STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525452	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elroy Health Services	307 Royall Ave Elroy, WI 53929

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure each resident receives adequate supervision and safety to prevent accidents and hazards for 1 of 1 Residents reviewed for smoking (R51).On 4/5/26, R51 was observed by staff to be smoking an illegal substance in his room. R51 had a history of illicit drug use, however, this was not addressed upon R51's admission. No monitoring was put in place for R51 regarding the use of illegal substances. R51 has a roommate, and residents in rooms near R51 use oxygen.The facility's failure to provide adequate supervision and protect residents from smoking in the facility and illegal substance use created a finding of immediate jeopardy (IJ) that began on 4/5/26. Surveyor notified NHA A (Nursing Home Administrator) and VPS E (Vice President of Success) of the immediate jeopardy on 5/7/26 at 1:50 PM. The immediate jeopardy was removed on 5/7/26. However, the deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan.Evidenced by:The facility policy, Safety for Residents with Substance Use Disorder, dated 10/18/22, states, in part: . Policy Explanation and Compliance Guidelines: 1. Residents with a history of SUD (substance use disorder) will be assessed for risks including the potential to leave the facility without notification and use of illegal/prescription drugs. Care plan interventions will be implemented to include increased monitoring and supervision of the resident and their visitors. 6. Residents with SUD may try to continue using substances during their stay in the nursing home. Facility staff will assess the resident for the risk for substance use in the facility and have knowledge of signs and symptoms of possible substance(s) that include, but are not limited to: a. Frequent leaves of absence with or without facility knowledge.The facility policy, Smoking Policy, dated 5/2019, with last review date of 9/10/24, states, in part: Policy: It is the policy of this facility to provide a safe and healthy environment for residents. including safety related to smoking. Safety protections apply to smoking and non-smoking residents. Policy Explanation and Compliance Guidelines: 1. Smoking is prohibited in all areas except the designated smoking area.R51 was admitted to the facility on [DATE] with diagnoses that include, in part: Parkinson's Disease, Cognitive Communication Deficit, Cardiac Arrhythmia, Dizziness and Giddiness, Syncope and Collapse, and Other Psychoactive Substance Dependence uncomplicated (added to diagnosis list on 4/7/26).R51's most recent Minimum Data Set (MDS) indicates R51 has a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating R51 is moderately cognitively impaired.R51's most recent Comprehensive Care Plan states, in part:Focus: History of smoking in community r/t (related to): Smokes occasionally both on and off premises. Date Initiated: 1/20/26. Goal: Will remain compliant with facility non-smoking policy. Date Initiated: 1/20/26. Revision on: 4/9/26. Will smoke safely in designated areas. Date Initiated: 1/20/26. Revision on: 4/9/26. Interventions: Allow to smoke independently in designated areas. Date Initiated: 1/20/26. Complete smoking eval per facility guidelines. Date Initiated: 1/20/26. Resident is aware of no smoking in room. Date Initiated: 4/6/26. Secure smoking materials at nurses station or other designated area for storage. Date Initiated: 1/20/26.R51's Nicotine Assessment, dated 9/17/25, indicates a Category of: Independent, that resident smokes cigars daily but understands and adheres (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to the smoking policy.R51's Nicotine Assessment, dated 4/7/26, indicates a Category of: At Risk, requiring staff supervision.On 7/7/25 an History of Present Illness (HPI) document states, in part: . Social History: Non-prescribed substance use: marijuana (any form); Non-prescribed substance use details: 4 times after 6 pm - last time used about 3 weeks ago.On 7/17/25: an office visit document for new admission follow-up states, in part: .Falls: Cannabis Abuse (Resolved).On 4/3/26 at 9:29 PM, R51's progress note states in part: Resident out to bank when writer here. Back approximately 7:00 PM. States had Chinese for supper.On 4/5/26 at 5:48 PM, R51's progress note states in part: Resident went out to dinner with Nephew to the Dalles (sic). Forgot to sign out of the facility.On 4/5/26 at 10:00 PM, R51's telehealth visit note states in part: Resident was out with family today had fallen and has an abrasion on his right knee but, resident returned with crack and was smoking it in his room.On 4/6/26 at 5:56 AM, R51's telehealth visit note states in part: . The patient had been smoking crack cocaine in his room. Social History: Substance Use: Recent crack cocaine use (smoking crack in his room) . called about. elevated blood pressure of 203/89 after recent