STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515147	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hidden Valley Center	422 23rd Street Oak Hill, WV 25901

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food safety. Additionally, the facility failed to follow the proper sanitation practices for the kitchen and the food preparation equipment. This practice had the potential to affect all of the residents. Facility census: 74. Findings include:a) Healthcare Services Group (HCSG) policy #28 titled Environment states:All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition.The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation.All food contact surfaces will be cleaned and sanitized after each use.The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces.The Dining Services Director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food service equipment and surfaces. b) The HCSG Policy #27 titled Equipment states: All foodservice equipment will be clean, sanitary, and in proper working order. All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials. All staff members will be properly trained in the cleaning and maintenance of all equipment. All food contact equipment will be cleaned and sanitized after every use. All non-food contact equipment will be cleaned and free of debris. The Dining Services Director will submit requests for maintenance or repair to the Administrator and / or Maintenance Director as needed. c) The HCSG policy #19 titled Food Storage: Cold Foods states: All Time / Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code. An accurate thermometer will be kept in each refrigerator and freezer. A written record of daily temperatures will be recorded. d) The HCSG policy #22 titled Ware washing states: All dishware, service ware, and utensils will be cleaned and sanitized after each use. All dishware will be air dried and properly stored. 04/13/26 at 10:36 AMe) Initial kitchen observationThe Healthcare Services Group (HCSG) District Manager (DM) accompanied me during this walkthrough and verified the findings.The reach-in refrigerator did not have a documented temperature for PM shift on 04/12/26 or for AM shift on 04/13/26.The can opener was soiled.The box of food thickener located in the dry storage room did not have an open or use by date.The steamer was broken down.The inside of the microwave was soiled.The toaster crumb tray was soiled.The ice scoop was in the ice machine stuck inside of the ice.There was one food cart soiled inside and out.There were three (3) ceiling vents that were soiled with debris.The HCSG DM stated that the temps for the reach-in refrigerator were missed. I will have the can opener based cleaned also. I will put a date on the food thickener. We are supposed to get a new steamer. He let the cook know about the toaster and microwave needing to be cleaned. He removed the ice scoop from the ice and had it sanitized and stored properly. He stated the food cart will be cleaned now, we were running behind today. He stated that I will put the ceiling vents needing to be cleaned in the maintenance system called TELS. 04/13/26 at 11:06 AM The microwave located in nourishment room [ROOM NUMBER] was soiled. 04/15/26 at 11:30 AM Follow up visit to the (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	kitchen findings: There was a soiled latex glove sitting on the counter top beside the steamer.There was one (1) soiled cleaning cloth sitting on the counter top beside the food processor.The HCSG DM tested two (2) buckets with a sanitizer test strip, neither one registered any sanitizer. The were located on a shelf under the table beside the steam table.There was one (1) oven rack sitting directly on the floor.There was one (1) cold food container not stored correctly.There was no sanitizer bucket log available.The HCSG DM stated that the oven rack should be anywhere but there. He also stated that the sanitizer bucket log should be hanging up, but I cannot find it. He told the kitchen staff that you need to place the cleaning cloths in a bucket with sanitizer, when not in use. I asked the DM for a copy of the last six (6) months of the sanitizer bucket log. He could only provide me with half of November 2025 and all of December 2025 and January 2026. Nothing for February, March or April 2026. 04/15/26 at 12:07 PM The meal trays that were being used to serve the residents on Mary's Garden unit were wet nesting. The DM stated that the meal trays should have been air dried prior to the lunch meal service.

