STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525430	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Hills Rehab Ctr	14400 Cty Hwy B Sparta, WI 54656

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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 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 interview and record review, the facility failed to have a system in place to ensure advance directive paperwork was on file for 1 of 19 sampled residents (R7) reviewed for advance directives.R7's chart did not contain a copy of her advance directive paperwork specifying her designated power of attorney.This is evidenced by:The facility's policy, titled Heath Care Power of Attorney, Advanced Directives and POST (Physician Orders for Scope of Treatment) Form Use, revised 5/8/26, states, in part: Policy: Rolling Hills Rehab Center recognizes the desires of a resident who is capable of making his/her own health care decisions supersedes the effect of an advance directive at all times. Advanced Directives can be a Health Care Power of Attorney (HCPOA) form, a POST Form, or a Living Will form. Procedure: 1. An Advance Directive is a written document representing the wishes and values of an adult, either while a resident in the nursing home or prior to becoming one, that: a) designates another person(s), i.e. agent, to make health care decisions on behalf of the resident if the resident is unable to make decisions for himself/herself; b) gives instructions to a health care professional as to the resident's desires about health care decisions; or both designates a surrogate and gives instructions. This will be reviewed on admission and offered on Quarterly assessments or as requested by resident if the resident does not have a Power of Attorney (POA).R7 admitted to the facility on [DATE]. R7 is her own person and does not have an activated POA. On 5/5/26 at 2:18 PM, during the record review portion of the initial pool process, Surveyor was unable to find documentation of a POAHC for R7 or evidence of a discussion with R7 about establishing one. On 5/6/26 at 4:45 PM, DON B (Director of Nursing) indicated that R7 does not have POA paperwork. On 5/7/26 at 11:00 AM, SW H (Social Worker) indicated the facility will get a copy of POA paperwork from the hospital if a resident is admitted from there. The facility offers assistance with completing POA documents when a resident is first admitted to the facility. During any point, a resident can request assistance with completing this paperwork. If a resident requests to change POA information, the facility can assist with that as well. If a resident would like to change POA information and the resident is already activated, the facility will work with an ethics committee on that.SW H confirmed they were unable to locate POA paperwork for R7. Surveyor asked what would happen if R7 had a sharp decline and was no longer able to make decisions for herself. SW H indicated without the POA documents, the facility would have to pursue a guardianship for R7. SW H indicated she would add POA documentation to a list of topics to discuss with R7 at her upcoming care conference.On 5/7/26 at 11:15 AM, Surveyor discussed POA paperwork with R7. R7 indicated she had previously completed POA paperwork and said one of her family members had it.On 5/11/26 at 12:15 PM, SW G located R7's POA paperwork in her clinical chart documents. SW G confirmed the facility never had the POA paperwork on file for R7 before today.On 5/11/26 at 2:25 PM, Surveyor discussed POA paperwork with NHA A (Nursing Home Administrator). NHA A confirmed the facility's process for advance directives is to offer assistance when a resident is admitted to the facility and then again if a resident is hospitalized or has something going on - like a decline. NHA A agreed a resident may forget about the paperwork if it is only discussed during admission. Surveyor discussed R7 being admitted to the (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility in 2023 and not having POA paperwork on file until today. NHA A agreed that pursuing a guardianship for R7 if she did not have paperwork may not be something she would have wanted. NHA A indicated the facility's social services department modified their process and will now discuss POA paperwork and code status with residents/resident representatives on a quarterly basis and if a resident is hospitalized .

