writing of the reason for the transfer to the hospital and send a copy of the notice to the ombudsman. This deficient practice had the potential to affect three (3) of three (3) residents reviewed for the care area of hospitalization. Resident Identifiers: #2, #11, and #9. Facility Census: 109. Findings included: a) Policy Review The facility's policy titled, Transfer or Discharge, Preparing a Resident for, with original date 10/01/21, gave no guidance regarding a discharge or transfer form. However, the policy stated the business office or social services were responsible for informing the resident or the resident representative of readmission appeal rights. b) Resident #2 Review of Resident #2's electronic health record showed the resident was transferred to the hospital on [DATE] due to abnormal vital signs. The resident's electronic health record showed no documentation of a transfer notice giving information regarding appeal rights and the contact information for the long-term care Ombudsman. On 06/03/2026 at 10:02 AM, the Director of Nursing (DON) stated the facility did not provide a notice of transfer to the resident or resident representative giving information regarding appeal rights and the contact information for the long-term care Ombudsman. The DON also stated there was no documentation that the Ombudsman had been notified of Resident #2's transfer to the hospital on [DATE]. c) Resident #11 Review of Resident #11's electronic health record showed the resident was transferred to the hospital on [DATE] due to abnormal vital signs. The resident's electronic health record showed no documentation of a transfer notice giving information regarding appeal rights and the contact information for the long-term care Ombudsman. On 06/10/2026 at 09:05 AM, the Director of Nursing (DON) stated the facility did not provide a notice of transfer to the resident or resident representative giving information regarding appeal rights and the contact information for the long-term care Ombudsman. The DON also stated there was no documentation that the Ombudsman had been notified of Resident #11's transfer to the hospital on [DATE]. d) Resident #9 Facility was unable to produce ombudsman notification for April transfers to the hospital for Resident (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#9. It was confirmed by Administrator at 12:15PM on 06/03/26 that there is no proof of ombudsman notification for transfers to the hospital for Resident #9 for 04/02/26 or 04/08/26.		

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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. Based on resident interview, record review, observation and staff interview the facility failed to develop and or implement the care plan for three (3) of sampled residents reviewed during the long term care survey process. For Resident #77 they failed to develop a care related to his feelings of being abandoned by his girlfriend. For Resident #6 they failed to implement her care plan related to her wheelchair cushion. Finally for Resident #98 they did not develop his care plan related to his discharge goals and preferences. Resident Identifiers: #77, #6, and #98. Facility Census: 109. a) Resident #77 During an interview with Resident #77 on 06/01/26 at 12:42 pm he stated his family abandoned him. Mostly his fiancée, with whom he lived. He stated, I have anxiety and depression and this is part of the reason I feel like that. A review of the resident's care plan showed no mention of the resident's feelings of being abandoned by his fiancée. During an interview with Social Worker #100 on the afternoon of 06/09/26 she confirmed she was aware the resident's relationship ended with his girlfriend and stated she was aware of his feelings of being abandoned upon admission to the facility. She agreed it was not addressed on the resident's care plan. b) Resident #6 On 06/08/26, an observation and interview with Resident #6 at 11:18 am found she had just returned from dialysis. She stated, They got me back on time today thank goodness because the girl this morning did not put my cushion in my wheelchair. The surveyor observed the resident's wheelchair, in which she was still sitting, and noted the cushion was not present. The cushion was located in Resident #6's room on the floor. Resident #6 stated, This chair hurts when the cushion is not in it. Nurse Aide #73 was present during this interview and observation and agreed the cushion was not in Resident #6's chair. A review of Resident #6's care plan found the following focus statement: : (First Name of Resident #6) is a long-term care resident and requires assistance with their ADL's related to chronic health conditions, muscle weakness, COPD, difficulty in walking, lack of coordination. The goal associated with this practice statement read as follows: (First name of Resident #6 will maintain her current level of function as able through review period. The interventions included: Pressure reduction cushion to wheelchair at all times. Observe proper placement Q shift. Replace as indicated. This intervention was added to the care plan on 12/14/24. c) Resident #98 An interview with Resident #98 on the afternoon of 06/01/26 found he was waiting on a bed at another Skilled Nursing Facility which would be closer to his family. He indicated this has been his plan since he was admitted to the facility. An interview with Social Worker #100 on the afternoon of 06/09/26 confirmed she had sent a referral to the other Skilled Nursing Facility on 03/19/26 and was just waiting for them to have a bed for him. A review of Resident #98's care plan found the following care plan related to discharge: Focus Statement: LONG TERM DISCHARGE PLAN: (First name of Resident #98) is expected to remain in the facility long term and has no plans to discharge at this time This was initiated on 02/02/26. Goal: (First Name of Resident #98)/resident representative will have their needs met thru the review period This was also initiated on 02/02/26. Interventions Included: -- assess for the resident's preference to return to the community and refer if needed Date Initiated: 02/02/26-- refer the resident to the local contact agency if indicated by the resident Date Initiated: 02/02/26-- review and update discharge plans with the resident when needed Date Initiated: 02/02/26 On the afternoon of 06/09/26 the care plan was reviewed with Nurse Consultant #131, who agreed it should have been updated to reflect the resident's desire to transfer to another facility.		

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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 record review, staff interviews, and resident interviews, the facility failed to include incapacitated residents in care plan meetings, and failed to revise care plans regarding tube feeding and transfer status. This deficient practice was found true for (3) three of 35 residents reviewed for care plan accuracy during the Long-Term Care Survey Process. Resident identifiers: #11, #4, and #6. Facility Census: 109. a) Resident #6 A review of Resident #6's care plan found the following: Focus Statement: MAINTENANCE: (First and Last Name of Resident #6) is a long-term care resident and requires assistance with their ADL's related to chronic health conditions, muscle weakness, COPD, difficulty in walking, lack of coordination. Date Initiated: 12/14/2024 Goal: (First Name of Resident #6) will maintain her current level of function as able through review period Date Initiated: 12/14/24 Revision on: 05/28/26 Target Date: 09/02/26. Interventions Included: TRANSFERS: Hoyer lift for all transfers x 2 staff Date Initiated: 12/14/2024. -- Wheeled [NAME] for ambulation and transfers date initiated 12/14/24. Both interventions were current at the time of this review on the morning of 06/08/26. An interview with Nurse Consultant #131 at 12:34 PM on 06/08/26 confirmed both could not be correct. She later stated, (Resident #6) needs a hoyer lift the other intervention should have been removed from the care plan. b) Resident #4 Review of Resident #4's current physician's orders showed an order written on 10/27/25 that stated, Enteral Feed: five times a day check G-tube [gastrostomy tube] placement by confirming the pH of aspirate; Notify PCP [primary care physician] if pH is greater than 5. Review of Resident #4's comprehensive care plan showed the following focus initiated on 11/06/24 and revised on 04/12/25: [Resident] is at risk for complications related to G-Tube. The following intervention was initiated on 11/06/24 and revised on 04/12/25: Two times a day check G-tube placement by confirming the pH of aspirate; Notify PCP [primary care physician] if pH (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	is greater than 5. On 06/03/26 at 10:57 AM, the Director of Nursing [DON] confirmed Resident #4's comprehensive care plan was incorrect regarding the number of times per day pH testing should be performed to confirm the gastrostomy tube was in correct placement. No further information was provided through the completion of the survey process. c) Resident #11 During the initial interview on 06/01/26 at 11:30 PM, Resident #11 said she had not been to a care plan meeting and that staff had not told her what was going on. A record review on 06/09/26 at 12:21 PM, revealed that Resident #11 was deemed incapacitated since admission until 03/24/26 when she regained capacity. Resident's care plan signature page, up until 03/24/26 was completed with the Medical Power of Attorney (MPOA), via telephone. Resident #11's signature was not present. During an interview on 06/09/26 at 2:11 PM, the Licensed Social Worker (LSW) #100 stated, That resident would not have got the notice before because she just recently got her capacity back. The State Agency (SA) asked, If the resident does not have capacity do they still invite or involve them in the care plan meeting? LSW #100 replied, If they do not have capacity then we do not involve them in the care plan meeting. A review on 06/09/26 at 2:37 PM, of the policy titled {Care Planning- Interdisciplinary Team} reads under number 3 as follows: The Resident, the resident's family and or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. Number 4 reads as follows: Every effort will be made to schedule the care plan meeting at the best time of the day for the resident and family.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review, resident interviews, and staff interviews, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice. This deficient practice affected four (4) residents reviewed in the long-term care survey sample. Resident Identifiers: #1, #76, #6, and #116. Facility census: 109. Findings included: a) Resident #116A policy titled, Social Services-Transportation, read as follows: our facility shall help arrange transportation for residents as needed. According to the hospital discharge orders for Resident #116 from 07/04/26, a follow up was scheduled with the Congestive Heart Failure (CHF) Clinic on 07/14/26 at 1:40 PM and a follow up was recommended with Nephrology, (name of physician) in one to two (1-2) weeks from hospital discharge. A review of the transportation schedule for July 2025 does not show either appointment. The facility was unable to produce evidence that they had provided transportation to scheduled appointments or that the resident attended those appointments. In an interview with Corporate Registered Nurse (CRN) #131 on 06/04/26 at approximately 1:00 PM, CRN #131 confirmed according to documentation Resident #116 was not provided transportation and did not attend follow up appointments. b) Resident #6A review of Resident #6's medical record on the morning of 06/02/26 found a physician order which read, : Post - Dialysis: obtain a full set of vital signs and weight after dialysis treatment on Monday, Wednesday and Friday. No BP (blood pressure) in left arm. This order was entered into the residents medical record on 01/09/26 and was the active order at the time of this review. A review of Resident #6's electronic medical record on the morning of 06/02/26 found under the vital signs tab under blood pressure the residents blood pressure had been obtained in her left arm on the following dates and times: 05/02/26 at 8:02 am 05/02/26 at 10:44 pm 05/03/26 at 8:32 am 05/04/26 at 12:03 pm 05/05/26 at 12:32 am 05/06/26 at 11:00 am 05/07/26 at 8:03 am 05/08/26 at 12:22 pm 05/09/26 at 9:55 pm 05/10/26 at 7:38 am 05/11/26 at 11:43 am 05/12/26 at 7:57 am 05/12/26 at 7:52 am 05/13/26 at 6:00 am 05/13/26 at 1:28 pm 05/14/26 at 1:13 am 05/14/26 at 9:45 am 05/15/26 at 11:00 am 05/16/26 at 7:59 am 05/16/26 at 8:33 pm 05/17/26 at 7:42 am 05/18/26 at 10:08 am 05/19/26 at 10:37 am 05/20/26 at 11:00 am 05/20/26 at 11:50 am 05/21/26 at 7:41 am 05/23/26 at 7:21 am 05/24/26 at 7:49 am 05/25/26 at 11:00 am 05/25/26 at 11:21 am 05/25/26 at 9:41 pm 05/26/26 at 7:44 am 05/27/26 at 6:00 am 05/27/26 at 6:11 am 05/27/26 at 1:27 pm 05/28/26 10:02 am 05/28/26 at 4:59 pm 05/29/26 at 11:00 am 05/31/26 at 8:05 am 06/01/26 at 5:46 am 06/01/26 at 12:30 pm and 06/02/26 at 10:10 am. An interview with the Director of Nursing (DON) at 2:17 pm on 06/02/26 confirmed there was an order for the blood pressure not to be taken in the left arm. She reviewed the blood pressure vital signs tab and agreed the staff had documented taking the blood pressure in Resident #6's left arm on multiple occasions. Hill Valley Healthcare policy titled Change In a Resident's Condition states: c) Resident #76 Policy: The facility will promptly notify the resident, his or her physician / practitioner, and representative of changes in the resident's medical / mental condition and / or status. Specific Procedures: The nurse will notify the resident's Attending Physician / practitioner or physician on call when there has been a (an): a. accident or incident involving the resident; b. discovery of injuries of an unknown source; c. adverse reaction to medication; d. significant change in the residents physical, mental, or psychological status (that is a deterioration in health, mental, or psychological status in either life-threatening conditions or clinical complications) e. need to alter the resident's medical treatment significantly; f. refusal of treatment or medications two (2) or more consecutive times; g. