STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515186	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluestone Health and Rehabilitation	1600 Bland Street Bluefield, WV 24701

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, resident interview and staff interview, the facility failed to allow a resident and/or their responsible party to exercise his or her right to file an anonymous grievance for facility and follow grievance policy on a grievance completed for another resident. Resident identifier: #22. Facility census: 57. a) Resident Council Resident Council meeting was held on 04/21/2026 at 11:00 AM with a group of 11 (eleven) residents who reported they had no method to anonymously file a grievance. Residents reported they did not want to report complaints for fear of retaliation. They felt concerns brought up in the resident council were not taken seriously. An interview with the Social Worker on 04/21/26 at 6:39 PM revealed there was no method for an anonymous grievance. She reported residents and family members had to ask a nurse or department head for a grievance form.Review of the Facility policy titled Grievances/Complaints states that residents and their representatives have the right to file grievances, either orally or in writing, with facility staff or the agency designated to hear grievances (e.g., the State Ombudsman). The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative.

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on resident interview and record review the facility failed to protect two (2) residents from neglect by failing to provide care timely incontinence care Resident #1 and failing to provide the correct texture of food for Resident #3. Resident identiifers: #1, and #3. Resident #1 sustained actual physical harm from this action. Facility Census 57. Findings Included: Findings include: a) Resident #1 A policy titled Abuse includes a definition for neglect that reads: neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. During the initial interview with Resident #1 on 04/20/26 at 1:55 PM, he stated he had been left overnight without having his brief changed and had been experiencing diarrhea. Resident #1 stated he requested to be changed. Resident #1 stated that when they did change his brief the next morning, the bowel movement had to be picked off and his bottom all the way to the front was sore. In an interview with Nurse Aide (NA) #25 via telephone at 12:50 PM on 04/21/26, she stated she changed Resident #1 on Saturday, 04/18/26 before she left for the day. She stated she went back on Sunday, 04/19/26 to assist his aide and Resident #1 stated he had not been changed since CNA #25 did it the day before. Resident #1 stated he had asked the night shift aides to change him, but they came in, changed his roommate and left. NA #25 states Resident #1 was raw and his skin was bad! CNA #25 stated she reported the issue to Licensed Practical Nurse (LPN) #69 immediately. In an interview with CNA #58 via telephone on 04/21/26 at 1:25PM. She stated she went in to change a wet and soiled brief on Sunday morning. Resident #1 stated he had not been changed all night. He stated he had asked the aides that came in to change his roommate, but the aide said they would come back. However the aide left and did not return. CNA #58 states his skin was pretty bad and raw and red. CNA #58 stated she showed LPN #69 immediately, who then notified Registered Nurse (RN) #63. An order written on 04/19/26 reads as follows: Wound Care: Cleanse excoriation to sacrum and scrotum with soap and water, allow to dry then apply barrier cream Shift until resolvedevery shift for wound healing. The active date/time on the order was 04/19/26 at 6:00 PM. The last skin assessments in the Electronic Medical Record (EMR) are from 04/08/26 and 04/15/26 which show no skin issues to the sacrum or scrotum. A record review of the reportables and grievances does not include this situation. In an interview with Administrator on 04/22/26 at approximately 12:00PM, she confirmed that this situation would be neglect if it is accurate. b) Resident #3 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the progress notes dated 04/26/26 for Resident #3 reads: Resident was given grilled cheese on dinner tray. Her diet order is for mechanical soft. Resident ate some of the grilled cheese before the Nurse Aide (NA) noticed and she coughed a few times and then was fine. NA took the tray and got her another one that she could eat without problem. Lumina contacted and spoke with [the provider] and she ordered to document situation and if there were any further coughing or congestion episodes to call back. The diet orders for Resident #2 include mechanical soft texture (a diet that consists of foods that are moist, soft-textured and easily formed into a bolus). The Diet and Nutrition Care Manual for a mechanical soft diet lists grilled sandwiches as foods to avoid. An interview with nurse consultant #87 on 04/29/26 at 1:30PM confirmed this incident occurred according to the documentation and was not reported.