crack cocaine use. They hypertensive episode appears to be related to recent recreational crack cocaine use.On 4/6/26 at 1:26 PM, NHA A sent an email to VPS E that states in part: .so (DON B's first name) and I just spoke with CNA (CNA H's Name) who was present yesterday. She states the following - (R51) left with his family and when he got back he said they took him to get Chinese food. He then told (CNA I's name) (another CNA) and myself that we had to come down to his room. We went down to see what he needed and he opened his glasses case and had a baggie with like white crystals or something in it. He asked if we wanted to smoke crack. We told him no and said he shouldn't be doing that either. He I don't care, then he picked it up and started to smoke. We told him you cant smoke inside but he wouldn't listen so I went and got (LPN J's name) and she handled it from there. I believe she took all the stuff out of his room.(CNA I's name) - I gave him a shower no problems and then he went back in his room I wanted to check on him around 340 and he was out with his nephew at Chinese in the dells with his nephew. He came back and had a scrape on his knee and told us he fell with his family. When he got back he pulled (CNA H's name) aside and showed her the stuff and he was being inappropriate towards her. (CNA H) then told the nurse and the nurse went down to address it and take his stuff, she then told us if he was going to go outside he needed to be supervised at all times. He did not show it to me at all. But I did see like little white specks on his table and the case he had. (CNA H) told me that he was smoking and I went into the room and told him if he wants to smoke anything he has to go outside. After I told him to stop he put it back on his table. It didn't look like it was still going when he put it on his table. Then (LPN J) came and took away his lighter and anything he had.(LPN J's name) - I spoke to LPN J this morning and she said that the girls came to get her and she went down when she got down to his room she took everything she could find. She did not see him smoking anything in the room, she also instructed him that if he is going to smoke he cannot do it in the building and that staff would assist with supervision if he was to go outside at all.On 4/6/26 at 2:07 PM, R51's provider notification states in part: . Situation: consumption of recreational drug use and hypertension. Background: . Resident participates in recreational drug activities. Assessment: . Resident has an elevated blood pressure after use of recreational drugs.On 4/6/26 at 2:34 PM, R51's progress notes states in part: Resident expressed signs of depression and recent use of recreational drug to help resolve his depression, behavioral health consult reviewed with resident.On 4/7/26 a Skilled Nursing Facility (SNF) Acute visit states, in part: . Incident: patient left the facility, he did not sign out, returned with knee abrasion and crack cocaine. Reportedly, patient flushed cocaine before it could be confiscated. Patient admits to use of recreational use of cocaine and marijuana/THC over many years. He notes he last did cocaine several years ago, before he moved into. SNF. Patient meets criteria for substance use disorder in that he continues to use marijuana/cocaine in situations that are physically hazardous (leaving the facility with family and acquiring the substance) and he continues to use marijuana/cocaine despite knowing that it has a negative effect on his physical health.Focus: History of substance use disorder as evidenced by : Use of illegal drugs. Date Initiated: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4/6/26. Goals: Will not harm self or others due to use of unauthorized substances. Date Initiated: 4/6/26. Revision on: 4/9/26. Will eliminate unauthorized use/consumption of illegal drugs (THC or crack). Date Initiated: 4/6/26. Revision on: 4/9/26. Resident will demonstrate understanding that substance use is not permitted in the facility through the next review date. Date Initiated: 4/6/26. Revision on: 4/9/26. Interventions: Contact emergency services for signs of overdose and administer opioid reversal agents as indicated. Date Initiated: 4/6/26. Discuss coping strategies. Date Initiated: 4/6/26. Educate on risks of leaving the facility to seek out substances and/or early, unplanned discharge. Date Initiated: 4/6/26. Encourage frequent contact with family and friends that are supportive of resident's recovery and do not encourage substance use, as desired by resident. Date Initiated: 4/6/26. Revision on: 5/7/26. If appears under the influence of unauthorized substance, notify MD and observe for safety/changes in condition. Date Initiated: 4/6/26. Increase monitoring and supervision of resident and their visitors. Date Initiated: 4/6/26. Instruct resident and visitors that alcohol/drugs may not be brought onto the premises. Date Initiated: 4/6/26. Monitor for signs and symptoms of a potential drug overdose. Administer