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	need to transfer the resident to a hospital / treatment center;h. discharge without proper medical authority;i. specific instruction to notify the physician / practitioner of changes in the resident's condition.Resident #76 had a fall with a major injury on 09/10/25 at 6:15 PM. He received a physicians order for an x-ray on 09/12/25. The X-ray findings were Cortical irregularity at the coronoid. The X-ray conclusion was question coronoid fracture, consider CT. The Physician ordered a CT scan on 09/12/25. The CT scan was not scheduled until 09/24/26. The CT scan findings were Moderate body wall edema. Marked edema within the dorsal soft tissues of the imaged upper extremity. Lucency can be seen within the radial head worrisome for traumatic fracture best appreciated within coronal and sagittal reformats. No dislocation. The CT scan conclusion was Traumatic radial head fracture with dorsal soft tissue edema.The Physician was not notified of the CT scan findings until 10/06/26. On 10/06/26 the Physician ordered an Orthopedic referral. Resident #76 went to the Orthopedic Specialist appointment on 10/17/25 at 8:00 AM. The Orthopedic Specialist ordered non weight bearing to the right upper extremity (RUE) and a follow up appointment in six (6) weeks. The appointment was scheduled for 12/05/25 at 8:00 AM. Resident #76 never made it to that appointment.On 10/08/25 at 1:05 PM the facility Physician wrote a progress note stating, The patient (Resident #76) is seen for a follow-up visit at Mountainview. Resident #76 received the CT past ordered.Interview with Director of Nursing (DON) on 06/04/26 at 1:42 PM. This surveyor asked the DON why the facility Physician was not notified of the CT scan results from 09/24/25 until 10/06/25, and why Resident #76 missed the follow-up appointment with the Orthopedic Specialist on 12/05/25. She stated, It was just missed.d) Resident #1A record review on 06/09/26 at 9:27 AM, revealed that from 10/20/25 to 12/09/25 Resident #1 had an order for dialysis Monday, Wednesday, and Friday, with chair time at 6:00 AM.A review of the Medication Administration Record (MAR) from 10/20/25 to 10/31/25 revealed that on 10/20/25, 10/22/25, 10/27/25, and 10/31/25 Resident #1 did not get the following morning medications as ordered: Docusate sodium Capsule 100 Milligrams (MG) for constipation, Eliquis Oral Tablet 2.5 MG for Atrial Fibrillation, and Nateglinide Oral Tablet 120 MG for Diabetes Mellitus.Additionally, Resident #11 did not receive a prescribed antibiotic (Cephalexin) on the mornings of 10/22/26 and 10/27/26.A review of the MAR from 11/01/26 to 11/30/26 revealed that on 11/05/26, 11/10/26, 11/14/26, 11/19/26, 11/25/26 and 11/28/26 Resident #1 did not receive the following morning medications as ordered: Docusate sodium Capsule 100 Milligrams (MG) for constipation, Eliquis Oral Tablet 2.5 MG for Atrial Fibrillation, Nateglinide Oral Tablet 120 MG for Diabetes Mellitus, and Multivitamin oral tablet as a supplement.Additionally, Resident #11 did not receive a prescribed antibiotic (Cephalexin) on the morning of 11/10/25.The above dates correlate with Resident #11's dialysis schedule.During an interview on 06/09/26 at 9:35 AM, Corporate Consultant Nurse (CCN) #131 confirmed that for the months of 10/2025 and 11/2025 Resident #1 did not receive all of her morning medications on dialysis days as prescribed by the physician.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interviews, and staff interviews, the facility failed to provide Dialysis services in accordance with professional standards of practice. Resident #1 did not receive dinner meals when returning from Dialyses. Resident #6 did not receive timely transportation back from Dialyses. This failed practice was found true for (2) two of (2) two residents reviewed for Dialysis services during the Long-Term Care Survey Process. Resident identifier: #1. Facility Census: 109. Findings include: a) Resident #1 During the initial interview on 06/01/2026 at 12:15 PM, Resident #1 stated, I go to dialysis three times a week. Two of those days are in the evening. They don't always save my dinner. Sometimes I just have to eat something I have in my room. I do not know why they can't just put it in the fridge and then heat it up. A record review on 06/03/26 at 1:42 PM, revealed an order for Resident #1 that reads as follows:Dialysis at (Local Dialysis center named) Q Monday and Friday; have ready for transport by 3:00 PM for scheduled chair time at 3:30 PM; facility to transport. (Address and phone number of Dialysis center). Further record review of the meal percentages for Resident #1 from 03/03/26 to present shows that there are 24 possible Monday and Friday dinner (Resident was out to the hospital from [DATE] to 04/09/26). Out of the possible 24 suppers, 15 are not recorded or are recorded as Resident not available. During an interview on 06/03/26 at 2:15 PM, The Director of Nursing (DON) confirmed that by looking at the documentation it does appear that Resident #1 did not receive dinner meals on the dates above, which correlate with her dialysis schedule.		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, record review and staff interview the facility failed to ensure each resident was provided with medically related social services. The facility failed to correctly interpret the results of abuse investigations. They failed to report all allegations of abuse in the required time frames. The facility failed to ensure residents knew how to file grievances and could do so anonymously. In addition they failed to ensure grievances were resolved timely once filed. The facility also failed to complete accurate social service assessments and trauma screens. They failed to provide discharge planning to short term care residents. They also failed to ensure all residents were invited to participate in their care plan meetings. They failed to ensure resident was afforded the right to formulate their own advance directives and to have those directives honored. They failed to ensure each resident was afforded the right to have their medical record remained private and confidential. Finally the facility failed to ensure resident were assisted to get dental and vision services in a timely manner resulting in delays in receiving glasses and needed dental work. This failed practice had the potential to affect more than a limited number of residents currently residing in the facility. Resident Identifiers: #21, #8, #49, #70, #74, #128, #55, #38, #129, #130, #63, #33, #77, #94, #76, #98, #7, #6, #11, #124, #4, and #26. Facility Census: 109 a) Privacy of Medical Record1) Resident #63 On [DATE] at 8:28 am an interview with the Medical Power of Attorney for Resident #63 it was discovered the facility sent excerpts of the medical record to another facility without the permission of the MPOA. She stated, things are better now but they did do that last year. A review of Resident #63's medical record found the following Social Service Progress note: Not Dated [DATE] ar 9:23 AM read as follows: (Name of out of state facility) contacted social services with an inquire of additional notes. 7 days of notes sent per request. Awaiting response.Note dated [DATE] at 12:08 pm read as follows: SS (Social Services) submitted 60 days worth of note to (Name of Out of State nursing facility) per their request. Will continue to follow up. Note Dated [DATE] at 2:42 PM read as follows: (First name of Resident #63) daughter declined the transfer to the psychological facility, after SW (social worker) got her a bed. An interview with Nurse Consultant #131 at 1:15 pm on [DATE] confirmed excerpts of Resident #63's medical record was sent to an out of state facility. She further confirmed the medical contained no evidence the MPOA gave permission for the records to be sent. b) Resident Grievances 1) Resident Council MeetingDuring the Resident Council Meeting on [DATE] at 2:10 PM, The Resident Council agreed that they do not know how to file a grievance in writing or anonymously.Resident #88 pointed at the wall and stated, They put that box up over there today and I guess that is what that is for, but there aren't any forms in it.During an interview on [DATE] at 12:55 PM, the Licensed Social Worker (LSW) #100 stated, They keep the forms behind the nurses station. Most of the residents would need help filling them out anyways. During an interview on [DATE] at 12:58 PM, at the A/B nurses station, Licensed Practical Nurse (LPN) #66 stated, I thought Social Services had the forms.LPN #85 stated, I am not sure where they are at. Let me look.The Director of Nursing (DON) came out to the A/B nurses' station to help LPN #85 locate a binder, in a cabinet that was for grievances. This process from the start of the interview until the form was found, took approximately 10 minutes.The DON further confirmed that the grievance forms were not readily available for residents and/or family members to file a grievance.2) Resolution of Missing Item GrievancesDuring an interview with Resident #33 at 3:53 PM on [DATE] she stated, I don't always get my clothes back from laundry. She stated she is still missing several items and stated she does not send her clothes (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to the laundry no more. She then asked the surveyor if she thought it would be okay for them to take her to the laundry mat so she could wash he own clothes.Review of the grievances found the resident filed a grievance on [DATE] reporting she was missing green, red blue elastic pants black pull on jacket white jacket Brand new underwear blue long sleeve shirt with grandmas love bugs all grandkids names listed.The grievance indicated they located the red elastic pants, new underwear, and her blue love bug shirt and her white jacket. The grievance indicated the other items were replaced by the facility with a resolution date of [DATE]. On the morning of [DATE] the facility was asked to provide evidence the other items were replaced since the resident was still claiming they were still missing. On the morning of [DATE] the facility provided a receipt from a local store which indicated the items had been purchased. The date on the receipt was [DATE] at 4:55 pm which was after the surveyor's request. An interview with Nurse Consultant on [DATE] at 11:00 am confirmed the items were not replaced until after the surveyor asked about them. A review of the grievance log found several other grievances related to missing items. The following grievances were identified as not being resolved by the facility in spite of the fact they claimed the items had all been replaced. There was no evidence to indicate the facility had replaced the items. Resident #128 Grievance filed on [DATE] which listed three (3) Pair of stretchy small sweatpants, one (1) long sleeve shirt (Local college team) small, one (1) Pair of house shoes rubber sole size 10m and missing blue jacket size small. The investigation found the items were not located. Actions taken was listed as Items will be replaced by facility. Resolved date was listed as [DATE]. The facility was unable to provide evidence that the items were replaced.Resident #55 Grievance filed [DATE] which listed blue shorts (Size 16-18), Tan/brown Shorts (size 16-18), grey sweater (size unknown), burgundy sweater (size unknown) all missing. The results of the investigation indicated the items were not found. The resolved date was listed as [DATE] and the summary of actions taken was that the items would be replaced. The facility was unable to provide evidence that the items were replaced.Resident #38 Grievance filed [DATE] which listed missing items as peach/orange nightgown, 4 pairs [NAME] socks and 1 single nonskid sock. The investigation revealed the items were not located. The resolved date was listed as [DATE] and the summary of actions taken was Items will be replaced. The facility was unable to provide evidence that the items were replaced.Resident #129 Grievance filed [DATE] which listed under the grievance details the