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review and staff interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards. This failure occurred because orders and a care plan directed applying a splint to the wrong hand for Resident #18. The facility also failed to notify the medical provider when a resident's blood sugar was over 400. Resident identifiers: #18 and #27. Facility census: 57.Findings included: a) Resident #18 During initial interviews on 04/20/26 at 2:20 PM, observeration noted that Resident #18's right hand was tightly fisted and lacked a splinting device. A record review of Resident #18's orders revealed orders to apply and remove a splint to the left hand as tolerated every night shift for mobility. Resident #18 has a diagnosis of a right hand contracture listed in the medical record. The care plan for Resident #18, revised on 03/09/26, reads: left hand splinting as ordered. During an interview with Occupational Therapist (OT) #62 on 04/22/26 at 1:27 PM, she confirmed the splinting order should be for the right hand. An interview with the Director of Nursing on 04/28/26 at 1:25 PM confirmed that the orders and the care plan are written to place a splint on Resident #18's functional hand rather than her contracted hand. b) Resident #27 During a record review, an order for Resident #27's Humalog Kwikpen dated 02/09/26 included, hold for [blood sugar] BS less than 100 and call provider for [blood sugar] BS over 400. A review of the Medication Administration Record for March and April of 2026 showed the following dates with blood sugar over 400:03/02/2603/03/2603/06/2603/11/2603/12/2603/16/2603/17/2603/30/2603/31/2604/03/26The facility could not provide proof of contacting the provider when blood sugars were over 400.Registered Nurse Consultant #87 confirmed at 12:05 PM on 04/29/26 that according to documentation the provider was not notified on the above dates when blood sugar was over 400.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based upon record review, staff interviews, resident interview, and observation, the facility failed to maintain a resident environment as free from accident hazards as possible. This was true for three (3) of the three residents reviewed during the long term care survey process. The facility's failure to thoroughly review circumstances and change the processes for deliveries to residents created a risk of serious harm related to residents ordering over-the-counter medications known to be abused as well as THC gummies and offering them to other residents. Resident identifiers: #27, #54, #57 #5 and #42. Facility census: 57. Findings included: a) During an Interview with an anonymous resident the following was reported: On 4/03/26, two female residents purchased cannabis gummies and had them delivered via Door Dash. The anonymous resident reported that the two female residents offered her a gummy, which she refused. She went on to report both female residents were sent out to the hospital after one of the residents was noticeably impaired. These residents were later identified as Resident #5 and #42. Record review completed on 04/21/26 of the facilities reportable and grievance logs revealed no investigation was completed for Resident #5 and Resident #42 regarding changes in condition due to cannabis gummies being brought into the facility and offered to other residents. The surveyor reviewed a change in condition dated 04/03/26 stating Resident #5 was sent to the local ER for further evaluation and a toxicology screen. The signs and symptoms the resident was displaying included altered mental status and suspicion of substance abuse. Resting pulse was noted as greater than 100 at 105 also. A review of a nursing progress note dated 04/03/26 at 2:00 PM labeled as a late entry revealed the following: Resident was educated on facility policies regarding not being allowed to have OTC medications or CBD products in the room; the resident voiced understanding and agreement. A nursing note dated 04/03/26 at 1:10 PM stated CNA approached this nurse and informed me that Resident #42 had informed her that this resident had given her two gummies and that she consumed one and it tasted bad, so she threw the other one away in her trash can. CNA removed the gummy from Resident #42's trash can and gave it to this nurse. A square red gummy with sugar coating was observed. I then went to speak with this resident, and she was observed lying on her bed with eyes reddened and voiced CO 'feeling tired'. VS then obtained; 108/84, 98.1, 16, 105, 95% off RA. I asked resident what type of gummy she consumed and she stated, 'pot gummies' and pointed towards a wooden box on her bedside table. I asked resident if I could look in the box and she stated, 'yes go ahead'. I opened the wooden box and observed several loose squared red gummies with sugar coating on them, three vape pens, one suspected CBD vape pen, a bottle of Benadryl, and several Imodium tablets in store foil packaging. Resident then informed this nurse that she purchased the gummies and CBD vape pen from door dash. I then asked resident if I could remove the items and she consented. Administrator, DON, and physician was notified. The wooden box with all belongings was released to administrator. New orders received per FNP to send resident out to local ER for further evaluation due to suspicion of substance abuse and obtain a toxicology screen. Resident made aware and in agreement with new order. 