Narcan per facility protocol. Date Initiated: 4/6/26. Revision on: 5/7/26. Offer resident a behavioral contract if cognitively able to consent, and only if will encourage resident to follow plan of care. Date Initiated: 4/6/26. Psychological or psychiatric services as indicated/ordered. Date Initiated: 4/6/26. Report changes in mood and suspected use of substance use to physician. Date Initiated: 4/6/26. Revision on: 5/7/26. Support resident's strengths and provide positive affirmations. Date Initiated: 4/6/26. Revision on: 5/7/26. Upon discharge, provide appropriate referrals and discharge instructions. Date Initiated: 4/6/26.Focus: Opioid use - risk of. Date Initiated: 4/7/26. Goals: Resident will not experience prolonged constipation, ileus, or impaction while taking opioids throughout the review period. Date Initiated: 4/7/26. Revision on: 4/9/26. Resident will not experience signs/symptoms of overdose or adverse drug event through review date. Date Initiated: 4/7/26. Revision on: 4/9/26. Interventions: Monitor for side effects. Date Initiated: 4/7/26. Monitor for signs and symptoms of a potential drug overdose. Administer Narcan per facility protocol. Date Initiated: 4/7/26.(of note: R51 is not receiving opioid medications)Focus: At risk for smoking related injury r/t (related to) disability. Date Initiated: 4/7/26. Revision on: 4/27/26. Goals: Resident will maintain safety while smoking independently. Date Initiated: 4/7/26. Revision on: 4/9/26. Resident will have no smoking relating injuries. Date Initiated: 4/7/26. Revision on: 4/9/26. Resident will remain compliant with facility smoking policy and procedure. Date Initiated: 4/7/26. Revision on: 4/9/26. Interventions: Allow resident to smoke independently in designated area. Date Initiated: 4/7/26. Assure smoking material is extinguished prior to resident leaving smoking area. Date Initiated: 4/7/26. Complete nicotine assessment per facility policy. Date Initiated: 4/7/26. Observe resident for unsafe smoking behaviors or attempts to obtain smoking material from outside sources. Immediately inform facility management of concerns. Date Initiated: 4/7/26. Resident not to have cigarettes or smoking material on person. Date Initiated: 4/7/26. Review smoking policy with resident and/or family. Date Initiated: 4/7/26. Storage of smoking materials per facility policy. Date Initiated: 4/7/26.(Of note: this care plan was added after the incident on 4/5/26 where R51 was found smoking crack cocaine in his room.)R51's physician orders include the following, in part: Opioid Medication Side Effects: Resident has no scheduled opioids. Due to risk/history of substance use, monitor for signs of possible opioid exposure or overdose. Monitor for: abdominal pain/distention, confusion, disorientation, hallucinations/delusions, dizziness/light-headedness, lethargy/increased sedation, agitation/anxiety, decreased responsiveness/unresponsiveness, decreased respirations. Notify: Nurse immediately; notify provider for any new or worsening symptoms or signs of overdose. Start Date: 4/7/26. This order is being signed out on R51's Treatment Administration Record (TAR) each shift.Of note: Cocaine is a stimulant drug and would require different monitoring for side effects and overdose than an opioid medication.R51's Certified Nursing Assistant (CNA) Care Plan/Kardex, as of 5/7/26, indicates the following, in part: . Resident Care: . Encourage frequent contact with family and friends that are (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	supportive of resident's recovery and do not encourage substance use, as desired by the resident. Monitor for signs and symptoms of a potential drug overdose. Administer Narcan per facility protocol. Safety: . Allow resident to smoke independently in designated areas. Increase monitoring and supervision of resident and their visitors. Resident not to have cigarettes or smoking material on person.(Of note: despite R51 having a history of THC use, this is the first time the facility has addressed R51's substance use. R51's care plan indicates Increase monitoring and supervision of resident and their visitors, but it does not indicate what type of increased monitoring or supervision such as what staff are to be doing or what this is to consist of.)On 4/8/26 at 9:53 AM, R51's Interdisciplinary Team (IDT) review states in part: Reason for Review: Unwitnessed fall outside of building. Resident is known to use substance abuse (sic).On 4/13/26 at 4:56 PM, R51's physician communication note indicates: Response: Patient meets criteria for substance use disorder.On 5/3/16 at 1:36 PM, R51's progress note states in part: . Still goes out with family at least once a month to go to bank. Staff to ask/monitor if he did any smoking or other meds/drugs while out.Of note, a review of the Resident Sign In/Sign Out sheets located at the front desk of the facility, indicated that R51 signs himself out of the facility approximately 1-2 times per month.On 5/6/26 at 8:42 AM, Surveyor interviewed