following: We did an audit and resident stated that she had a robe missing. The investigation indicated the item was not located. The resolved date was listed as [DATE] and the summary of the actions taken was the items will be replaced. The facility was unable to provide evidence that the items were replaced.Resident #130 Grievance filed [DATE] which listed un the grievance details the following: We did an audit and resident stated that had clothes missing. Summary of investigation indicated the items were not located. Summary of actions taken indicated the items would be replaced by the facility. The resolved date was [DATE]. The facility was unable to provide evidence that the items were replaced.Resident #63 Grievance filed [DATE] which listed un the grievance details the following: We did an audit and resident stated that had clothes missing. Summary of investigation indicated the items were not located. Summary of actions taken indicated the items would be replaced by the facility. The resolved date was [DATE]. The facility was unable to provide evidence that the items were replaced.An interview with the Corporate Nursing Home Administrator (CNHA) #140 at 1:09 pm on [DATE] confirmed they were unable to locate any receipts to show that Residents #128, #55, #38, #129, #130 and #63 had their items replaced. He stated, we are going to follow up with them and get the items replaced now. c) Advance Directives 1) Resident #11A review of Resident #11's medical record on the morning of [DATE] found a physician determination of capacity which was completed by Resident #11's (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	attending physician on [DATE]. This form indicated Resident #11 had capacity to make medical decisions. This was the most recent capacity form located in Resident #11's medical record. Further review of the medical record found a Physician Order for Scope of Treatment (POST) form which was dated [DATE]. The medical record revealed Resident #11 was admitted to the facility on 11//22. This post form was the most recent POST form in the resident's medical record and indicated the resident was to be a full code. Further review of the post form found it was signed by someone other than Resident #11. Social Worker #100 at 12:57 pm on [DATE] confirmed during an interview the POST form was not signed by Resident #11. When asked if Resident #11 should have been given the opportunity to complete a new post form when she regained her capacity on [DATE] she stated, Yes she should have. 2) Resident #124 A review of Resident #124's medical record found a POST form signed by Resident #124 on [DATE] which indicated the resident wished to not receive CPR and wanted only comfort focused treatments. A review of the physician's orders entered into Resident #124's medical record found the following order entered on [DATE], ADC: Full Code/ Full treatments/no artificial means of nutrition desired/has capacity. An interview with Nurse Consultant #131 and the Nursing Home Administrator in the afternoon of [DATE] confirmed the order entered into the physician's orders did not match Resident #124's expressed wishes and needed to be corrected. d) Reporting of Abuse Allegations 1) Resident #74A review of a reportable incident dated [DATE] involving alleged victim Resident #74 and alleged perpetrator Resident #97. Under the section what was reported the following was written:(First and Last name of Resident #74) was sitting by nurses station (First name of Resident #97) he rolled by and reached between (First name of Resident #74's) legs and (First name of Resident #74) smacked his hands away CNA redirected the residents.The date and time of the incident was listed as [DATE] at 1:12 PM. Further review of the reportable incident found the report was faxed to the state agency at 5:49 PM on [DATE] which was four (4) hours and 37 minutes after the time of the incident. An interview with Corporate Nurse #131 and the Nursing Home Administrator (NHA) at 1:44 PM on [DATE] confirmed this incident was not reported within the required two (2) hours. e) Interpretation of Abuse Investigation Findings and Protection of Residents during the investigation. 1) Resident #21, #8, #49A policy titled, Abuse reads, in the event of an allegation or observation of abuse, the facility will immediately assess the resident, notify the physician and resident representative, and protect the resident and other residents from further harm or incident.In a nurse note dated [DATE] at 5:58PM it is documented, It was reported to this nurse that resident 94036643 and resident 94036696 was sitting in the hallway holding hands and resident 94036643 had resident 94036696 hands in between resident 94036643 legs. Resident's were separated and resident 94036643 was put on [one-on-one] 1:1 and [every fifteen] q15 minute checks. PCP [Primary Care Physician] and RP [Responsible party] notified. According to the witness statements, this incident occurred at approximately 2:30PM between Resident #8 and Resident #21. The intervention was to place Resident #8 on one-on-one (1:1) observations immediately pending investigation. Resident #21 is listed as non-verbal with a Brief Interview of Mental Status (BIMS) score on the Minimum Data Set, dated [DATE] of 00 indicating Resident #21 is not capable of making decisions regarding daily living activities and has no recall ability.During an interview with Resident #49 on [DATE] at 3:40PM, she stated she was yelled at and called names over a man and it made me feel degraded. Upon further investigation, a nursing note dated [DATE] at 6:27PM reads, It was reported to this nurse that resident 94036643 verbally threatened to kick resident 94036540's but. Resident 94036540 reported that she didn't want resident 94036643 to kick her but. Resident 94036643 put on 1:1 [one-on-one]. PCP [primary care physician] and RP [responsible party] notified. According to witness statements, this incident occurred at approximately 4:00PM between Resident (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#49 and Resident #8. Another incident occurred on [DATE] at 4:31PM per documentation involving Resident #8 in which Resident[#8] called this nurse in resident's room demanding to speak to the administrator now. Resident stated that unit manager had hit her. Resident pointed to her wrist and lower arm and stated She hit me right here. This nurse reported incident to risk nurse. This nurse assessed resident's skin and there was no marks or redness on resident's skin. According to witness statements and facility reported incident investigation, this incident occurred due to unit manager attempting to separate Resident #8 and Resident #21. In an interview with Social Services #100 on [DATE] at 3:00PM, she confirmed Resident #8 was not on one-on-one (1:1) at the time of these incidents. During an interview with Corporate Registered Nurse #131 on [DATE] at 3:50PM, she confirmed, per documentation, Resident #8 was supposed to be on one-on-one (1:1) observations from the 2:30PM incident. According to the Medication Administration Record, the one-on-ones did not start until 7:00PM on [DATE]. 2) Resident #74A review of a reportable incident with an incident date of [DATE] involving Resident #74 as the victim and Resident #90 as the alleged perpetrator found the following description of the incident, (First and Last Name of Resident #74) was sitting by the nurses station, (First name of Resident #90), he rolled by and reached between (First Name of Resident)' s legs. and (First name of Resident #74) smacked his hands away/CNA redirected the residents. A review of the five day follow up found the following listed under conclusion: Due to the incident being witnessed by center staff, the incident has been verified. The investigation confirms that the event did occur due to staff witness account. However, the investigation is inconclusive for abuse due to not indication of physical or psychosocial harm, unknown if intentional due to incapacity of alleged perpetrator and BIMS of 3.0 and no recollection of incident by either resident. During an interview with the Nursing Home Administrator (NHA), Nurse Consultant #131 and Social Worker #100 on [DATE] at 1:44 PM they agreed abuse should have been verified and the investigation was not inconclusive. 3) Resident #70A review of a reportable incident with an incident date of [DATE] found the following description of the incident: Resident made contact with other resident. The alleged victim was identified as Resident #70 and the alleged perpetrator was Resident #63. A review of the investigation found a statement from Nurse Aide #72 who assigned 1:1 aide for Resident #63 at the time of the incident. The statement read as follows, I was following the 1:1 (resident #63's assigned medical record number) when I saw (First Name of Resident #70) coming out of (Resident #63's assigned Medical record number) room. I immediately approached (First Name of Resident #70) to guide him out of the room and back into his room which is next) door. Resident (resident #63's assigned medical record number) became irate as soon as she saw someone in her room, they propelled self suddenly forward in the wheelchair and kicked (first name of Resident #70) in the lower legs. Resident (resident #63's assigned medical record number) attempted to punch (First name of Resident #70) again. I continued to separate and redirect. Other staff came and assisted. (First Name of Resident #70) presented to be unaware of the situation. A review of the Five day follow up related to this incident found the following conclusion, The facility has unsubstantiated abuse due to diagnosis and low BIMS score related to intent. Facility did interview like residents on hall with no variances regarding safety. During an interview with the Nursing Home Administrator (NHA), Nurse Consultant #131 and Social Worker #100 on [DATE] at 1:44 PM they agreed abuse should have been verified. The NHA indicated he thought because Resident #63 had a diagnosis of dementia and a low BIMS he could not find intent. When asked if the resident kicked the other resident voluntarily, he stated, yes. He agreed it was not an accident, she did it on purpose but she did not know what she was doing cognitively. He stated, I understand now what that means. f) Discharge Planning 1) Resident #77An interview with Resident #77 in the afternoon of [DATE] he stated, I want to go home but I lived with (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	my fiancé and she don't want me there so I don't know what I will do. Resident #77 was admitted to the facility on [DATE]. A review of Resident #77's record found only one capacity statement which was completed on [DATE] which indicated the resident has capacity to make medical decisions. A review of Resident #77's Minimum Data Set with an Assessment Reference Date (ARD) of [DATE]. Found Section Q. Was completed by interviewing the resident's family and was coded to indicate the resident did not wish to return to the community and that active discharge planning was not underway. A review of Resident #77's care plan found the following care plan related to discharge: Focus Statement: Short term Discharge plan: (First Name of Resident #77) is expected to be at the facility on a short term basis and return to the community. This focus statement was initiated on [DATE] and has not been revised since. The goal associated with this focus statement reads: Resident will return to the community successfully when ready thru the review period. This was also initiated on [DATE] and has a target date of [DATE]. The interventions include: -- Coordinate with physician regarding discharge plans as indicated--make community DME referrals as indicated--refer for community resources as indicated and per resident/resident representative preference-- refer the resident to the local contact agency if indicated by the resident -- review and update discharge plans with the resident when needed A review of Resident #77's medical record found a Social Service Quarterly Note dated [DATE] completed by Social Worker #100. Under Section N. Quarterly Discharge Plan Review the following was noted: Mr. (Last name of Resident #77) could live alone with some assistance he has voiced he would like to find a place. During an interview with Social Worker #100 on the afternoon of [DATE] she indicated she was aware the resident wanted to go home. She stated, I just found that out and was going to start working on his discharge planning this week but have not had the chance. When asked about the care plan dated [DATE] and the social service note date [DATE] the social worker remained silent. g) Inviting Residents to Care Plan Meeting 1) Resident #11 During the initial interview on [DATE] at 11:30 PM, Resident #11 said that she has not been to a care plan meeting and they don't tell her what is going on. A record review on [DATE] at 12:21 PM, revealed that Resident #11 was deemed incapacitated since admission until [DATE] when she regained capacity. Resident's care plan signature page, up until [DATE], was completed with the Medical Power of Attorney (MPOA), via telephone. Resident #11's signature is not present. During an interview on [DATE] at 2:11 PM, The Licensed Social Worker (LSW) #100 stated, That resident would not have got the notice before because she just recently got her capacity back. The State Agency (SA) asked, If the resident does not have capacity do they still invite or involve them in the care plan meeting? LSW #100 replied, If they do not have capacity then we do not involve them in the care plan meeting. 