1:20 PM- (name of emergency medical transport) notified for transport (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1:25 PM- Report called to (name of hospital) ER nurse 1:45 PM- (name of local emergency medical transport) on site x2 attendees to transport resident to local ER. All transfer paperwork was sent with resident. Resident #42 was on the following medications and possible side effects taking medications with Cannabis gummies Prozac (Fluoxetine) 40 MG: Major interaction. Prozac can increase THC levels, causing increased drowsiness, worsening depression, cognitive impairment, or mania. Buspar (Buspirone) 7.5 MG: Potential for serotonin syndrome (confusion, muscle twitching, rapid heart rate) when combined with other serotonergic agents and cannabis. Keppra (Levetiracetam) 750 MG: Increased risk of drowsiness, dizziness, confusion, and difficulty concentrating. Prazosin 1 MG: Potential for increased dizziness or fainting due to additive blood-pressure-lowering effects. A note dated 04/03/26 at 2:27 PM stated, LPN #69 came and notified me that two residents (#42 and #5) consumed unknown substance like gummies. I immediately went to assess this resident while the LPN #29 was notifying the DON, administrator, and Dr. Resident #42 eyes were very red and stated she feels paranoid. Vitals 115/76, 108, 18, 97.9, 92% RA. Resident told this Nurse that she received Two Gummies from (resident #5). She stated the Gummies tasted bad, so she threw the gummy in the trash. The CNA #58, took the Gummy out of the trash and took it to the nurse station. Resident #42 also told this nurse that another resident (#15), knew about the Gummies. This Nurse went and spoke to Resident #15 and the resident stated that Resident #5 came into her room and told her that she has Gummies and THC pens. Resident #5 told Resident #14 that she was going to give resident #42 two gummies. Resident #15 also stated that Resident #5 wrote a letter to a worker, Restorative aide #46 letters and she still had the letter on her bed, and I can have the letter if I want it. Nurse went to the room and got the letter and gave it to the administrator. Nurse did not read the letter. LPN #24 and LPN #69 were on our way to check on (resident #5) when we noticed a man from Door Dash knocking on the door. The man gave the nurse the bag and exited the facility quickly. It was a pack of cigarettes with a receipt with two CBD purchases on the receipt. The facility administration (administrator and director of nursing) had no evidence that a thorough investigation into this matter had been completed. Because only a limited action was taken following the incident on 04/03/26 the facility administration was presented with an Immediate Jeopardy template on 04/21/26 at 6:00 PM. The failure to identify a situation where residents were susceptible to drug abuse from other residents created an immediate jeopardy situation. On 04/21/26 at approximately 8:45 PM, the facility presented the following Plan of Correction: 1. Corrective Action for Residents Affected Resident #5 and Resident #42 were immediately assessed on 04/03/2026 for any adverse effects related to ingestion of suspected cannabis gummies. Nursing assessments, vital signs monitoring, and physician notifications were completed. Residents were transferred to the hospital as indicated and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	monitored upon return with no ongoing adverse effects identified. Anonymous Resident #1 was interviewed and confirmed no ingestion occurred. The resident remained safe with no identified concerns. The facility immediately initiated an abuse investigation on 04/21/2026 and reported the allegation in accordance with regulatory guidelines. The facility ensured that all required notifications were completed. 