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility did not notify and consult with a resident's physician when there was a change in condition. This occurred for 1 of 19 Residents (R25) reviewed for notification of change in condition. R25 had unwitnessed falls on 1/2/26 and 3/26/26 with no notification to the medical provider. Evidenced by: Facility Policy Subject: Falls Assessment Procedure: 3. CONSULT WITH Physician if head injury or injury caused a significant change in status. R25 was admitted to the facility on the 10/29/24. Her diagnoses include: Hallucinations(a false sensory experience that feels readl, even though it is created by the mind), Generalized anxiety disorder(chronic uncontrollable and excessive worrying about everyday things that feels impossible to turn off).R25's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/28/26 indicates R25 has a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating she is cognitively moderately impaired. On 01/02/26 R25's nursing fall report stated in part: MD (medical doctor) notify: no need to notify, resident did not hit head. Of Note: this fall was unwitnessed. On 3/26/26 nursing fall report stated in part: MD notify: no need to notify, resident did not hit head.Of Note: this fall was unwitnessed(It should be noted that both falls were unwitnessed, there is no way to definitively know if R25 hit her head or not due to being unwitnessed.)On 5/11/26 at 10:36 AM Surveyor interviewed RN K (Registered Nurse). Surveyor asked RN K what is your process for when someone has a fall? RN K responded if an LPN is on the floor, an RN needs to come before getting the person up. Then I (RN) conduct my assessment and start the investigation. Surveyor asked RN K if a fall is unwitnessed, how do you know if the resident hit their head. RN K stated that she would do her own assessment looking at where the resident is seated, what is around them and their environment, but I don't know if you could be sure that they didn't hit their head. Surveyor asked RN K when you would notify the MD. RN K stated if injured would notify right away, within 4 hours if concerned for a head injury. On 5/11/26 at 10:53 AM Surveyor interviewed RN E. Surveyor asked RN E what is your process if someone falls. RN E reported that she would go down and assess the resident and continue with fall investigation. Surveyor asked if the fall was unwitnessed when should you notify the physician. RN E stated if the resident couldn't tell you if they hit their head or not you would notify the MD within 4 hours. On 5/11/26 surveyor interviewed DON B. Surveyor asked DON B when there is a fall is anyone notified. DON B stated the residents' representative is called. MD is called if there is an injury. Surveyor asked DON B Is a fall a COC (change of condition). DON B stated that they have never looked at a fall as a COC. Surveyor asked DON B does a physician need to be notified of a COC. DON B stated yes. Surveyor asked DON B if a resident had an unwitnessed fall, would there be a way to know if they hit their head? DON B stated that her nurses would use their critical thinking skills and assess the environment. Surveyor asked DON B when a fall is unwitnessed can you be sure the resident did not hit their head. DON B stated unwitnessed is unwitnessed. R25 had two unwitnessed falls without any indication a physician/MD was updated.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to fully prevent further potential abuse, neglect, exploitation, or mistreatment of residents while an investigation was in process for 1 of 3 residents (R7) investigated for an incident involving alleged abuse. A staff member involved in a facility reported incident was not directly supervised at all times while working to ensure protection of other residents after the facility became aware of an allegation of abuse made by R7.This is evidenced by: The facility's policy, titled Misconduct Investigation & Reporting, reviewed 2/24/25, states, in part: Policy: Rolling Hills Senior Living prohibits abuse, neglect, exploitation and misappropriation of resident property. We have established and implemented measures to prevent incidents from occurring through comprehensive background checks, credentialing, training and establishing a culture where residents are cared for with respect and dignity. All concerns will be thoroughly investigated and reported. Procedure: .7. The building supervisor must take action to protect the resident or other residents who may be at risk while the incident is being investigated. (I.e. staff person is sent home on administrative leave, is directly supervised to maintain all residents' safety, or is reassigned to non-resident duties.). R7 admitted to the facility on [DATE] with diagnoses that include: spinal stenosis - lumbar region with neurogenic claudication (narrowed spinal canal causing pain, weakness, or tingling in the legs that may get worse