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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. Based on record review, staff interview and observation, the facility failed to provide a homelike dining environment for the resident's in the facility's main dining room. This failed practice had the potential to affect more than a limited number of residents. Facility Census: 74.Findings included:a) On 04/13/26 at 11:20 AM, the Dining Room task was initiated in the facility's main dining room. The wallpaper beside the kitchen door was torn in multiple places and had separated at the seams. Holes where screws had been removed and multiple screws were observed in the wall. [NAME] glue was spread over the wall in places. The length of the damaged wall was approximately eight (8) feet in length.On 04/13/26 at 11:26 AM, Administrator #79 confirmed the wall damage and reported there was no maintenance director at this time, but the repair was on a list. At 11:30 AM, Administrator #79 reported the wall repair would be a priority this afternoon. The facility's Policy and Procedure for Meal Service stated, Meal service may occur in dining room, patient rooms, and other suitable locations that promote a homelike environment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review and staff interview, the facility failed to ensure the residents' environment remains as free, from accident hazards as possible, by leaving a medication cart unlocked. This was a random opportunity for discovery. Facility Census: 74.a) Medication Cart On 04/15/26 at 4:40 PM, staff observed an unlocked medication cart near the nurses' station. At this time, no staff members were near the medication cart. Assistant Administrator #83 was present during this observation. Assistant Administrator #83 entered the nurses' station and asked, Whose medication cart is this? Licensed Practical Nurse (LPN) #76 stated, It's mine . I usually always lock it. Assistant Administrator #83 confirmed the medication cart was unlocked while unattended. b) Facility Medication Administration Policy On 04/21/26 at 9:00 AM, Corporate Registered Nurse (RN) #80 was notified of the observation from 04/15/26. Corporate RN #80 provided the facility policy entitled Medication Administration General Guidelines, Number 17, which stateD, During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse . The cart must be visible to the personnel administering medications when unlocked.

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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 food tray temperatures, resident interviews and staff interviews, the facility failed to serve food that was palatable and at a safe and appetizing temperature to prevent foodborne illness. The facility failed to ensure hot foods were served hot. This failed practice was true for one (1) of one (1) meal trays tested throughout the survey process. Residents identified: #20 and #50. Facility census: 74.Findings include: a) Healthcare Services Group policy #16 titled Food: Preparation states: All foods are prepared in accordance with the FDA Food Code. b)This surveyor made a second visit to the kitchen and observed the lunch meal service. When the dietary staff started to make the meal trays for the residents located on Mary's Garden Memory Unit, I asked for a test tray to be made and sent. After all the residents were served at 12:39 PM, the Healthcare Services Group (HCSG) District Manager (DM) used a thermometer to take the temperatures of each food item served. The Administrator was present for this. The temperatures were as follows: Hotdog 110.7 degrees Fahrenheit (F)Baked beans 128.9 degrees FChicken noodle soup 146 degrees FVanilla ice cream 27.4 degrees FAt the time of receipt by the resident, foodsshall be at a temperature of no less than 120 F for hot foodsand no more than 50 F for cold foods. Per the Food Code.c) Resident #20 stated the food is terrible.d) Resident #50 stated some food is so bad, I have to spit it out.