2. Identification of Other Residents with Potential to be Affected On 04/21/2026, the facility started conducting a comprehensive room-to-room audit of all residents, that either they or their responsible party consent too, to identify the presence of non- prescribed medications, suspected cannabis and/or CBD products, or unauthorized substances. The facility is attempting to interview all residents regarding knowledge of any residents sharing or giving each other over-the-counter medications or other non-prescribed substances or anyone offering non-prescribed substances to them or ingesting any non-prescribed or over-the-counter medications or substances. The facility has started and is conducting interviews with all staff regarding knowledge of residents sharing or giving over-the-counter medications, or health or pharmaceutical products; noticed any situations where staff or resident may have exchanged non-prescription products outside of the standard process; and any challenges or concerns seen related to residents accessing or using non-prescription products safely. All residents are being assessed for signs and symptoms of impairment or changes in condition. A retrospective review of incident reports, 24-hour reports, and grievance logs is being completed for the previous 30 days to ensure no additional unreported or uninvestigated incidents existed in violation of F600, F609, and F610 requirements. 3. Systemic Changes to Prevent Recurrence The facility implemented the following systemic changes to address compliance with F600, F609, and F610: External deliveries by DoorDash will be inspected by staff upon delivery, in accordance with Federal Regulation 557, Respect, Dignity/Right to have Personal Property and follow guidelines on how to search residents' deliveries with consent. Residents will be re-educated on the facility's expectations regarding safety, including the prohibition of non-prescribed medications and substances within the facility, and the importance of not sharing or accepting medications or items from other residents. All staff will be re-educated on 04/21/2026 or prior to their next scheduled shift on the following: Abuse prevention and resident-to-resident abuse (F600) Mandatory reporting requirements, including timelines and immediate reporting expectations (F609) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Investigation requirements, including documentation, interviews, and follow-through (F610) Identification of impairment and prohibition of non-prescribed medications and substances New hires will receive this education during orientation, and ongoing education will be reinforced through monthly in-services and QAPI review. 4. Monitoring to Ensure Compliance The facility implemented the following monitoring systems: The Administrator and/or designee will audit all reportable events and grievances daily for two (2) weeks, then weekly for four (4) weeks, and monthly thereafter to ensure compliance with F609 reporting requirements. The Director of Nursing (DON) or designee will audit all abuse investigations weekly for four (4) weeks, then monthly for two (2) months to ensure investigations are completed timely and thoroughly in accordance with F610 requirements. The facility will conduct weekly audits of delivery logs and contraband checks for four (4) weeks, then monthly for two (2) months. Findings will be reviewed through the QAPI program, and corrective actions will be implemented as needed to ensure sustained compliance. c) The State Agency accepted the Plan of Correction on 04/21/26 at 9:07 PM. d) Education and Post Tests Staff Interviews Have you ever observed residents sharing or giving each other over-the-counter medications, or health or pharmaceutical products? Have you you noticed any situations where staff or residents may have exchanged non-prescription products outside of the standard process? Are there any challenges or concerns you've seen related to residents accessing or using non-prescription products safely? Recognizing Substance Use in Long-Term Care Quick Reference For Clinical Staff Why It Matters- Substance use in older adults is often under- recognized, Signs may mimic dementia, delirium or depression, Early recognition improves safety and outcomes. Common Substances in Long Term Care- Alcohol, Prescription medications (opioids, benzodiazepines, sleep aides), Over- the-counter misuse (sleep/cough products). General Warning Signs- Falls, unsteady gait, slurred speech, New or worsening confusion or memory changes, Mood swings, agitation, withdrawal, Decline in ADL's or therapy participation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Substance-Specific Clues- Alcohol: odor, flushed face, tremors, unexplained injuries. Opioids: excessive drowsiness, pinpoint pupils, slow breathing. Benzodiazepines/Sedative: confusion, falls, daytime sleepiness. Higher-Risk Residents- Chronic pain or anxiety/depression, Cognitive impairment, History of substance use, Polypharmacy or recent life transitions. What Staff Should Do- Observe and compare to baseline, Document objectively and factually, Report concerns through proper channels. Escalate Immediately If- Unresponsiveness or respiratory depression, Suspected overdose, Sudden severe confusion or repeated unexplained