while walking or standing) and osteoarthritis (condition causing degenerative joint pain and stiffness and reduced mobility). R7's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 2/4/26 indicated R7 has a BIMS (Brief Interview for Mental Status) score of 15 out of 15, indicating R7 is cognitively intact. The facility self report states, in part: [R7] reported to [RN E] (Registered Nurse) that [CNA L] (Certified Nursing Assistant) was rough with her this morning and pushed her over to the side when she was on the toilet. This was reported to [RN E] at approximately 1:00 pm on 1/21/26 by the resident. It is noted that [CNA L] did report to the RN and LPN (Licensed Practical Nurse) this morning that [R7] was not transferring well and nearly fell getting onto the toilet. [CNA L] did report that she had to slide her over onto the toilet to keep her from falling. [CNA V] did enter the resident room to respond to the call light. She did witness the interaction and saw [CNA L] assist [R7] to the toilet when she had trouble standing. The resident complained to [CNA V] that she wanted to move out. This was reported to the RN.The resident, [R7], reported that [CNA L] was mean to her and was too rough.The accused CNA, [CNA L] was immediately instructed not to work with [R7] and to only provide care to other residents with a second staff person present during the course of the investigation.On 5/7/26 at 11:00 AM, Surveyor interviewed SW H (Social Worker) about this incident, as she had investigated it along with NHA A (Nursing Home Administrator). SW H indicated CNA L was not to work with R7 and had to be with another staff member when she went in to do cares with any other residents. CNA L could be seen by nursing staff on the unit when she was not with residents. CNA L would tell someone if she was going into a residents' room and they would go with her. Surveyor asked how the administrators could guarantee that CNA L wasn't around any residents by herself while the investigation was ongoing. SW H indicated this was not 100% guaranteed and indicated CNA L was usually respectful with following the rules; the facility did not have any issues with her in the past.On 5/11/26 at 11:41 AM, Surveyor interviewed CNA V. CNA V confirmed she was in the room with CNA L when the incident with R7 occurred. CNA V indicated CNA L had to push R7 onto the toilet so R7 didn't land on the floor when she got weak while standing up and holding the grab bar as she was being cleaned up. Surveyor asked what interventions were put in place after this occurred. CNA V indicated CNA L was required to do cares with residents with another staff member present. Surveyor asked if she was always with CNA V during this time. CNA L indicated that CNA V was required to do charting in the main room within sight of the nurses so she wasn't alone with residents and when she had to go into a resident's room, CNA L would get CNA V so she could go with (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her.On 5/11/26 at 11:55 AM, Surveyor interviewed CNA L about the incident with R7. CNA L indicated she was not allowed to do any cares with R7 following the incident. Administrators talked to her, other staff members, and residents. While the investigation was ongoing, CNA L indicated she had to get another staff member if she went into a resident's room. When not working with residents, she would stock linen carts, wipe down the hallway railings, and wipe down wheelchairs within viewing range of the nurses' station. Surveyor asked what CNA L would do if she had to go to a hallway closet or out of eyesight of the nurses. CNA L indicated she would notify a nurse that she'd be right back and they wouldn't follow her to where she was going.On 5/11/26 at 11:37 AM, Surveyor spoke with RN E regarding the incident with CNA L and R7. RN E indicated she remembered the incident but not the exact details. RN E indicated CNA L was removed from working with R7 and nursing staff was updated and told to keep an eye on staff members and residents to ensure no further incidents occurred.On 5/11/26 at 2:25 PM, Surveyor spoke with NHA A regarding the incident with CNA L and R7. NHA A indicated CNA L was not to be working with anyone or doing anything by herself; she was only supposed to work with other staff present - whether that was in a room doing cares with another staff member or with nurses keeping an eye on her. NHA A indicated administration felt like they had a good idea of what had occurred after speaking with CNA V, who had been present when the incident occurred. Surveyor brought up that CNA L indicated she would tell nursing staff if she had to go down the hallway to get something and they wouldn't go with her. NHA A indicated she was just going down the hallway and not into a resident's room. Surveyor indicated it was possible for CNA L to go into a resident's room during that time without someone watching her.