2) Policy A review on [DATE] at 2:37 PM, of the policy titled {Care Planning- Interdisciplinary Team} reads under number 3 as follows: The Resident, the resident's family and or the residents legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the residents care plan. Number 4 reads as follows: Every effort will be made to schedule the care plan meeting at the best time of the day for the resident and family. h) Vision 1) Resident #7 On initial interview on [DATE] at 1:00PM, Resident #7 states he went to the eye doctor a month or so ago but never got his glasses. In an interview with Social Services #100 at 11:55AM on [DATE], she stated, I don't know anything about it. As far as I know, they [Resident's glasses] could be sitting at that doctor's office. At 12:00PM on [DATE], the Director of Nursing (DON) stated she did not know anything about new glasses, but she would check into everything. The facility was able to produce one page of the visit note from the visit to the eye doctor on [DATE] which did not show any follow-up information. In an interview with [NAME] Virginia Eye Consultants on [DATE] at 1:00PM, the receptionist stated there are two (2) prescriptions for glasses waiting at (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the office. It was confirmed with the DON at 1:20PM on [DATE] that Resident #7 did not receive his glasses after his eye appointment and no effort was made by the facility to get further notes or glasses. 2) Resident #6 During an interview with Resident #6 on [DATE] at 3:15 PM she stated, I saw the eye doctor eight (8) weeks ago and still have not received them. She stated, I asked the social worker about them and found out they had not been paid for but that was a few weeks ago and she still has not heard anything. A review of Resident #6's medical record found she saw the eye doctor in house on [DATE] and the invoice was sent to the facility on [DATE]. Social Worker #100 was asked to provide any information she had concerning Resident #6's glasses on the afternoon of [DATE]. On the afternoon of [DATE] no information had been provided to the surveyor. The surveyor again asked for any information regarding Resident #6's glasses and the Nursing Home Administrator (NHA) stated they paid for them yesterday after the surveyor asked what was going on with them. The social worker then provided the following emails between Social Worker #100 and the in-house eye doctor: Email from Social Worker #100 to the in-house eye doctor sent on [DATE] at 2:41 pm read red as follows: We have Several residents that still haven't received glasses. Do you know when they may be in? Reply received from the in house eye doctor at 3:39 pm on [DATE], read as follows: Can you send me a list of who is still waiting as I will have to look in their charts to get the status. Social Worker #100 replied on 3:51 pm on [DATE]th 2026 which read as follows: (First and Last Name of Resident #6) and (First and Last Name of Resident #6) for sure . They keep asking and they were seen four weeks ago. Another reply from Social Worker #100 at 3:57 pm listed the following residents (First and Last Name of Resident #8), (First name of Resident #10 and a different last name.) (First and Last Name of Resident #15), (First and Last Name of Resident #6). May Be more! Please let me know. Reply from in house eye doctor at 4:26 pm [DATE] read as follows: (First Initial and Last Name of Resident #15) Invoice was sent to the facility on [DATE]. (First Initial and Last name of Resident #6) invoice was sent to the facility on [DATE] (First and Last Name of Resident #8) - Invoice Sent to the facility on d[DATE] (First name of Resident #10 and different last name similar to Resident #10's)- Not in our system. Email from Social Worker #100 to in house eye doctor on [DATE] at 4:42 pm read as follows: We did not receive them, were they signed for, how were they sent? Email from in house eye doctor at 9:56 am on [DATE] read as follows: The invoices will need to be paid in full before the glasses will be ordered. Email from Social Worker 100 to in house eye doctor on [DATE] at 10:02 am read as follows, What the Glasses were not sent because they need payment? Can I have the invoices and we will pay it. Please. Reply from in house eye doctor on [DATE] at 10:12 am read as follows, Attached are all the invoices that will need to be paid before the glasses can be ordered. I did not find a (First name of Resident #10 and a Last Name similar to Resident # 10) in our system however there is a (First and Last Name of Resident #10) with that same DOB (date of birth) and I have attached his invoice as well Please let me know if you have any other questions. Social Worker #100 also provided a copy of a check for Resident #6's glasses which was sent to the in house eye doctor on [DATE]. The NHA confirmed the glasses were not paid until after the surveyor asked about them but it was taken care of then. i) Dental Services 1) Resident #26 During an initial interview on [DATE] at 1:13PM, Resident #26 stated she had an appointment for dentures about a year ago. However, she states her wheelchair would not fit through the door and therefore she was not seen. A review of the records showed Resident #26 had a denture evaluation appointment with Dr. (name) on [DATE]. Across the top of the paper in black marker is written: Please use smaller wheelchair! The facility could not produce evidence of having rescheduled this appointment. In an interview with Director of Nursing at 3:25PM on [DATE], she confirmed Resident #26 has not had any dental follow up since appointment on [DATE]. 2) Resident #4 Review of Resident #4's physician's orders showed (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an order written on [DATE] for Resident needs referral to dental for mouth pain. A change in condition assessment had been completed on [DATE] at 6:55 PM which stated, Resident is having continued complaints of mouth pain in the upper teeth. Tylenol administered as ordered. Documentation showed Tylenol was effective in relieving the resident's pain. Review of Resident #4's electronic health record showed the resident had a dental appointment on [DATE] for a toothache. He was prescribed an antibiotic. No reports for a more recent dental appointment were located in the resident's records. On [DATE] at 4:14 PM, Registered Nurse (RN) #119 stated [DATE] was Resident #4's most recent dental appointment. She stated the resident was on the list for a dental appointment, but an appointment had not yet been made. j) Inaccurate Social Service Assessments and Trauma Screens 1) Resident #76 A review of Resident #76's medical record on the morning of [DATE] found a Social Service Initial Evaluation version two (2) which was completed on [DATE] at 11:29 am. This evaluation indicated Resident #76 was a female. It should be noted Resident #76 is a male. During an interview with Nurse Consultant #134 in the morning of [DATE] she confirmed Resident #76 was a male and the Social Service evaluation incorrectly identified his gender. 2) Resident #98 A review of Resident #98's medical record on the morning of [DATE] found a Trauma Screen Dated [DATE]. This screen indicated Resident #98 was not interviewable. However Resident #98's name was listed under Name of the person interviewed. A review of Resident #98's capacity statement indicated the resident was capacitated to make medical decisions. A review of Resident #98's Brief Interview of Mental Status (BIMS) found he scored a 15 which indicated the resident is cognitively intact. An interview with Corporate Nurse #131 on the morning of [DATE] confirmed the Trauma Screen dated [DATE] was inaccurate because Resident #98 is interviewable. 3) Resident #77 A review of Resident #77's medical record on the morning of [DATE] found a social service assessment dated [DATE] which indicated the resident needed and/or requested an interpreter. An interview with Social Worker #100 at 3:36 pm on [DATE] confirmed the social service assessment was inaccurate and Resident #77 did not need an interpreter.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and staff interview, the facility failed to ensure an account of all controlled drugs was maintained and periodically reconciled. The facility failed to ensure the controlled substance count was signed by the on-going and off-going nurses performing the count. The facility also failed to identify and investigate a possible drug diversion for Resident #98. These findings were random opportunities for discovery. Resident Identifier: #98. Facility Census: 109. Findings included: a) Controlled substance counts The facility's policy titled, Controlled Substances, with effective date September 2018 and revision date August 2020, stated that an accurate inventory of all controlled medications would be maintained at all times. However, no specific information regarding counting the medications was given in the policy. On 06/03/2026 at 7:30 AM, the B hallway medication cart was inspected with Licensed Practical Nurse (LPN) #103 in attendance. LPN #103 stated the number of controlled substance cards were counted whenever the medication nurse left and a new medication nurse came. The cards are packs that contain medications for each resident. LPN #103 stated number of medications remaining on each card are also counted at that time. LPN #103 presented forms located in a notebook on the medication cart. The forms were titled, Narcotic count. LPN #103 stated the controlled substance count was recorded on these forms. The forms had areas for the date and times of the controlled substance count to be recorded as well as the signatures of the off-going nurse and on-coming nurse. The amount of cards were also recorded. On 06/03/26 at 7:00 AM, the off-going nurse had not signed the form. On 06/02/26 at 7:00 PM, the on-coming nurse had not signed the form. On 06/01/26 at 7:00 PM, the off-going nurse had not signed the form. On 05/31/26 at 7:00 PM, the off-going nurse had not signed the form. On 05/30/26 at 7:00 PM, the off-going nurse had not signed the form. LPN #103 confirmed the controlled substance counts had not been signed by both the on-coming and off-going nurses. No further information was provided through the completion of the survey process. b) Resident #98 A review of Resident #98's medical record found he was ordered oxycodone 1r 10 mg every 8 hours. A review of the Controlled Substance Log and the Medication Administration Record (MAR) for (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/01/26 through 06/07/26 found on the following four (4) occasion Liscensed Practicalk Nurse #58 signed out Resident #98's Oxycodone on the Controlled Substance Log but failed to document it as administered on the MAR . The dates and times are as follows: -- 05//15/26 at 6:00 am -- 05/28/26 at 6:00 am -- 06/02/26 at 6:00 am and -- 06/07/26 at 6:00 am An interview with Nurse Consultant #131 at 4:00 PM on 06/08/26 confirmed the above findings and agreed it should have been identified as possible drug diversion.		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, record review and staff interviews, the facility failed to provide each resident with a nourishing, palatable, well-balanced diet that meets their daily nutritional and special dietary needs, taking into consideration each resident's preferences. This deficient practice was found during the dining observation. This deficient practice has the potential to affect more than a limited number of residents. Resident identifier: #13, #23, #68 and #89 . Facility census: 109. Findings included: a) Resident #13 On 06/01/26 at 12:35 PM during the lunch meal service, Resident #13 received her lunch and did not receive a nutritious pudding, as stated on her tray ticket. I asked the Business Office Manager (BOM) if Resident #13 received the nutritious pudding, and she stated she does not have it and I will go get it. Physicians order dated 02/04/26, for Nutritional Supplement in the afternoon, fortified pudding with lunch, 4oz serving. b) Resident #23 On 06/01/26 at 12:40 PM during the lunch meal service, Resident #23 received her lunch and did not receive her mandarin oranges. I asked Certified Nurse Assistant #82 if Resident #23 should have received the mandarin oranges , and she stated yes she should have, I will go ask for them. c) Resident #68 On 06/02/26 at 12:27 PM during the lunch meal service, Resident #68 received her lunch and did not receive her key lime pie. I asked the facility staff in the dining room if they could go get a serving of this for Resident #68, and they did. d) Resident #89 On 06/01/26 at 2:19 PM, Resident #89 stated I have told them I do not like mixed vegetables, and I still receive them. Resident #89 has capacity with a BIMS of 15.		