falls. Remember- Substance use is a medical issue, not a moral one. Use dignity, respect and teamwork. DoorDash Delivery Protocol To help ensure the safety and well-being of all residents, the facility will no longer allow DoorDash services to deliver items directly to residents. All deliveries must be received by facility staff before being given to the resident. Facility staff will inspect these deliveries with resident consent. Facility staff will respect the resident tights to refuse inspection. This process helps us confirm that items are appropriate, safe, and in compliance. Residents are encouraged to plan accordingly and understand that this protocol is in place to protect their health and maintain a safe living environment for everyone. Medication Safety For your safety, residents are not permitted to share prescribed medications, non-prescribed (over-the-counter) medications, or other substances with others. Medications are ordered specifically for each individual and may be harmful if taken by someone for whom they were not intended. Residents should also not accept medication or other substances if it is offered by another resident, even if it seems harmless. If you feel unwell or believe you need medication, please notify staff so they can assist you appropriately and safely. The IJ was abated on 04/22/26 at 4:28 PM. b) Resident #27 Resident #27 has capacity to make own medical decisions. Progress notes from the resident's medical record documented the following: 02/18/2026 12:40*Nursing NoteNote Text: The Administrator, with the DON [Director of Nursing] and UM [Unit Manager] present, spoke with resident regarding staff reports that they had witnessed her having a vape in her room that she refused to allow the nurse to secure per policy. She initially denied having a vape at all and then she admitted to having had one that was now empty. Administrator asked where she got the vape and resident stated, I'm not going to tell you where I got it. She then stated she threw it away. The Administrator attempted to clarify when and where it was discarded. She said today, in the trash barrels in the hallway. She would not elaborate on the time she discarded (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During the period of the survey, it was still not known whether the resident had vape pens in her possession, and resident refused a room search. This possible serious fire hazard was reviewed with RN Consultant #87 on 04/29/2026 at 12:22 PM. RN Consultant indicated she would be taking care of this immediately. b) Resident #54 An observation on 04/14/26 at 1:00 PM, Resident #54 was observed lying in his bed with the right fall mat leaned along the wall behind the headboard. Record review completed on 04/14/26 showed the care plan had an intervention stating Fall matts to bilateral sides of bed while resident is in the bed During an interview with LPN #65 on 04/14/26 at 1:05 PM who confirmed floor matt was not in place and statedI'll get that down now they just laid Resident #54 down c) Resident #57 During a check for fall prevention measures on 04/23/26 at 9:15AM, Resident #57 was observed lying in his bed with the bed not in the low position. A review of the care plan for Resident #57 includes the following: RISK FOR FALLS: the resident is at riskfor falls related to: muscle weakness,cognitive impairment, incontinence,psychoactive medication use, recenthospitalizations, visual impairment; historyof traumatic brain injury and multiple CVAswith deficits. Bed in lowest positionDate Initiated: 12/05/2025 It was confirmed in an interview with Registered Nurse Consultant #86 that Resident #57's bed was not in lowest position with resident in the bed at 04/23/26 at 9:21 AM.

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	515186	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluestone Health and Rehabilitation	1600 Bland Street Bluefield, WV 24701

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, staff interview, staff postings review and resident interview the facility failed to ensurse sufficient nursing staff across all shifts and units to meet the needs of depdendent residents. Resident identifiers: #1. Facility census: 57. a) Findings included:During the resident council meeting on 04/22/25, the residents voiced concerns of call lights are answered sometimes after 1-3 hours. Residents stated that staff would say they would be right back, but they never returned or came back hours later claiming they had been outside smoking with a resident. -04/20/26 Resident #8 stated, Sometimes it takes a while to get help.-04/20/26 at 12:39 PM, Resident #2 stated, Night shift takes forever to answer a call light.-04/20/26 at 1:43 PM, Resident #25 stated, It takes an hour to answer the call light. I have to go to the bathroom a lot because of my meds.