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review, resident interview, and staff interview, the facility failed to maintain an infection control program during medication administration and offering hand hygiene prior to the meal service. These were random opportunities for discovery. Resident identifiers: #45, #84, #41, #87 and #50. Facility Census: 74. Findings Include: a) Resident #45 On 04/21/26 at 8:15 AM, observations were made of Licensed Practical Nurse (LPN) #24 during medication administration. LPN #24 touched the pills while removing them from the bubble pack: -Norvasc 5mg (milligram) -Depakote DR (delayed release) 250mg -Oxybutyin ER (extended release) 10mg --Lasix 40mg --Prednisone 20mg On 04/21/26 at 9:01 AM, LPN #24 was asked, Do you normally touch the pills as you pop them out of the bubble packs? LPN #24 stated, oh did I? .I didn't realize I did, b) Resident #84 On 04/21/26 at 8:21 AM, observations were made of LPN #24 during medication administration. LPN #24 touched the pills while removing them from the bubble pack and administered insulin without donning gloves: -Norvasc 5mg -Doxycycline 100mg -Eliquis 2.5mg -Potassium Chloride 10meq (milliequivelant) -Lantus 15 units On 04/21/26 at 9:01 AM, LPN #24 was asked, Do you normally touch the pills as you pop them out of the bubble packs? Do you normally administer insulin without wearing gloves? LPN #24 stated, Oh, did I? . I didn't realize I did . You are right . I didn't wear gloves. c) Resident #41 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/21/26 at 8:49 AM, observations were made of LPN #24 during medication administration. LPN #24 touched the pills while removing them from the bubble pack: -Eliquis 5mg -Novantik 25mg -Protonix 40mg On 04/21/26 at 9:01 AM, LPN #24 was asked, Do you normally touch the pills as you pop them out of the bubble packs? LPN #24 stated, oh did I? .I didn't realize I did, On 04/21/26 at approximately 9:06 AM, the Corporate Registered Nurse (RN) #80 was notified regarding LPN #24 touching the pills and administering insulin without donning gloves. Corporate RN #80 stated, they know what to do . d) Resident #87 On 04/13/26 at 12:25 PM, nurse aides were observed passing lunch trays on A hallway. Resident #87 received her lunch tray at 12:27 PM. The resident was asked, Did the staff offer you a way to complete hand hygiene? Resident #87 stated, No . they didn't. On 04/13/26 at approximately 12:33 PM, the Director of Nursing (DON) was notified that residents were not offered a way to complete hand hygiene on A hallway. The DON stated, She hasn't been given a lunch tray yet. At this time, the DON observed the resident eating the food from her lunch tray. The DON stated, hand hygiene should be offered to the resident from the staff. On 04/13/26 at approximately 1:15 PM, Corporate RN #80 was advised Resident #87 was not offered a way to complete hand hygiene prior to the noon meal. The Corporate RN #80 stated, staff should be offering residents a way to complete hand hygiene. e) Resident #50 - On 04/13/26 at 11:50 AM, during the Main Dining Room Investigation, Resident #50 returned to the dining room for the lunch meal. The resident's lunch tray was set up by Activity Assistant #85. No hand hygiene was observed to be performed upon return to the main dining room. At 11:55 AM, Activity Assistant #85 confirmed the resident did not receive hand hygiene upon return to the dining room. The facility's policy and procedure for Patient Hand Hygiene stated, Staff should assist patient/residents (hereinafter patient) with hand hygiene after toileting and before meals, as needed.

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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, observation and staff interview, the facility failed to promote respect and dignity during care for a resident during mealtime. This failed practice had the potential to affect a limited number of residents. Resident Identifier: #48. Facility Census: 74. Findings included: a) Resident #48 On 04/13/26, during the Dining Room observation on the unit (Mary's Garden), Nurse Aide #41 was observed feeding Resident #48 lunch. The nurse aide did not give the resident time to chew and swallow before repeatedly offering another bite during the lunch meal. The resident would shake her head 'no', move her head away from the presented food bolus and verbally state No! This occurred when feeding attempts were made before she was given adequate time to chew and swallow what was already in her mouth. Nurse Aide #41 repeatedly asked the resident, Wanna bite? and put the utensil to the resident's mouth before the resident swallowed. The resident spit the food out of her mouth once and Nurse Aide #41 stated, Don't spit .that's yucky. The resident attempted to feed herself with her fingers and a fork during the meal. Salt was put on the resident's food without asking, and no more food was consumed. Nurse Aide #41 fed the resident large bites, and the resident coughed once during the lunch meal. On 04/12/26 at 12:58 PM, Administrator #84 for Mary's Garden confirmed the issue and stated, Ok, I'll talk to her. The facility's Policy and Procedure for Meal Service stated, Staff will promote care for patients during meal service in a manner and environment that maintains or enhances patient dignity and honors the patient's right to make choices about meal preferences.