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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 record review, resident interviews and staff interviews, the facility failed to ensure all food was temped before leaving the kitchen, to ensure safe food temperatures to prevent foodborne illness and an appetizing temperature of the food. The facility failed to ensure hot foods were served hot and cold foods were served cold. This failed practice was true for one (1) of one (1) meal tray tested throughout the survey process. This failed practice had the potential to affect more than a limited number residents. Resident identifier: #49, 12, 89, 44 and 65. Facility census: 109 Findings include: a) Policy #ADM-015-Food Temperature Control states: Policy: All foods shall be cooked, held, and served at safe temperatures to prevent foodborne illness. Purpose: To ensure compliance with FDA Food Code and CMS F812 standards Procedure: Hot foods > 135 degrees F; cold foods < 41 degrees F. Food temperatures will be taken once cooked, before, during and after service. Thermometers shall be calibrated daily and sanitized after use. Corrective action will be taken immediately for any unsafe reading. b) Initial walkthrough of the kitchen on 06/01/26 at 11:00 AM. The Director of Dining Services (DDS) accompanied this surveyor and verified the findings to be true. I asked to see the food temps for the meals for the month of May 2026, and the facility were only taking and recording the temperatures of the food items that were on the main menu. They were not recording any alternate or always available food items before serving them to the residents. The DDS stated We will start recording temps for those items also. The facility is not following state or federal guidelines, or their own policy for taking and recording food temperatures on all food items prepared in the dietary department, before serving the residents these items. They do not know if the temperatures meet the food code standards, because they were not taking all of them per the guidelines. c) Resident Council on 06/02/2026 at 2:00 PM The residents attending this meeting stated the bread is always hard. d) Resident #89 stated the food is cold sometimes, and the breadsticks are hard as a rock. e) Resident #44 stated the food is not good here. f) Resident #65 stated the hot food is cold at times. g) Resident #49 stated the food is nasty.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interviews, the facility failed to store, prepare, distribute and serve food in accordance with professional food safety standards. Additionally, the facility failed to follow proper sanitation practices for the kitchen and the food preparation equipment. This practice had the potential to affect more than a limited number of residents. Facility census: 109Findings include: a) Policy #ADM - 077 - Label and Dating Requirements states: Policy: All prepared, opened, or repackaged foods shall be labeled and dated to ensure proper rotation and safety. Purpose: To prevent spoilage and maintain compliance with sanitation standards. Procedure: Each container must be labeled with product name, preparation or open date, and discard date. b) Policy #ADM - 018 - Equipment Cleaning and Maintenance states: Policy: All dietary equipment shall be maintained in good repair and kept in a clean, sanitary condition at all times. Purpose: To ensure food is prepared and served safely and that equipment operates efficiently in accordance with CMS F812. Procedure: Equipment will be cleaned and sanitized after each use following manufacturer guidelines. c) Policy #ADM - 024 - Master Cleaning Schedule (sanitation Program) states: Policy: All dietary areas, equipment, and utensils shall be cleaned and sanitized on a defined schedule to maintain sanitary conditions. Purpose: To prevent food contamination and ensure regulatory compliance. Procedure:A written cleaning matrix (daily / weekly / monthly / PRN) will assign tasks and responsible staff.Food-contact surfaces: wash-rinse-sanitize between tasks and at shift end.Non-food-contact surfaces (walls, floors, hoods, vents) are cleaned per schedule and as needed.Approved detergents / sanitizers are used per label instructions.The Dietary Manager audits completion and corrective actions weekly.d) Policy #ADM-153-Manual Ware Washing Procedures states: Policy: Manual washing of pots, pans, and utensils shall follow the three-compartment-sink method using approved detergents and sanitizers. Purpose: To ensure all food-contact items are properly cleaned and sanitized when dish machines are unavailable or for oversized equipment. Procedure: Set up sink compartments.ScrapWash (110 degrees F minimumRinseSanitizeRecord sanitizer test results before each meal period to ensure proper PPM.e) Policy #ADM-440-Mechanical Dish Machine Standards Policy: All mechanical dish machines shall operate per manufacturer and regulatory standards for time, temperature, and sanitizer concentration. Purpose: To ensure all dishware and utensils are effectively sanitized during mechanical cleaning. Procedure:Verify wash temperature > 150 degrees FFinal rinse temperature > 180 degrees F (high-temp machines)Record results each meal service period f) Initial walkthrough of the kitchen on 06/01/26 at 11:00 AM. The Director of Dining Services (DDS) accompanied this surveyor and verified the findings to be true. -The floor in the walk-in refrigerator was soiled and needed sweeping and mopping.-Multiple juice cups were not dated in the walk-in and the reach-in refrigerators.-The reach-in refrigerator had beverage spilled on the bottom shelf.-Two (2) containers of honey thickened juice were not dated properly in the reach-in refrigerator.-The drip pan located under the stove was soiled with food debris.-The top interior of the microwave was soiled.-The toaster was soiled.-The fronts of both conventional ovens were soiled.-One (1) package of flour was opened, not sealed, and not dated properly.-The dish machine was missing multiple temperatures that were not recorded for the month of May 2026 and for breakfast on June 1 2026.-All three (3) handwashing sinks located in the dietary department were soiled.-One foam cup of sugar was not sealed, labeled or dated properly in the side one (1) pantry.-One container of coffee was not dated properly in the side one (1) pantry.-The microwave in the side one (1) pantry was heavily soiled on the inside.-Two (2) can openers were soiled.-Interview (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with Director of Dining Services (DDS) at 11:40 AM on 06/01/26 DDS stated, We will get these items cleaned, and I will discard the items not dated properly. Follow up visit to the kitchen on 06/02/26 at 10:15 AM-One (1) can opener was soiled.-The dish machine temperature was not taken and recorded prior to washing breakfast dishes this morning.-The three (3) compartment sink water temperatures are not being recorded. The facility is only recording the sanitizer's parts per million (PPM).One soiled pair of gloves was located on the countertop near the coffee maker.-Interview with Director of Dining Services (DDS) on 06/02/26 at 10:25 AM DDS stated, The can opener will be replaced today. I will update the form and we will start taking the water temperature for the three (3) compartment sink.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation and staff interview, the facility failed to store and dispose of garbage and refuse properly. The lids for the trash cans located in the kitchen and the dish room were not on during two different observations of the kitchen during the survey process. This failed practice has the potential to affect more than a limited number of residents at the facility. Facility census: 109. Findings include: a) Policy #ADM -300 - Garbage and Waste Disposal states: Policy: All garbage and food waste shall be handled and disposed of safely and frequently to maintain sanitation and odor control. Purpose: To prevent pest attraction, odor buildup, and contamination in food-service areas. Procedure:Keep the lids closed at all times and when not in use.Clean and sanitize garbage cans daily, including exterior surfaces.b) The Initial walkthrough of the kitchen took place on 06/01/26 at 11:00 AM The Director of Dining Services (DDS) accompanied this surveyor and verified the findings to be true. There was no lid on the trash can located beside the handwashing sink. I asked The DDS if there was a lid available for this trash can and she stated, Yeah somewhere, but I cannot find it. I will remove it from the kitchen. At 11:20 AM on 06/01/26, the trash can located in the dish room did not have a lid on it. The DDS did put the lid on after the surveyor brought it to her attention. At 11:46 AM on 06/01/26 the trash can located in the dish room did not have the lid on it again. The DDS stated, I will speak to my staff about leaving the lids on the trash cans when not in use.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure medical records were complete and accurate. This deficient practice had the potential to affect nine (9) of 35 residents reviewed in the long-term care survey sample. Resident Identifiers: #11, #12, #98, #94, #77, #76, #20 and #6. Facility census: 109. Findings included: a) Resident #11 Review of Resident #11's physician's orders showed an order written on 04/07/26 for gabapentin oral capsule, 100 milligrams (mg), give one (1) capsule by mouth every eight (8) hours related to neurocognitive disorder with Lewy bodies. Gabapentin (Neurontin) is a medication typically used to prevent seizures or to treat nerve pain. A physician's progress note written on 04/07/26 stated, Seen today at the request of the resident to discuss escalating pain control with gabapentin. On 06/08/2026 at 1:07 PM, Corporate Nurse #131 confirmed the indication given for the gabapentin order for Resident #11 was incorrect. Corporate Nurse #11 stated gabapentin was prescribed for the resident for pain and not for neurocognitive disorder with Lewy bodies. No further information was provided through the completion of the survey process. b) Resident #12 Resident #12 had the capacity to make his own medical decisions. On 09/04/25, Resident #12 completed and signed a tuberculosis questionnaire and consent. The questionnaire stated: To your knowledge in recent years, has the resident ever had: A TB (tuberculosis) skin test? (The resident answered yes and also wrote in a question mark.) An allergic reaction to a TB skin test? (The resident answered no.) A positive reading from a skin test? (The resident answered no.) A chest x-ray to detect TB? (The resident answered yes.) I do authorize a TB skin test to be performed to determine if I have active TB or have been exposed to (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	TB in the past. (The resident answered no.) Review of Resident #12's medication administration record (MAR) for September 2025 showed the resident received TB skin tests on 09/05/25 and 09/15/25. On 06/09/26 at 1:52 PM, Registered Nurse (RN) #97 stated she was the Infection Preventionist in September 2025 and had completed the TB test consent form with Resident #12. She stated the resident verbally consented to TB testing but had misunderstood the consent form. He thought the last item on the form had been asking if he had ever received a TB skin test. RN #97 confirmed Resident #12's TB test form had been incorrectly completed. No further information was provided through the completion of the survey process. c) Resident #98 The facility's policy titled, Administration Procedures for All Medications, with effective date September 2018 and revision date August 2020, stated that after a medication is administered, the administration should be documented in the Medication Administration Record (MAR) or Treatment Administration Record (TAR). Review of Resident #98's physician's orders showed an order written on 01/12/26 for tuberculin purified protein derivative (PPD) intradermal injection to screen for tuberculosis (TB) infection. The injection had not been signed as given on the resident's MAR for January 2026. On 06/09/26 at 2:19 PM, Registered Nurse (RN) #97 stated she was the Infection Preventionist in January 2026. She presented a notebook in which she made hand-written notes to track vaccinations given to residents. In the notebook was a page for Resident #98 labeled Vaccination Consents/TB information. The document indicated that the resident had received a tuberculin PPD test on 01/12/26. RN #97 verified the tuberculin PPD test had not been signed out on the MAR to indicate the test had been given. No further information was provided through the completion of the survey process. e) Resident #94 A review of Resident #94's medical record on the afternoon of 06/02/26 found a Physician Determination of Capacity statement dated 12/10/25. The form indicates Resident #94 does not have capacity to make medical decisions. Further review of the record found it was void of any paperwork identifying who would be making the medical decisions for Resident #94. Nurse Consultant #131 was asked to provide paperwork identifying who was making medical decisions for Resident #94 in the late morning of 06/02/26. The facility provided a Surrogate Appointment form dated 11/26/25 which appointed the residents son as his Health Care Surrogate. This form was completed at a local hospital. Further review of the (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	form found the form was not printed from the hospitals system until 06/02/26 at 12:27 PM which was after the surveyor had requested the facility provide the paperwork. An interview with Social Worker #124 at 1:00 PM on 06/02/26 confirmed the facility did not have a copy of the Health Care Surrogate Form in Resident #94's medical record. She stated, I called the hospital after you asked for it and they sent it to us. f) Resident #76 A review of Resident #76's medical record on the morning of 06/10/26 found a Social Service Initial Evaluation version two (2) which was completed on 08/05/25 at 11:29 am. This evaluation indicated Resident #76 was a female. It should be noted Resident #76 is a male. During an interview with Nurse Consultant #134 in the morning of 06/10/26 she confirmed Resident #76 was a male and the Social Service evaluation incorrectly identified his gender. g) Resident #6 A review of Resident #6's medical record on the morning of 06/09/26 found under the task documentation for Walking 10 foot and 50 foot the resident was coded as dependent on staff for walking 10 foot and/or 50 foot once standing on the following days: 10 Foot: 05/04/26 05/05/26 05/07/26 05/10/26 05/13/26 05/14/26 05/18/26 05/19/26 05/22/26 05/23/26 (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/24/26 05/26/26 05/27/26 05/28/26 and 06/01/26 50 Foot 05/02/26 05/04/26 05/05/26 05/07/26 05/10/26 05/13/26 05/14/26 05/15/26 05/18/26 05/19/26 05/22/26 05/23/26 05/24/26 05/26/26 05/27/26 05/28/26 and 06/01/26. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with consultant nurse #131 in the afternoon of 06/09/26 it was confirmed Resident #6 is not able to stand and walk at all. She stated, They said she has not walked since coming back from the hospital. Further review of the medical record found Resident #6 was readmitted to the facility from the hospital on [DATE] and has had no discharges since. h) Resident #20 A review of Resident #20's medical record on the morning of 06/08/26 found two (2) dental/oral assessments dated 01/17/25 and 05/22/26 under number 7. Number of teeth no answer was recorded on either assessment. Corporate Nurse #131 completed an oral assessment on Resident #20 at 2:00 pm on 06/08/26 and confirmed Resident #20 has six (6) natural teeth. She reviewed the assessments and confirmed they were inaccurate. i) Resident #98 A review of Resident #98's medical record on the morning of 06/10/26 found a Trauma Screen Dated 02/01/26. This screen indicated Resident #98 was not interviewable. However Resident #98's name was listed under name of the person interviewed. A review of Resident #98's capacity statement indicated the resident was capacitated to make medical decisions. A review of Resident #98's Brief Interview of Mental Status (BIMS) found he scored a 15 which indicated the resident was cognitively intact. An interview with Corporate Nurse #131 on the morning of 06/10/26 confirmed the Trauma Screen dated 02/01/26 was inaccurate because Resident #98 is interviewable. j) Resident #77 A review of Resident #77's medical record on the morning of 06/09/26 found a social service assessment dated [DATE] which indicated the resident needed and/or requested an interpreter. An interview with Social Worker #100 at 3:36 pm on 06/09/26 confirmed the social service assessment was inaccurate and Resident #77 did not need an interpreter.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review, staff interviews and resident interviews the facility failed to treat each resident with respect and dignity by not recognizing their individuality. This failed practice was found true for (2) two of (3) three residents reviewed for dignity during the Long-Term Care Survey. Resident identifiers: #88 and #101. Facility census: 109. Findings Include: a) Resident #88 During an interview on 06/02/26 at 3:10 PM, Resident #88, who has a Brief Interview for Mental Status (BIMS) score of 15 stated, Last night an agency CNA came into my room at 1:00 in the morning and woke me up and said she needed to put my name on my personal stuff. I told her no and to get out. That is ridiculous. I think she went into other rooms and did the same thing. b) Resident #101 During an interview on 06/02/26 at 3:20 PM, Resident #101, who has a BIMS score of 12 stated, A CNA came in my room last night about 2 in the morning and wanted to put my name on some stuff. She said she had to go get something but then didn't come back. Do they have to do that at 2 in the morning? c) Staff interview During an interview on 06/02/26 at 3:55 PM, the Director of Nursing (DON) stated, I am not sure if they were labeling personal items, or if the direction came from the nurse. But no, they should not do that at that time of the morning.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on record review, observation, staff interview and resident interview, the facility failed to ensure a resident's call light was within reach. This was a random opportunity for discovery. Resident Identifier: #52. Facility Census: 109. Findings include:a) Resident #52 The Hill Valley Healthcare policy titled Answering the Call Light states under general guidelines: 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. On 06/01/26 at 3:47 PM, this surveyor interviewed Resident #52. The only concern she had was that she could not find her call light. She stated, I tried to find it earlier. This surveyor found the call light behind her pillow and pressed the button. At 3:49 PM Certified Nurse Aide (CNA) #82 entered the room and asked Resident #52 if she needed anything? I told CNA #82 that I was the one who pushed the call light and asked her if the call light was within Resident #52's reach? CNA #82 stated, It was not within her reach and I will fix it.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to ensure all residents were afforded the opportunity to formulate their own advance directive and to have their wishes honored after an advance directive is formulated. This was true for two (2) of seven (7) residents reviewed for the care area of advance directives during the long term care survey process. Resident identifiers: #11 and #124. Facility Census: 109. a) Resident #11 A review of Resident #11's medical record on the morning of [DATE] found a physician determination of capacity completed by Resident #11's attending physician on [DATE]. This form indicated Resident #11 had capacity to make medical decisions. This was the most recent capacity form located in Resident #11's medical record. Further review of the medical record found a Physician Order for Scope of Treatment (POST) form dated [DATE]. The medical record revealed Resident #11 was admitted to the facility on 11/22. This POST form was the most recent in the resident's medical record and indicated the resident was to be a full code. Further review of the post form found it was signed by someone other than Resident #11. Social Worker #100 confirmed during an interview at 12:57 pm on [DATE] that the POST form was not signed by Resident #11. When asked if Resident #11 should have been given the opportunity to complete a new post form when she regained capacity on [DATE] she stated, Yes she should have. b) Resident #124 A review of Resident #124's medical record found a POST form signed by Resident #124 on [DATE], indicating the resident wished to not receive CPR and wanted only comfort focused treatments. A review of the physician's orders entered into Resident #124's medical record found the following order entered on [DATE], ADC: Full Code/ Full treatments/no artificial means of nutrition desired/has capacity. An interview with Nurse Consultant #131 and the Nursing Home Administrator on the after noon of [DATE] confirmed the order entered into the physician's orders did not match Resident #124's expressed wishes and needed correction.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on record review, family interview and staff interview the facility failed ensure Resident #63 maintained privacy of her medical record. The facility sent excerpts from the residents medical record to an out of state facility without the permission of the healthcare decision maker. This was true for one (1) of one (1) residents reviewed for the care area of privacy during the long term care survey process. Resident Identifier: 63. Facility Census: 109. a) Resident #63 On 06/02/26 at 8:28 am an interview with the Medical Power of Attorney (MPOA) for Resident #63 revealed that the facility sent excerpts of the medical record to another facility without the MPOA's permission. She stated, Things are better now but they did do that last year. A review of Resident #63's medical record found the following Social Service Progress note: -- Not Dated 05/07/25 ar 9:23 AM read as follows: (Name of out of state faiclty) contacted social services with an inquire of additional notes. 7 days of notes sent per request. Awaiting response. --Note dated 05/07/25 at 12:08 pm read as follows: SS (Social Services) submitted 60 days worth of note to (Name of Out of State nursing facility) per their request. Will continue to follow up. --Note Dated 10/29/25 at 2:42 PM read as follows: (First name of Resident #63) daughter declined the transfer to the psychological facility, after SW (social worker) got her a bed. An interview with Nurse Consultant #131 at 1:15 pm on 06/09/26 confirmed that excerpts of Resident #63's medical record were sent to an out of state facility. She further confirmed the medical record contained no evidence that the MPOA gave permission for the records to be sent.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and resident and staff interviews, the facility failed to ensure Resident #49 was free from abuse. This was true for one (1) of five (5) residents sampled for abuse during the Long-Term Care survey process. Census: 109 Resident identifier: #49a) Resident #49 A policy titled Resident-To-Resident Altercations defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse. During an interview with Resident #49 on 06/03/26 at 3:40PM, she stated she was yelled at and called names over a man and it made me feel degraded. Upon further investigation, a nursing note dated 02/17/26 at 6:27 PM revealed, It was reported to this nurse that resident 94036643 verbally threatened to kick resident 94036540's but. Resident 94036540 reported that she didn't want resident 94036643 to kick her but. Resident 94036643 put on 1:1 [one-on-one]. PCP [primary care physician] and RP [responsible party] notified. A review of the facility reported incident (FRI) showed the resident who yelled at Resident #49 was supposed to be placed on one-on-one (1:1) observation at 2:30 PM on 02/17/26. A review of the Medication Administration Record (MAR) for 02/17/26 shows the other resident was not put on one-on-one (1:1) observation until 7:00 PM on 02/17/26. The FRI also showed that the incident was unverified despite both parties admitting it happened. In an interview with Social Services #100 on 06/03/26 at 3:00PM, she confirmed the offending resident was not on one-on-one (1:1) at the time of the incident with Resident #49. During an interview with Corporate Registered Nurse #131 on 06/03/26 at 3:50PM, she confirmed, per documentation, Resident #49 was yelled at by another resident who was supposed to be on one-on-one (1:1) observations.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review and staff interview the facility failed to implement their Abuse Investigation and Reporting policy. The policy indicated all allegations of abuse will be reported to required state agencies within two (2) hours of the incident. This was true for one (1) of nine (9) residents reviewed for the care area of abuse during the long term care survey process. Resident Identifier: #74 Facility Census: 109. Findings Included: a) Resident #74 A review of the facilities Abuse Investigation and Reporting policy found the following under the heading Reporting: . 2. An alleged violation of abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury A review of a reportable incident dated 01/19/26 involving alleged victim Resident #74 (female) and alleged perpetrator Resident #97 (male). Under the section what was reported the following was wrote: (First and Last name of female Resident #74) was sitting by nurses station (First name of male Resident #97) he rolled by and reached between (First name of female Resident #74's) legs and (First name of female Resident #74) smacked his hands away CNA redirected the residents. The date and time of the incident was listed as 01/19/26 at 1:12 PM. The facility identified this incident as sexual abuse. Further review of the reportable incident found the report was faxed to the state agency at 5:49 PM on 01/19/26 which was four (4) hours and 37 minutes after the time of the incident. An interview with Corporate Nurse #131 and the Nursing Home Administrator (NHA) at 1:44 PM on 06/04/26 confirmed this incident was not reported within the required two (2) hours		