-04/21/26 at 10:33 AM, Resident #27 stated, I frequently wait 45 minutes or more to get changed. At the 4:00 PM smoke break, all the Nurse Aides and one nurse accompany the residents outdoors to smoke, leaving one nurse to cover the entire floor. After 5:00 PM, they won't even bother to answer call lights, you are forced to wait until day shift comes on. If you need to be changed during meal tray pass, they will tell you to wait until they are through with passing trays.-04/20/26 at 9:36 PM, Resident #5 stated, They need more help. A record review of the following days was completed. This involved using the posted daily nurse staffing sheet along with the detail punch time sheets for each staff member to match the posted daily nurse staffing sheet, and calculating the Hours Per Patient Day (HPPD). -On 04/25/26, the HPPD was calculated at 1.99 using posted staffing data and 2.59 using punch detail sheets.On 02/14/26, the HPPD was calculated at 2.19 using staffing data sheets and 2.14 using punch detail sheets, below the minimum required 2.25 HPPD. These findings were reviewed with RN Consultant #87 on 04/29/26 late afternoon. b) Resident #1 A policy titled Abuse includes a definition for neglect that reads: neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. During the initial interview with Resident #1 on 04/20/26 at 1:55 PM, he stated he had been left overnight without having his brief changed and had been experiencing diarrhea. Resident #1 stated he requested to be changed. Resident #1 stated that when they did change his brief the next morning, the bowel movement had to be picked off and his bottom all the way to the front was sore. In an interview with Nurse Aide (NA) #25 via telephone at 12:50 PM on 04/21/26, she stated she changed Resident #1 on Saturday, 04/18/26 before she left for the day. She stated she went back on Sunday, 04/19/26 to assist his aide and Resident #1 stated he had not been changed since CNA #25 did it the day before. Resident #1 stated he had asked the night shift aides to change him, but they came in, changed his roommate and left. NA #25 states Resident #1 was raw and his skin was bad! CNA #25 stated she reported the issue to Licensed Practical Nurse (LPN) #69 immediately. In an interview with CNA #58 via telephone on 04/21/26 at 1:25PM. She stated she went in to change a wet and soiled brief on Sunday morning. Resident #1 stated he had not been changed all night. He stated he had asked the aides that came in to change his roommate, but the aide said they would come back. However the aide left and did not return. CNA #58 states his skin was pretty bad and raw and red. CNA #58 stated she showed LPN #69 immediately, who then notified Registered Nurse (RN) #63.An order written on 04/19/26 reads as follows: Wound Care: Cleanse excoriation to sacrum and scrotum with soap and water, allow to dry then apply barrier cream Shift until resolvedevery shift for wound healing. The active date/time on the order was 04/19/26 at 6:00 PM.The last skin assessments in the Electronic Medical Record (EMR) are from 04/08/26 and 04/15/26 which show no skin issues to the sacrum or scrotum.A record review of the reportables and grievances does not include this situation.In an interview with Administrator on 04/22/26 at approximately 12:00PM, she confirmed that this situation would be neglect if it is accurate.c) During an observation on 04/28/26 at 12:02 AM, the staffing numbers for the night shift on the daily nurse (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staffing sheet documented two (2) Licensed Practical Nurses (LPN), three (3) Nurse Aides (NA) and zero (0) Registered Nurses (RN) working. A visual count confirmed one (1) LPN, 0 RN, and 2 NA. Nurse Aide #5 was sleeping on duty upon arrival to the facility. Nurse Aide #10 was in the breakroom with a makeshift office set up using a table, laptop, battery charger, and large rolling briefcase. Later, the surveyor learned one NA was sitting 1:1 with a resident, leaving two NAs to cover the 56 other residents in the facility. During an interview with LPN #36, when asked about another LPN working per the posted daily nurse staffing sheet, he replied the other LPN is pregnant and called in sick. When asked if this would cause some work to not be completed, he responded that if he worked hard, they would get it all done. During an interview with the Regional Director of Operations (RDO) on 04/28/26 at 12:35 AM, the surveyor reviewed the staffing sheet discrepancy, and the findings: one NA was sleeping, and the other was conducting business on his laptop. Review of the CASPER report also revealed the facility triggered for low weekend staffing during Quarter 1 of 2026.