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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 interview and record review, the facility failed to ensure they implemented their policy on abuse to ensure allegations of abuse were properly identified, reported, and thoroughly investigated in accordance with the facility's abuse prevention policies. This deficient practice placed residents at risk for unrecognized and unaddressed abuse. Resident identifier: #25. Facility census: 74. Findings included:a) Resident #25On 04/20/26 at approximately 12:59 PM, the surveyor interviewed Administrator #18. During the interview, the Administrator acknowledged observing Resident #25 unclothed and confirmed the incident occurred. However, the Administrator stated the facility did not classify the incident as an allegation of sexual abuse. The Administrator reported, I think because she was fully clothed. There was no evidence of her being touched. The Administrator further indicated that the facility conducted interviews and completed a skin assessment as part of its review process.On 04/20/2026 at approximately 12:59 PM, the surveyor interviewed Administrator #18. During the interview, the Administrator acknowledged a resident was observed unclothed and confirmed the incident occurred within the facility. The Administrator stated the facility did not classify the incident as an allegation of sexual abuse, reporting, I think because she was fully clothed. There was no evidence of her being touched. The Administrator further indicated staff interviewed the individuals involved and completed skin assessments of the residents.A review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy revealed residents had the right to be free from abuse, including sexual and physical abuse. The policy further indicated that the facility maintained a facility-wide commitment and allocated resources to protect residents from abuse by anyone, including other residents. The policy required the facility to establish and implement a QAPI review and analysis process for reports, allegations, or findings of abuse.A review of the facility's Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy revealed all reports of resident abuse were to be reported and thoroughly investigated by facility management. The policy further directed that findings of all investigations were to be documented and reported.These findings were reviewed and confirmed with Corporate Nurse #80 on 04/21/2026 at approximately 10:00 AM.

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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 report an allegation of physical abuse between residents within two (2) hours of the incident. This was discovered during an investigation into a Facility Reported Incident (FRI) and was true for Resident #28. Resident Identifier: #28. Facility Census: 74. Findings Include: a) Resident #28 A review of a Facility Reported Incident (FRI) dated 11/09/24 found the following: A co-resident punched the resident in the shoulder. An X-ray was completed, and the resident was not injured. The incident occurred on 11/09/24 at 12:40 PM. A further review of the initial report showed it was filed on 11/09/24 but no time was identified. A further review of the information provided by the facility found no fax confirmation sheet to identify when the facility submitted the report. The five-day follow-up was reviewed and showed the fax confirmation sheet was attached, indicating when the five-day follow-up was submitted. The nursing home administrator (NHA) was asked to provide the fax confirmation sheet for the initial report filed on 11/09/24. On the afternoon of 04/21/26 the NHA confirmed she could not find anything that would prove what time the initial report was filed.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on a review of a facility reported incident (FRI) and staff interview it was determiend the facility failed to use the results of the investigation to determine the appropriate action to take regarding education of staff following a resident's fall with major injury. Resident identifier: #78. Facility census: 74. a) Resident #78 An investigation for a Facility Reported Incident (FRI) was initiated on 04/20/26. A random discovery was found pertaining to an additional FRI dated 06/13/25 that was reviewed during the investigation. It was determined the facility failed to implement corrective action for staff education following a fall with major injury for Resident #78 for FRI dated 06/13/25. The Initial Report of Allegations dated 06/13/25 stated the resident had a fall and was sent to the hospital. The hospital called the facility and stated the resident had a fracture of the right shoulder and collarbone on 06/14/26. The Five-Day Follow-Up Investigation Report, submitted 06/18/25, stated the nurse assessed the resident for injuries, noting a hematoma to the top right side of her scalp at the time of the incident. Resident complained of right knee pain on assessment. The resident's Medical Power of Attorney requested the resident be sent to the Emergency Room. A verbal report from the emergency room was received by the facility that the resident had sustained a right scapula fracture. The facility's actions to be taken as a result of the investigation or allegation stated, All staff are being educated on safe resident handling. Education provided to the state surveyor was completed on 06/18/25 for two (2) nurse aides only. No training was provided to additional staff members. Corporate Registered Nurse #80 confirmed two (2) staff members were educated for the FRI dated 06/13/25. \