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that 1 of 19 Residents (R25) received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing.R25 requested side rails to aid in bed mobility and the facility did not provide the side rails to R25 timely.This is evidenced by:R25 admitted to the facility on [DATE] with diagnoses including Parkinson's disease (a progressive neurodegenerative disorder of the central nervous system), restless leg syndrome (a neurological disorder characterized by an irresistible urge to move the legs), rheumatoid arthritis (a chronic autoimmune disorder where the immune system attacks the joint lining causing inflammation, swelling, and stiffness) and chronic pain.R25's BIMS (Brief Interview for Mental Status), dated 3/11/26, has a score of 15, indicating R25 is cognitively intact.On 5/6/26 at 7:54 AM, Surveyor interviewed R25. R25 indicated he had requested side rails for bed mobility, and the facility has not provided him with side rails. R25 indicated he cannot get into bed without side rails. R25 indicated he needed side rails so he can reposition himself when he is in bed. R25 indicated he would lay in bed more if he had side rails so he could move himself around if he wanted. Surveyor observed R25's bed. R25's bed did not have side rails.R25's PT (Physical Therapy) Discharge summary, dated [DATE], includes: he had laid in his bed several times and then has not rested in bed since, unsure if he is refusing or if he is not requesting. Patient reports that he would lay in bed if he had bed rails to assist him in rolling and scootingOn 5/6/26 at 11:59 AM, Surveyor interviewed RN K (Registered Nurse) regarding side rails for R25. RN K indicated staff are encouraging R25 to spend time in bed and therapy is working with R25. RN K indicated they were working on getting side rails for R25. RN K indicated R25 is agreeable to lay down during the day. RN K indicated that a resident can usually have side rails installed on the same day the request is made.On 5/6/26 at 11:07 AM, Surveyor interviewed DOR P (Director of Rehab) regarding R25. DOR P stated at one point, therapy had encouraged side rails but R25 did not want a bed and chose to sleep in his recliner. DOR P stated a bed was put back into R25's room because he was unable to stand for personal cares and cares were then provided in the bed. DOR P indicated R25 did well in therapy with simulated side rails. DOR P indicated on 4/27/26, therapy put in a request to maintenance to install side rails to R25's bed. DOR P indicated therapy made the request for side rails so R25 can have increased independence with bed mobility. DOR P indicated therapy also spoke with nursing about getting side rails for R25.On 5/7/26 at 9:11 AM, Surveyor interviewed MT Q (Maintenance) regarding side rails. MT Q indicated either maintenance or housekeeping are notified by therapy or nursing if a resident needs side rails placed on their bed. MT Q indicated getting side rails attached to a bed takes a couple of hours after the request is made. MT Q indicated he is unaware of a request for side rails for R25. MT Q indicated there are 5 maintenance staff. MT Q indicated he spoke with the other maintenance staff, and all were unaware of the request.On 5/7/26 at 9:30 AM, Surveyor interviewed ESC R (Environmental Services Coordinator). ESC R indicated she was notified on 5/6/26 by therapy that R25 needed side rails. ESC R indicated once she was notified of the request, she transferred a new bed with side rails into R25's room. ESC R indicated side rails can be put on a bed usually the same day the request is made.On 5/7/26 at 9:17 AM, Surveyor interviewed DON B (Director of Nursing). DON B indicated once a request is made for side rails, housekeeping or maintenance will install the side rails. Surveyor informed DON B that therapy requested the side rails for R25 on 4/27/26 and the side rails were not placed until 5/6/26. DON B indicated R25's side rails should have been dealt with sooner. DON B indicated that installing the side rails should not have taken so long.