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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 record review and staff interview the facility failed to ensure all allegations of abuse are reported to required state agencies within two hours of the alleged incident. This was true for one (1) of nine (9) residents reviewed for the care area of abuse during the long term care process, Resident Identifiers:#74. Facility Census: 109. Findings Included: a) Resident #74 A review of a reportable incident dated 01/19/26 involving alleged victim Resident #74 and alleged perpetrator Resident #97. Under the section what was reported the following was wrote: (First and Last name of Resident #74) was sitting by nurses station (First name of Resident #97) he rolled by and reached between (First name of Resident #74's) legs and (First name of Resident #74) smacked his hands away CNA redirected the residents. The date and time of the incident was listed as 01/19/26 at 1:12 PM. Further review of the reportable incident found the report was faxed to the state agency at 5:49 PM on 01/19/26 which was four (4) hours and 37 minutes after the time of the incident. An interview with Corporate Nurse #131 and the Nursing Home Administrator (NHA) at 1:44 PM on 06/04/26 confirmed this incident was not reported within the required two (2) hours.		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, record review and staff interview the facility failed to ensure Resident #77 received timely and adequate discharge planning when he indicated to facility staff it was his desire to return to the community. This was a random opportunity for discovery and was true for Resident #77. Resident Identifier: #77. Facility Census: 109. a) Resident #77 During an interview with Resident #77 in the afternoon of 06/01/26 he stated, I want to go home but I lived with my fiance and she don't want me there so I don't know what I will do. Resident #77 was admitted to the facility on [DATE]. A review of Resident #77's record found only one capacity statement which was completed on 04/07/26 which indicated the resident has capacity to make medical decisions. A review of Resident #77's Minimum Data Set with an Assessment Reference Date (ARD) of 03/02/26. Found Section Q. Was completed by interviewing the residents family and was coded to indicate the resident did not wish to return to the community and that active discharge planning was not underway. A review of Resident #77's care plan found the following care plan related to discharge: Focus Statement: Short tem Discharge plan: (First Name of Resident #77) is expected to be at the facility on a short term basis and return to the community. This focus statement was initiated on 03/04/26 and has not been revised since. The goal associated with this focus statement reads: Resident will return to the community successfully when ready thru the review period. This was also initiated on 03/04/26 and has a target date of 08/26/26. The interventions include: -- Coordinate with physician regarding discharge plans as indicated--make community DME referrals as indicated--refer for community resources as indicated and per resident/resident representative preference-- refer the resident to the local contact agency if indicated by the resident -- review and update discharge plans with the resident when needed A review of Resident #77's medical record found a Social Service Quarterly Note dated 05/22/26 completed by Social Worker #100. Under Section N. Quarterly Discharge Plan Review the following was noted: Mr. (Last name of Resident #77) could live alone with some assistance he has voiced he would like to find a place. During an interview with Social Worker #100 on the afternoon of 06/09/26 she indicated she was aware the resident wanted to go home. She stated, I just found that out and was going to start working on his discharge planning this week but have not had the chance. When asked about the care plan dated 03/04/26 and the social service note date 05/22/26 the social worker remained silent.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and staff interview, the facility failed to identify all mental disorders for Resident #99 on the Pre-admission Screening and Resident Review (PASSAR). This was true for one (1) of two (2) residents sampled for PASSAR during the Long-Term Care Survey Process. Census: 109 Resident identifier: #99 Findings included: a) Resident #99 The diagnosis list for Resident #99 includes bipolar disorder on admission, however, bipolar disorder is not included on the PASARR. In an interview with Social Services #100 at 1:15 PM on 06/03/26, it was confirmed that Resident #99 had bipolar disorder on admission but it was not included on the PASARR.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review, and staff interview the facility failed to ensure a resident who is unable to perform their own activities of daily living is provided assistance with completing them. This was true for one (1) of residents reviewed for the care area of Activities of Daily living during the long term care survey process. Resident Identifier: #20. Facility Census: 109. Findings Included: a) Resident #20 A review of Resident #20's medical record found that she was scheduled to receive a shower and/or bed bath on Mondays and Thursdays on day shift. Resident identified she preferred to take a bed bath instead of a shower. A review of the bathing report from 03/09/26 through 06/09/26 found the following time frames when Resident #20 did not receive her baths as required: 04/15/26 to 04/22/26 a total of seven (7) days between baths. 05/01/26 to 05/10/26 a total of nine (9) days between baths. An interview with Nurse Consultant #134 on the afternoon of 06/09/26 confirmed the above findings. She agreed that she should have received a bath or a refusal should have been documented, but neither occurred.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, record review, and staff interviews, the facility failed to ensure Resident #7 received glasses to maintain vision ability, furthermore, the facility failed to make payment for Resident #6's glasses in a timely manner to make sure she received them. This was true for two (2) of two (2) residents sampled for vision. Census: 109. Resident identifiers: #7, #6. a) Resident #7 On initial interview on 06/01/26 at 1:00PM, Resident #7 stated he went to the eye doctor a month or so ago, but never got his glasses. In an interview with Social Services #100 at 11:55 AM on 06/02/26, she stated, I don't know anything about it. As far as I know, they [Resident's glasses] could be sitting at that doctor's office. At 12:00 PM on 06/02/26, the Director of Nursing (DON) stated she did not know anything about new glasses, but she would check into everything. The facility produced one page of the visit note from the eye doctor visit on 03/06/26 which did not show any follow up information. In an interview with [NAME] Virginia Eye Consultants on 06/02/26 at 1:00 PM, the receptionist stated there are two (2) prescriptions for glasses waiting at the office. It was confirmed with the DON at 1:20PM on 06/02/26 that Resident #7 did not receive his glasses after his eye appointment and the facility made no effort to get further notes or glasses. b) Resident #6 During an interview with Resident #6 on 06/01/26 at 3:15 PM she stated, I saw the eye doctor eight (8) weeks ago and still have not received them. She stated, I asked the social worker about them and found out they had not been paid for but that was a few weeks ago and she still has not heard anything. A review of Resident #6's medical record found she saw the eye doctor in house on 04/16/26 and the invoice was sent to the facility on [DATE]. Social Worker #100 was asked to provide any information she had concerning Resident #6's glasses on the afternoon of 06/02/26. On the afternoon of 06/03/26 no information had been provided to the surveyor. The surveyor again asked for any information regarding Resident #6's glasses and the Nursing Home Administrator (NHA) stated they paid for them yesterday after the surveyor asked what was going on with them. The social worker then provided the following emails between Social Worker #100 and the in house eye doctor: Email from Social Worker #100 to the in house eye doctor sent on 05/12/26 at 2:41 PM read as follows, We have several residents that still haven't received glasses. Do you know when they may be in? (continued on next page)		

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

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reply received on from the in house eye doctor at 3:39 pm on 05/12/26, read as follows: Can you send me a list of who is still waiting as I will have to look in their charts to get the status. Social Worker #100 replied on 3:51 pm on May 12th 2026 which read as follows: (First and Last Name of Resident #)Traloni [NAME] and (First and Last Name of Resident #6) for sure. They keep asking and they were seen four weeks ago. Another reply from Social Worker #100 at 3:57 pm listed the following residents (First and Last Name of Resident #8), (First name of Resident #10 and a different last name), (First and Last Name of Resident #15), (First and Last Name of Resident #6). May Be more! Please let me know. Reply from in house eye doctor at 4:26 pm 05/12/26 read as follows: (First Initial and Last Name of Resident #15) Invoice was sent to the facility on [DATE]. (First Initial and Last name of Resident #6) invoice was sent to the facility on [DATE] (First and Last Name of Resident #8) - Invoice Sent to the facility on [DATE] (First name of Resident #10 and different last name similar to Resident #10's)- Not in our system. Email from Social Worker #100 to in house eye doctor on 05/12/26 at 4:42 pm read as follows: We did not receive them, were they signed for, how were they sent? Email from in house eye doctor at 9:56 am on 05/13/26 read as follows: The invoices will need to be paid in full before the glasses will be ordered. Email from Social Worker 100 to the in-house eye doctor on 05/13/26 at 10:02 am read as follows, What the Glasses were not sent because they need payment? Can I have the invoices and we will pay it. Please. Reply from the in-house eye doctor on 05/13/2026 at 10:12 am read as follows, Attached are all the invoices that will need to be paid before the glasses can be ordered. I did not find a (First name of Resident #10 and a Last Name similar to Resident #10) in our system; however, there is a (First and Last Name of Resident #10) with that same DOB (date of birth) and I have attached his invoice as well. Please let me know if you have any other questions. Social Worker #100 also provided a copy of a check for Resident #6's glasses, which was sent to the in house eye doctor on 06/02/26. The NHA confirmed the glasses were not paid until after the surveyor asked about them but it was taken care of then.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview, and staff interview the facility failed to ensure a resident with pressure ulcers receives necessary treatment and services to promote healing, and prevent new ulcers from developing by not removing the equipment that caused the pressure ulcer. This failed practice was found true for (1) one of (2) two residents reviewed for pressure ulcers during the Long-Term Care Survey Process. Resident identifier #12. Facility Census 109. Findings Include: a) Resident #12 During the initial interview on 06/01/26 at 2:15 PM, Resident #12 stated, I have sores on my left and one on my butt. I think they take good care of them. The one on my left foot comes from this trapeze bar base. They were supposed to take it out but have not done it yet. The observation showed that the trapeze bar was in place. It was on a metal stand that came approximately halfway down each side of the bed. An observation on 06/02/26 at 3:35 PM, revealed that the trapeze bar was still in the room. A record review on 06/03/26 at 8:34 AM, revealed an E interact Change in Condition assessment dated [DATE], under description reads as follows: Pressure area due to the way resident transfers putting weight on trapeze mobility device when transferring from bed to W/C (Wheelchair). A skin and wound note dated 05/26/26 at 11:00 AM reads as follows: Stage II noted to left out foot above stage 3 to left lateral foot (facility doctor name) present to look at wounds. Resident has his bed against the wall. Resident demonstrated how he transfers from bed to his wheelchair and his foot was resting on the base of his trapeze bar during transfer. Resident stated that this is how he injured his foot. Area cleansed with saline patted dry calcium alginate with silver applied and covered with ABD pad, kerlix, and ace wrap PCP and resident aware. A Nursing Note dated 05/29/26 at 2:22 PM that reads as follows: Spoke with resident on use of trapeze bar stated, He doesn't use it for transfers or bed mobility; he uses it for pull-ups. So he agreed with discontinuing trapeze r/t causing injury to foot stated, 'My foot is really more important than being able to do pull ups'. During an interview on 06/02/26 at 4:20 PM, Nursing Assistant (NA) #69 stated, When I transfer him he kind of uses one leg. He faces his bed and pivots around and then I hold the gate belt and he sets down. NA #69 confirmed that the trapeze bar was still in Resident # 12's room. During an interview on 06/03/26 at 10:00 AM, (Physical Therapy Assistant) PTA #128 stated, They removed the trapeze bar which was a contributing factor. We have recommended because of the extensive wound on his left foot that he be a Hoyer lift, but he refuses. During an interview on 06/03/26 at 4:20 PM, NA #69 confirmed that the Trapeze bar was still present in Resident #12's room. During an interview on 06/04/26 at 10:40 AM, the Director of Nursing (DON) confirmed that the trapeze bar had now been removed. The DON further confirmed that the facility left the trapeze bar in Resident #12's room for 13 days after identifying it as the cause of the pressure ulcer.		