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to provide an accurate Minimum Data Set (MDS) assessment upon discharge for Resident #79. This was true for one (1) of four (4) residents reviewed under the care area of discharges. Resident Identifier: #79. Facility Census: 74.Findings Include: a) Resident #79 On 04/21/2026 at 1:20 PM, a record review was completed for Resident #79. The review found the resident was discharged from the facility on 08/27/24. The resident would not be returning to the facility. However, the MDS, dated [DATE], indicated the resident was discharged but return to the facility was anticipated. On 04/21/26 at 1:40 PM, Corporate Nurse #80 confirmed the resident was discharged from the facility and did not return.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based upon record review and staff interviews, the facility failed to refer one (1) of one (1) residents who had a newly evident serious mental health disorder diagnosis for a level II review. This was true for one (1) of one (1) records reviewed. Resident identifier: #20. Facility census: 74. a) Resident #20 On 04/14/26 During a record review for Resident #20, the surveyor could not find the level II PASARR. 04/15/26 9:22 AM Record review and interview revealed that on 03/27/26 a PASARR was completed on Resident #20. A level II was identified as needing to be completed and never was. At 8:58 AM, the surveyor asked the Administrator why the Level II was not completed as required. She stated, I will find out and get back to you. 04/15/26 11:08 AM On 04/15/26 at 11:08 AM Corporate nurse (CN) #80 stated, The level II PASARR has not been completed yet, but is scheduled for tomorrow (04/16/26). 4/15/26 09:45 AM a reivew of a General Note revealed, A phone call was made to Level II Evaluator (Name and phone #) regarding the completion of the Level II Evaluation. (Name) reported that she is coming to facility to complete the Level II Evaluation on 4/16/26 (tomorrow). IDT notified. Record review on 04/21/26 at 11:32 AM revealed, the level two (2) PASRR was completed on 04/16/26 for Resident #20 by Psychological Consultation & Assessment Inc.

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure a resident's Pre-admission Screening and Resident Review (PASARR) included a diagnosis of Post-Traumatic Stress Disorder (PTSD). This was true for one (1) of 28 residents reviewed during the survey process. Resident #13. Facility Census: 74. Findings Include: a) Resident #13 Resident #13 was admitted on [DATE]. A review of the resident's comprehensive minimum data set (MDS) with an assessment reference date (ARD) of 03/03/26 revealed a diagnosis of Post-Traumatic Stress Disorder (PTSD). A review of the PASARR dated 02/20/26 found that the diagnosis of Post-Traumatic Stress Disorder (PTSD) was not included in the PASARR. On 04/13/26 at 4:00 PM, Corporate Registered Nurse (RN) #80 confirmed the PTSD diagnosis was not included on the PASARR.

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	515147	A. Building B. Wing	04/22/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and staff interview, the facilty failed to develop a care plan regarding a urinary catheter for Resident #5 and failed to implement a care plan for blood glucose monitoring for Resident #8. Resident Identifiers: #5 and #8. Facility Census: 74.a) Resident #8 Review of clinical documentation revealed a blood glucose (BG) result of 67 mg/dL on 04/1/26 at 08:07 AM The resident's care plan specified that the physician must be notified for blood glucose readings less than 70 mg/dL or greater than 450 mg/dL. However, the medical record contained no evidence that the physician was notified of the low blood glucose result as required by the care plan. This failure to implement the care plan interventions placed the resident at risk for delayed recognition and treatment of hypoglycemia. This was confirmed with Corporate Nurse #80 on 04/15/26 at approximately 9:00 AM. Findings Include: b) Resident #5 On 04/20/2026 at 11:40 AM, a record review was completed for Resident #5. The review found on the care plan, a incomplete focus area for a urinary catheter. The focus area states,Resident requires indwelling (supra-pubic or foley or urostomy) catheter due to other:_____. (Typed as written.) The resident did require an 18 french (FR) foley catheter for urinary retention and obstruction. On 04/21/2026 at 10:49 AM , the Corporate Registered Nurse (RN) #80 confirmed the focus area had not been developed to indicate the type of catheter or the reason for the catheter.