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that a resident who needs respiratory care is provided with such care consistent with professional standards of practice for 1 of 2 residents (R6) reviewed for oxygen.R6 did not have oxygen tubing/nasal cannula changed on a monthly basis.Evidenced by:The facility's Oxygen Therapy policy, dated 1/2026, states, in part: .8. Replace nasal cannula monthly.R6 admitted to the facility on [DATE] and has diagnoses that include: acute and chronic respiratory failure with hypercapnia (a condition when the lungs cannot adequately supply oxygen to the blood or remove carbon dioxide); Cor pulmonale, chronic (the enlargement and failure of the right ventricle of the heart caused by high pressure in the lungs arteries, linked to lung disease); chronic obstructive pulmonary disease (a progressive lung disease that makes breathing difficult by damaging airways)R6's Physician Orders include, in part:*2/18/26 Treatment: Respiratory: oxygen 2 l/pm (Liters per minute) at rest - 3 lpm with activity three times a day AM PM NOC (morning, evening, and night shifts) keep sats (oxygen saturation; the amount of oxygen in the blood) > (greater than) 90%. TX (treatment) first date: 1/27/26*5/5/26 Treatment: Respiratory: Change nasal cannula on portable and concentrator one time per month 3rd Thursday AM Hospice Supplies Tx first date: (blank)On 5/5/26 at 4:21 PM, Surveyor observed R6 during initial screening. R6 was sitting in his/her recliner in his/her room, wearing a nasal cannula attached to an oxygen concentrator. No date labeling noted on cannula/tubing. On 5/5/25 at 4:29 PM, Surveyor interviewed RN W (Registered Nurse) and asked about nasal cannula/oxygen tubing. RN W stated it is changed every 30 days, more often if it is dirty or defective. RN W stated the change is triggered by the resident's treatment record. Surveyor asked if the cannula/tubing is labeled with a date. RN W stated not sure. Surveyor asked when R6's was last changed. RN W reviewed R6's treatment record and stated there is no order for changing R6's cannula/tubing. Surveyor and RN W observed the nasal cannula that R6 was wearing and the cannula attached to the portable tank in R6's room. RN W stated there is not a label with date. Surveyor asked if there was any way to tell when the cannula was last changed. RN W stated I'd look at the treatment record to see when it was signed out and assume it was done. RN W stated it would be best practice to be labeled.Important to note: There was no order for changing of the cannula on R6's treatment record at the time of this observation.On 5/11/26 at 12:05 PM, Surveyor observed R6 sitting in bedroom recliner wearing a nasal cannula connected to the oxygen concentrator. No labeling was noted on this cannula tubing or the cannula connected to the portable in the room. On 5/11/26 at 12:12 PM, Surveyor and RN K observed R6's nasal cannula. RN K indicated there was no labeling on the cannula. Surveyor asked when cannulas are changed. RN K stated monthly. Surveyor asked when R6's cannula had last been changed. RN K stated it pops up on the orders, you cannot tell from the tubing. RN K reviewed R6's chart and stated it looks like it is to be changed the 3rd Thursday of the month, but I am having a hard time seeing it signed off. RN K confirmed that the order for changing the cannula had been added 5/7/26 and stated it should be entered when oxygen therapy starts. The cannula may have been changed, but there is no way to tell from looking at the tubing.On 5/11/26 at 1:39 PM, Surveyor interviewed DON B (Director of Nursing) and asked about changing oxygen tubing/nasal cannula. DON B stated that cannulas are changed monthly. Surveyor asked if tubing is unlabeled, can it be verified that the tubing was changed. DON B stated no.

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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. Based on observation, interview, and record review, the facility did not maintain a safe and sanitary environment in which food is prepared, stored, and distributed. This has the potential to affect all 49 residents who reside in the facility.Surveyor observed [NAME] U not allow thermometer to air dry before probing food.Surveyor observed [NAME] U reheat mashed potatoes in the microwave and then serve them without getting the internal temperature to 165 degrees F (Fahrenheit).Surveyor observed the facility's mixer to have food particles on the undercarriage.Surveyor observed [NAME] BB remove gloves, use a marker to label a plastic bag and then go back to working with food without washing his hands. Evidenced by:Example 1Facility policy, titled Food Handling, reviewed 5/7/26, includes: To take temperatures, a clean, rinsed, sanitized and air dried thermometer, which is the metal stem type, numerically scaled and accurate to plus or minus 2 degrees F, is needed. After taking the temperature the thermometer should be cleaned with a new alcohol pad.On 5/5/26 at 12:10 PM Surveyor observed [NAME] U use an alcohol wipe to wipe her thermometer