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to ensure residents received proper treatment and care to maintain mobility and good foot health. This was true for two (2) of Two (2) residents reviewed related to foot health. Resident Identifiers: Resident #98 and #57. Facility Census: 109. a) Resident #98 A review of Resident #98's hospital Discharge summary, dated [DATE] indicated the resident was to follow up with the podiatrist in two (2) to four (4) weeks regarding black spots on his toes. On 06/02/26 the facility was asked to provide the surveyor a copy of this consult because it could not be located in the medical record. Nurse Consultant #131 confirmed on 06/03/26 that Resident #98 had not been to a podiatrist; she presented a note indicating he had an appointment in April 2026, but it was cancelled by the podiatrist's office, and the facility had not rescheduled it. Further review of the resident record found that on 06/09/26 the facility called to reschedule the appointment and it was scheduled for 06/17/26. b) Resident #57 During the initial interview on 06/01/2026 at 12:30 PM, Resident #57 stated, Look how long my toenails are. I don't think I have ever seen a Podiatrist. The observation on 06/01/26 at 12:30 PM, revealed both feet with toenails approximately 1/2 an inch long, above the tip of the toes. The toenails appeared thick. A record review on 06/02/26 at 10:45 AM, revealed a Diabetes care plan for Resident #57 that read as follows: Focus: (Resident #57 name) is at risk for complications and blood glucose fluctuations related to diagnosis of Diabetes Mellitus. Goal: (Resident #57 name) will be free from complications secondary to diabetes thru the review period. Interventions: (continued on next page)		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Labs as ordered Observe for signs and symptoms of hyper/hypoglycemia and notify MD as indicated. Provide diabetic foot care and checks as needed. RD consult as needed. The medical record showed that Resident #57 was admitted to the facility on [DATE]. No Podiatry consultations were provided by the of survey. An Observation on 06/04/2026 at 11:16 AM, Resident #57's toe nails continue to be long and thick. Resident #57 stated, I wish they would cut these soon. During an observation and interview on 06/04/2026 at 11:18 AM, The Director of Nursing (DON) confirmed that Resident #57's toenails were long and stated, I will put her on the Podiatrist list and get the RN to cut them. c) Policy for Diabetes Mellitus A review on 06/04/26 at 1:00 PM of the policy titled {Diabetes Mellitus}, Section titled {Skin and Foot Care}, Number 5 reads as follows: Toenails should only be trimmed y personnel qualified to do so; the resident will be referred to a Podiatrist as needed and approved by the Physician/Practitioner.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, resident interview, record review, and staff order, the facility failed to provide oxygen services within accepted standards of practice. The physician's orders for the supplemental oxygen flow rate was not followed. This deficient practice had the potential to affect one (1) of one (1) residents reviwed for the care area of oxygen. Resident Identifier: #69. Facility Census: 109. Findings included: a) Resident #69 The facility's policy titled, Oxygen Administration, with no effective date given, gave instructions to Turn on the oxygen at the number of liters/minute as ordered by the physician/practitioner. Review of Resident #69's physician's orders showed an order written on 05/19/26 for Oxygen @ [at] 2 LPM/NC [liters per minute/nasal cannula] continuous. Verify O2 [oxygen] setting at eye level every shift for monitor related to chronic obstructive pulmonary disease, unspecified. On 06/01/2026 at 12:36 PM, Resident #69 was noted to be sitting in a chair in his room. He was receiving supplemental oxygen therapy via nasal cannula. The oxygen flow rate was set to 5 liters per minute. On 06/02/2026 at 11:31 AM, Resident #69 was noted to be sitting in a chair in his room. He was receiving supplemental oxygen therapy via nasal cannula. The oxygen flow rate was set to 5 liters per minute. Corporate Nurse #131 confirmed the oxygen flow rate was not set to the physician prescribed rate. She asked the resident if he had adjusted the oxygen rate. Resident #69 stated he did not adjust the rate. He stated he usually used 2 liters of oxygen. No further information was provided through the completion of the survey.		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and staff interview the facility failed to ensure they had a Registered Nurse (RN) for eight (8) consecutive hours daily. This failed practice has the potential to effect more than an isolated number of residents currently residing in the facility. Facility Census: 109. A review of the facility's hours per patient day (HPPD) found they had 4.33 hours of RN coverage for 03/22/26. An interview with the Nursing Home Administrator (NHA) on 06/03/26 at 1:30 PM confirmed they did not meet the eight (8) hour requirement on 03/22/26.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, and staff interview, the facility failed to follow accepted standards of practice for medication labeling and storage. A multi-use vial of tuberculin purified protein derivative (PPD) had been in use longer than the time period recommended by the manufacturer. This was a random opportunity for discovery. Facility Census: 109. Findings included: a) Side 2 Medication RoomThe facility's policy titled, Vials and Ampules of Injectable Medications, with effective date September 2018 and revision date August 2020, stated that medication in opened multi-dose vials may be used until the manufacturer's recommended expiration date. The expiration date triggered by opening the vial should be available on the medication label or packaging insert. On 06/03/2026 at 7:54 AM, the medication room for side 2 of the facility (C and D hallways) was inspected with Licensed Practical Nurse (LPN) #11 in attendance. In the refrigerator was a multi-use vial of tuberculin purified protein derivative (ppd), a medication given by injection to determine whether a resident has had tuberculosis. The vial was dated 04/30/26 to indicate the date the vial had first been accessed. The box containing the vial gave the instructions that once entered, the vial should be discarded after 30 days. LPN #11 confirmed the multi-use vial of tuberculin ppd had been in use more than 30 days and should have been discarded. No further information was provided through the completion of the survey process.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview, and staff interview, the facility failed to ensure residents received dental services to meet their needs. This deficient practice had the potential to affect two (2) of five (5) residents reviewed for the care area of dental services. Resident Identifiers: #4 and #26. Facility census: 109. Findings included:a) Resident #4 Review of Resident #4's physician's orders showed an order written on 04/28/26 for Resident needs referral to dental for mouth pain. A change in condition assessment had been completed on 04/28/26 at 6:55 PM which stated, Resident is having continued complaints of mouth pain in the upper teeth. Tylenol administered as ordered. Documentation showed Tylenol was effective in relieving the resident's pain. Review of Resident #4's electronic health record showed the resident had a dental appointment on 12/04/24 for a toothache. He was prescribed an antibiotic. No reports for a more recent dental appointment were located in the resident's records. On 06/02/2026 at 4:14 PM, Registered Nurse (RN) #119 stated 12/04/24 was Resident #4's most recent dental appointment. She stated the resident was on the list for a dental appointment, but an appointment had not yet been made. b) Resident #26 During an initial interview on 06/01/26 at 1:13PM, Resident #26 stated she had an appointment for dentures about a year ago. However, she states her wheelchair would not fit through the door and therefore she was not seen. A review of the records show Resident #26 had an appointment on 02/18/25 for denture evaluation with Dr. [NAME]. Across the top of the paper in black marker is written: Please use smaller wheelchair! The facility could not produce evidence of having rescheduled this appointment. In an interview with Director of Nursing at 3:25PM on 06/02/26, she confirmed Resident #26 has not had any dental follow up since appointment on 02/18/25.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER Mountain View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 107 Miller Drive Ripley, WV 25271	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on Resident Interview, record review, observation and staff interview the facility failed to ensure Resident #20's food preferences were identified and honored as required. This was a random opportunity for discovery during the long term care survey process. Resident Identifier: #20. Facility Census: 109. a) Resident #20 During an interview on 06/01/26 Resident #20 was asked how the food at the facility was she stated, The food sucks. I am a vegetarian and get meat constantly. I have told them this for years. A review of Resident #20's medical record found a quarterly dietary profile dated 05/15/25. This was the most recent dietary profile in the medical record. This dietary profile failed to identify the fact the resident does not like to eat meat. The dislikes section was left blank. An observation of the noon time meal on 06/02/26 found the resident was served spaghetti with meat sauce. The nurse aid who was assigned to the resident looked at the tray and said, I told them this morning not to send that because she doesn't eat meat. Observation of the breakfast meal on 06/03/26. Found the resident had sausage, oatmeal and eggs and pureed blueberry muffin bake. All foods were pureed. The nurse aide who was feeding the resident stated she is not a fan of meat so she did not eat the sausage. The resident chimed in and stated I am a vegetarian. An Interview with the Certified Dietary Manager (CDM) and Corporate Nutritional Consultant at 10:05 am on 06/03/26 found they had not completed a Dietary Profile since 05/15/25 she stated they should have been completed quarterly. She stated the resident told her the only meat she likes is chicken in chicken noodle soup. She stated, the resident told them she did not want pork or beef but chicken would be okay. She stated the next assessment would have been due in two (2) days. She then agreed it was actually overdue and had not been completed in over a year.		

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NAME OF PROVIDER OR SUPPLIER Mountain View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 107 Miller Drive Ripley, WV 25271	
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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to offer residents pneumococcal vaccinations within accepted standards of practice. This deficient practice had the potential to affect one (1) of five (5) residents reviewed for the care area of vaccinations. Resident Identifier: #76. Facility Census: 109. Findings included: a) Resident #76 The facility's policy titled, Pneumococcal Vaccine, with no implementation date given, stated upon admission residents would be assessed for eligibility to receive pneumococcal vaccines. Pneumococcal vaccination would be offered to the residents within 30 days of admission unless the vaccine was contraindicated or the resident had already been vaccinated. Residents would be offered pneumococcal vaccination based on Center for Disease Control (CDC) or Advisory Committee on Immunization Practices (ACIP) guidelines. Review of Resident #76's immunization records showed the resident had received pneumococcal polysaccharide (PPV23) vaccination on 08/07/20, which was before he was admitted to the facility. An undated vaccine consent form in Resident #76's medical records showed the resident consented to PPSV23 vaccination after admission to the facility. The resident was [AGE] years old and had been admitted in July 2025. The ACIP/CDC guidelines for pneumococcal vaccines for adults over [AGE] years of age, available on-line on the CDC Website, stated adults vaccinated only with the PPSV23 vaccine should be offered vaccination with Pneumococcal Valent Conjugate 20 (PCV20) vaccine, Pneumococcal Valent Conjugate 21 (PCV21) vaccine, or Pneumococcal Valent Conjugate 15 (PCV15) vaccine. The vaccine should be given at least one (1) year after the PPSV23 vaccine. Review of Resident #76's medical records showed no documentation that the resident had been offered or had received an additional pneumococcal vaccination. On 06/09/2026 at 11:48 AM, the Infection Prevention nurse confirmed there was no documentation that Resident #76 had been offered or had received an additional pneumococcal vaccination as recommended in CDC guidelines. No further information was provided through the completion of the survey process.		

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NAME OF PROVIDER OR SUPPLIER Mountain View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 107 Miller Drive Ripley, WV 25271	
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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and staff interview, the facility failed to offer residents COVID-19 vaccinations within accepted standards of practice. This deficient practice had the potential to affect two (2) of five (5) residents reviewed for the care area of vaccinations. Resident Identifiers: #11 and #24. Facility Census: 109. Findings included:a) Policy and Standards of Practice Review The facility's policy titled, COVID-19 Vaccination for Residents, with no implementation date given, stated COVID-19 vaccinations would be administered according to Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), Food and Drug Administration (FDA), and manufacturer guidelines. On 11/04/25, the CDC published guidance that the COVID-19 2025-2026 vaccine was recommended for people ages six (6) months and older. b) Resident #11Resident #11 was admitted to the facility in January 2026. The resident's medical records contained no documentation the resident had been offered COVID-19 2025-2026 vaccination until 06/04/26. On 6/4/2026 at 5:26 PM, a nursing note was written which stated, Spoke with [resident] regarding the COVID-19 vaccine. Educated per VIS [vaccine information sheet] dated 1/31/2025. [Resident] declined vaccine at this time, verified x 2 nurses.c) Resident #24Resident #24 was admitted to the facility in 2024. The resident's medical records contained no documentation the resident had been offered COVID-19 2025-2026 vaccination until 06/04/26. On 6/4/2026 at 4:50 PM, a nursing note was written which stated, Resident has capacity, spoke with him regarding COVID-19 vaccine. Educated via using VIS sheet. Resident stated he did not want it. Witnessed by 2 nurses.d) Infection Preventionist Interview On 06/09/2026 at 10:10 AM, the Infection Prevention Nurse confirmed Resident #11 and Resident #24 were not offered the COVID-19 2025-2026 vaccination until 06/04/26, which was after surveyor had asked for evidence that the vaccine had been offered.		