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and staff interview, the facility failed to ensure a resident's plan of care was updated for a Change in Condition (CIC). This failed practice had the potential to affect a limited number of residents. Resident Identifier: #46. Facility Census: 74.Findings included: a) Resident #46 A Change in Condition (CIC) was completed on 04/14/26 for Resident #46 for the following: Nursing observations, evaluation, and recommendations are: resident was scratching right cheek and left a scratch. Fingernails were checked and were short. Resident was educated not to scratch face. A scratch was observed on the resident's right cheek by the state surveyor on 04/13/26 and 04/14/26. The resident's care plan was reviewed and no update was found for the CIC.b) On 04/20/26 at 11:50 AM, Corporate Registered Nurse #80 confirmed that the Change of Condition for Resident #46 was not initially updated on the care plan and stated, I updated the care plan.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, resident interview and observation, the facility failed to provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests, and the physical, mental, and psychosocial well-being of the residents. This failed practice had the potential to affect a limited number of residents. Resident Identifiers: #68 and #69. Facility Census: 74.Findings included: a) Resident #68 On 04/13/26, during the initial interview process, Resident #68 stated, I don't get to go outside enough. I'm an outdoor person. The resident stated that the facility Need[s] to have more activities. The resident was waiting for his lunch and stated it was a long break before now and suppertime.The resident's care plan stated, It is important for me to go outside when the weather is good and enjoy eating/drinking, napping, sitting, talking/visiting, walking, sitting with wife. b) Resident #69 On 04/13/26, during the initial interview process, Resident # 69 stated, I'm putting on weight just sitting here. The resident reported she like it at the facility, but she was bored, she wanted/needed something to do and got tired of sitting. The resident stated, I tell them I'll help - tell me they don't need no help. The resident stated, I want something to do .pick up, clean up, put up . The residents care plan stated, That it is important that she has the opportunity to engage in daily routines that are meaningful and relative to her preferences. and the resident will have opportunities to make decisions/choices related to/for self-directed involvement in meaningful activities. c) On 04/15/2026 at 10:15 AM to 12:15 PM, activities provided for the residents were observed. Observation of Mary's Garden included: 10:15 AM - Residents were watching TV.10:30 AM - Named Capitols of US - cognitive activity and phrase completion activity Ex. Hit below the . with the Activity Director.10:50 AM to 11:30 AM - Watching TV - The [NAME] Hillbillies.11:19 AM - Administrator for Mary's Garden #84 was observed working with one resident on a puzzle.11:30 AM - Coloring sheets for three (3) residents in dining room.11:46 AM - Reminiscing about gardens in TV room with the Activity Director. Wednesday's Calendar for April 2026 stated: 10:00 AM Individual 1:1, 10:30 AM Outdoor Activity, 11:00 AM Social Activity and 11:30 AM Sensory Activity. On 04/15/26 at 11:50 AM, Administrator for Mary's Garden #84 confirmed the weather was appropriate for the residents to go outside and confirmed the activities were not provided as scheduled. d) The facility's policy and procedure for Therapeutic Program stated, the purpose was To provide therapeutic programming based on patients' interests, abilities, and disease stage. To optimize patients' existing skills, functional independence, and mental status. To maintain patients' dignity and self-esteem and promote success.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. The facility failed to follow physician orders regarding required notification parameters for abnormal blood glucose results. Resident #8.The physician order directed staff to notify the physician when blood glucose levels were less than 70 mg/dL or greater than 450 mg/dL. On 4/1/2026 at 08:07, a blood glucose reading of 67 mg/dL was obtained and documented; however, the physician was not notified of this abnormal result.During confirmation on 4/15/2026 at 4:30 PM with Corporate Nurse, it was acknowledged that physician notification did not occur as required. This failure to follow physician orders placed the resident at risk for delayed medical intervention and potential adverse outcomes related to hypoglycemia.