and without allowing it to air dry she probed chicken noodle soup. She then used the same wipe to wipe the thermometer again. [NAME] U used another alcohol wipe to wipe the thermometer and without allowing it to air dry she probed mashed potatoes.On 5/7/26 at 10:15 AM Dietary Manager S indicated [NAME] U should allow the alcohol to sit on the surface of the thermometer until it air dries completely before probing the next food. Dietary Manager S also indicated [NAME] U should use a clean wipe every time she sanitizes the thermometer. Example 2Facility policy, titled Food Handling, reviewed 5/7/26, includes: Hot food temperatures. All hot food must be served to the residents at the temperature of 135 degrees F at the time the resident receives them. Hot food items may not fall below 135 degrees F. and reheated to at least 165 degrees F prior to next serving.On 5/5/26 at 12:10 PM Surveyor observed [NAME] U probe mash potatoes measuring the internal temperature. [NAME] U stated the internal temperature of the mashed potatoes was 121 degrees F. [NAME] U put the mashed potatoes in the microwave. [NAME] U probed the mashed potatoes again and indicated the internal temperature was 151 degrees F. [NAME] U served the mashed potatoes at this temperature.On 5/7/26 at 10:15 AM Dietary Manager S indicated [NAME] U should reheat items to 165 degrees F. Example 3Facility policy, titled Cleaning Mixers, reviewed 5/7/26, includes: the mixers will be cleaned and sanitized after each use. Wash and sanitize mixer stand and allow to air dry. Inspect the underside to ensure no areas were missed.On 5/5/26 at 10:00 AM Surveyor observed the facility's mixer to be stored uncovered with food particles on the undercarriage. Dietary Manager S indicated during interview that the mixer should be cleaned after each use. Example 4Facility policy, titled Handwashing and Sanitizing, effective date 8/1/1996, includes: . handwashing is the single most effective means of preventing the spread of bacteria and viruses. Each food handling employee is responsible to wash their hands. after touching any surface of contamination such as phone, money, door handles, soiled linen. after removing gloves. On 5/5/26 at 10:00 AM Surveyor observed [NAME] BB cutting onions with gloves on. [NAME] BB removed his gloves and used a marker to label a plastic bag. [NAME] BB then grabbed a new glove and used it like a patty paper to pick up the pieces of onion and place inside of the plastic bag.On 5/5/26 at 10:20 AM Dietary Manager S indicated [NAME] BB should have washed his hands after handling the marker and before returning to handling the onion pieces. Dietary Manager S indicated it is a good practice to wash hands every time you remove your gloves.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and interview, the facility did not maintain a quality assessment and assurance committee consisting of the required members to identify issues through the committee. This deficient practice has the potential to affect all 49 residents currently in the facility.The IPC (Infection Prevention and Control nurse) did not attend Quality Assurance Performance Improvement (QAPI) meetings on 2 out of 4 quarterly meetings.This is evidenced by:The facility's policy Quality Assurance/Assessment and Performance Improvement Plan, undated, includes: The Quality Assessment and Assurance (QAA) Committee consist of the Director of Nursing Services, the Medical Director, the Administrator, at least two other members of the facility staff, and the infection control and prevention officer.On 5/4/26 at 10:00 AM during entrance conference, Surveyors asked DON B (Director of Nursing) and NHA A (Nursing Home Administrator) who is the facility's IPC. DON B indicated IPC T is the facility's infection prevention and control nurse.The facility's QA (Quality Assurance) Committee Attendance sign-in-sheet, dated 10/24/25, does not include an IPC.The facility's QA Committee Attendance sign-in-sheet, dated 4/24/26, does not include an IPC.On 5/5/26 at 4:28 PM, Surveyor asked DON B if she was certified in infection prevention and control. DON B indicated she was not.On 5/11/26 at 1:55 PM, Surveyor interviewed NHA A regarding the facility's QAPI program. NHA A indicated the Medical Director, the NHA, the pharmacist and the DON were the required members to be in the QAPI meeting. NHA A indicated IPC T does not always attend. Surveyor asked NHA A if IPC T should attend the QAPI meetings since the IPC is a required member of the QAPI committee and NHA A indicated IPC T should attend the meetings.