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review, observation, and staff interview, the facility failed to post accurate nurse staffing data in a prominent location viewable by staff and visitors. This was found to be true for 22 days of 23 days of staffing reviewed during the long term care survey process. Facility census: 57.Findings included: a) The surveyor attempted to find the daily nursing staffing data sheet upon entrance to the facility on [DATE], and could not find it. Upon asking where it was posted, the Director of Nursing took me to the nurse's station where the posting was located on the wall near the nurses station. The surveyor requested nursing staffing data sheets and time punch detail sheets for staff for the following days:-04/25/26-04/19/26-04/18/26-03/29/26-03/28/26-02/15/26-02/14/26-12/27/25-12/26/25-12/24/25-11/29/2[illegible] review of the posted nurse staffing sheets found the following inaccuracies:-Inaccurate dates were posted nurse staffing sheets on the following dates:10/5/25 actual date, 10/5/26 was date listed on the posting04/18/26 actual date, 4/18/25 was date listed on posting04/19/26 actual date, 04/19/25 was date listed on posting During an observation on 04/28/26 at 12:02 AM, the staffing numbers for the night shift on the daily nurse staffing sheet documented two (2) Licensed Practical Nurses (LPN), three (3) Nurse Aides (NA) and zero (0) Registered Nurses (RN) working. A visual count confirmed one (1) LPN, 0 RN, and 2 NA. Nurse Aide #5 was sleeping on duty upon arrival to the facility. Nurse Aide #10 was in the breakroom with a makeshift office set up using a table, laptop, battery charger, and large rolling briefcase. Later, the surveyor learned one NA was sitting 1:1 with a resident, leaving two NAs to cover the 56 other residents in the facility. During an interview with LPN #36, when asked about another LPN working per the posted daily nurse staffing sheet, he replied the other LPN is pregnant and called in sick. When asked if this would cause some work to not be completed, he responded that if he worked hard, they would get it all done. During an interview with the Regional Director of Operations (RDO) on 04/28/26 at 12:35 AM, the surveyor reviewed the staffing sheet discrepancy, and the findings: one NA was sleeping, and the other was conducting business on his laptop. Other inaccuracies found were:-04/25/26 Unable to discern actual number of NAs working on day and evening shifts, as changes were made on top of writing-04/19/26 Total hours worked were wrong on staffing sheet, 165.5 were posted, versus 156.8 actual hours worked.-04/18/26 Total hours worked were wrong on staffing sheet. 150.5 was posted, versus168.08 actual hours worked.-03/29/26 Total hours worked were wrong on staffing sheet. 159 was posted, versus167.6 actual hours worked.-03/28/26 Total hours worked were wrong on staffing sheet. 142.5 was posted, versus150.33 actual hours worked.-02/14/26 Total hours worked were wrong on staffing sheet. 127.5 was posted, versus 124.66 actual hours worked.-12/27/25 Total hours worked were wrong on staffing sheet. 162 was posted, versus 180.36 actual hours worked.-12/26/25 Total hours worked were wrong on staffing sheet. 155.5 was posted versus168.8 actual hours worked.-12/24/25 Total hours worked were wrong on staffing sheet. 181.5 was posted, versus 191.98 actual hours worked.-11/29/25 Total hours worked were wrong on staffing sheet. 146.75 was posted, versus 157.2 actual hours worked.-11/28/25 Total hours worked were wrong on staffing sheet. 158.75 was posted, versus 170.2 actual hours worked.-11/27/25 Corrections made on top of actual hours and number of staff, so it is not clear which numbers are correct.-11/01/25 Total hours worked were wrong on staffing sheet. 151 was total based on staffing sheet, actual actuals were 164.25.-10/31/25 Total hours worked were posted as 155.62. Adding the hours on the nurse staffing sheet, you get 147.5. Using time detail report, total hours worked were actually 167.33.-10/30/25 It is unclear as to the number of Nurse Aides working on 1st shift. Total hours worked were 143 versus actual hours worked being 178.98.-10/11/25 Total hours worked were wrong on staffing sheet. 129 hours was posted, versus 160.31 actual hours worked.-10/10/25 Total hours worked were wrong on staffing sheet. 158 hours was posted, versus 175.05 actual hours worked.-10/09/25 Total hours worked were wrong on (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	staffing sheet. 158.75 was posted, versus 205.97 actual hours worked.-10/08/25 Total hours worked were wrong on staffing sheet. 158.25 was posted, versus 176.71 actual hours worked.-10/07/25 Total hours worked were wrong on staffing sheet. 146 was posted versus 160.62 actual hours worked.-10/06/25 Total hours worked were wrong on staffing sheet. 135 was posted versus 144.69 actual hours worked.-10/05/25 Actual number of NAs working on 1st shift is posted as three (3,) when according to punch detail report there were four (4). Total hours worked were wrong on staffing sheet. 154,5 was posted versus 168.12 actual hours worked. Samples of the descrepancies were reviewed with RN Consultant on 04/28/26 mid afternoon.