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to ensure pharmacy recommendations were acted upon by the resident attending physician. This was true for one (1) of six (6) residents reviewed for the care area of unnecessary medications. Resident Identifier: 72. Facility Census: 74. Findings Include: a) Resident #72 A review of Resident #72's medical record found a pharmacy recommendation dated 10?04/25 which read as follows: This resident is diagnosed with dementia and receiving the antipsychotic Zyprexa 5 mg twice daily. Please indicate the appropriate clinical situation the continued use of this medication: () Behavioral symptoms present a danger to the resident or other AND one or both of the following() Symptoms identified due to mania or psychosis (auditory, visual hallucinations, delusions (paranoia or grandiosity) or () Behavioral interventions have been attempted and included in the plan of care. Resident continues to benefit from continued therapy. Further review of this recommendation the attending physician placed a check mark in the parentheses in front of the following statement: () Behavioral symptoms present a danger to the resident or other AND one or both of the following However the last two statement both remained unchecked. The attending physician signed the recommendation on 10/29/25. An interview with the the Market Clinical Advisor in the afternoon of 04/20/26 confirmed the physician did not completely address the pharmacy recommendation. No NotesWOLFE, [NAME] (72) Lucas, [NAME] (31826) - RESIDENT NOTE No Notes

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff interview, the facility failed to ensure a Physician's Order for Scope of Treatment (POST) and eight (8) consents were signed and dated by Resident #13, who has capacity, and ensure a resident's code status was correctly documented in the medical record for Resident #48. This was true for two (2) of 28 residents reviewed during the survey process. Resident Identifiers: Resident #13 and #48. Findings Include: a) Resident #13 On 04/14/2026 at 1:12 PM, a record review was completed for Resident #13. The review found the resident had capacity to make medication decisions. The physician's determination of capacity was completed by the facility physician on 03/04/26. Upon further review, the following forms and consents were not signed by the resident: --POST form --Influenza Vaccine informed consent --Vaccination informed cosent/declination for varicella (chicken pox), shingles, respiratory syncytial virus (RSV), Measles, Mumps, Rubella, Varicella (MMRV) and Tetanus, Diptheria, Pertussis (Tdap) --Psychotropic Medication Administration Administration Disclosure --Patient Informed Consent or Declination COVID-19 Vaccine 2025-2026 --Consent and Authorization to Screen, Evaluate and Treat by MTC care --Pneumococcal Vaccine Informed Consent --Consent for Wound Photography The above listed consents were signed by the resident's spouse. On 04/14/26 at 2:30 PM, Corporate Registered Nurse (RN) #80 stated, he had a stroke and he cannot sign his name.Corporate RN #80 was asked, Is there any documentation to verify the resident wanted his spouse to sign the consents? The Corporate RN stated, no there is no documentation to verify this .I understand .the reason needed to be documented and the consent could have been taken verbally with 2 (two) witnesses. b) Resident # 48 On 04/13/26, Resident's #48's Advanced Directive was reviewed. The Resident's Advance Directive Acknowledgement Form was marked, Do not perform cardiopulmonary resuscitation. and was signed by the physician on 04/01/26. The resident's order stated , DO NOT RESUSCITATE (DNR). COMFORT MEASURES. NO ARTIFICIAL MEANS OF NUTRITION. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the documentation review, a physician progress note, dated 04/01/26, was initiated on 04/02/26 and signed on 04/06/26 stating that the resident was a Full Code. A physician's progress note dated 04/08/26 also stated that the resident was a Full Code. On 04/14/26 at 3:45 PM, the Director of Nursing confirmed the physician progress notes documenting Full Code. and stated, Okay.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on resident interview, staff interview, record review and observation, the facility failed to ensure a call light was placed within a resident's reach while in bed. This failed practice had the potential to affect a limited number of residents. Resident Identifier: #40. Facility Census: 74.Findings included: a) Resident #40 On 04/13/26 at 3:00 PM, during the initial interview process, Resident #40's call light was behind the resident's headboard, on the floor, and tangled in cords under the bed. When the state surveyor asked the resident where his call light was, the resident patted his blanket and pillow and reported he didn't know its location. At 3:11 PM, Nurse Aide #41 confirmed the call light's location, retrieved it, and fastened it to the resident's blanket. b) Resident #40's Care Plan stated that the resident is at risk for falls and required staff to place call light within reach while in bed or close proximity to the bed. c) The facility's policy and procedure for Call Lights stated, 4. Staff will ensure the call light is within reach of the patient and secured as needed.