R51 about his smoking. R51 stated that he quit smoking cigarettes years ago but that he smokes the occasional cigar. Surveyor asked R51 if he ever smoked in his room. R51 stated that a couple of weeks ago he was smoking an illegal substance in his room. R51 did not indicate what the illegal substance was but stated that he smoked it in a pipe and that he got the materials while he was out with family.On 5/6/26 at 10:11 AM, Surveyor interviewed CNA F (Certified Nursing Assistant) and asked what monitoring was being done for R51. CNA F stated she wasn't sure, since she usually works night shift. Surveyor asked CNA F if she had received any education recently on smoking and illegal substance use. CNA F stated yes that she did some online training a month or two ago.On 5/6/26 at 10:13 AM, Surveyor interviewed CNA G and asked what monitoring was being done for R51. CNA G stated that she makes sure he has proper footwear, and his call light is within reach. Surveyor asked CNA G if she had received any education recently on smoking and illegal substance use. CNA G stated yes that she had received training within the last 30 days.On 5/6/26 at 10:15 AM, Surveyor interviewed LPN C (Licensed Practical Nurse) and asked what monitoring was being done for R51. LPN C stated that when R51 is out of his room, she makes sure that he is using his cane. LPN C stated that when R51 leaves she is also making sure that he doesn't bring any illegal substances back to the facility with him. Surveyor asked LPN C if she had any knowledge of R51 smoking in his room. LPN C stated she saw the pipe on his table on PM shift the day he was out, but she didn't know what it was, otherwise she would have done something about it.On 5/6/26 at 1:35 PM, Surveyor interviewed MD T (Medical Director) about the incident of R51 smoking an illegal substance in his room. MD T stated that the facility had informed her that R51 came back from visiting family on Easter and the nurses reported that he had smoked crack while out with family. MD T indicated that she had never been informed that R51 was smoking in his room. MD T stated that the opioid monitoring was not something that she ordered, but that it was something initiated by the nursing staff. MD T stated that the facility might have put the opioid monitoring in place just for R51's safety, however they should be monitoring for signs of cocaine use. MD T indicated that administering Narcan for a cocaine overdose would not be appropriate.On 5/6/26 at 2:07 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked what they are doing to keep R51 and the other residents safe. NHA A stated that they have updated R51's care plan while being respectful of his resident rights. NHA A indicated that when R51 returns from being out of the facility they ask him if he needs to turn in anything on his person. NHA A stated that he had R51 re-sign the smoking policy and that materials need to be turned in and stored appropriately. NHA A indicated that he discussed with R51 that illicit substances are not allowed in the building.On 5/6/26 at 3:00 PM, Surveyor interviewed CNA H (Certified Nursing Assistant) via telephone. CNA H said she walked into R51's room at around 7:30 PM because his call light was on and she saw him with a pipe in his hand. CNA H stated she asked (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RN K stated yes, they had recently gone over that.On 5/6/26 at 4:17 PM, Surveyor interviewed CNA L and asked her what monitoring was being done for R51. CNA L stated that she monitors R51 when he is up and walking and asks him hourly if he needs anything. Surveyor asked CNA L if she had received any education on smoking and illegal substance use. CNA L stated no, she had not received any education on that recently.On 5/6/26 at 4:19 PM, Surveyor interviewed CNA M and asked her what monitoring was being done for R51. CNA M stated she was monitoring every hour to make sure R51 was not self-transferring. Surveyor asked CNA M if she had received any education on smoking and illegal substance use. CNA M stated no, she had not received any education recently. On 5/6/26 at 4:21 PM, Surveyor interviewed CNA N and asked her what monitoring was being done for R51. CNA N stated that R51 is not supposed to be ambulating by himself, so she makes sure to check on him every hour. Surveyor asked CNA N if she had received any education on smoking and illegal substance use. CNA N stated yes, on smoking a couple weeks ago.On 5/6/26 at 5:03 PM, Surveyor interviewed RN K and asked her if Narcan would be effective for someone using cocaine. RN K stated it couldn't hurt, as it could save someone's life who needed it and only make them feel crappy if they received it and didn't need it. Surveyor asked RN K how often R51 left the facility with family. RN K stated that R51 left the facility with family frequently, at least weekly. RN K indicated that sometimes R51 leaves the facility and forgets to sign out the book at the front desk.On 5/6/26 at 5:05 PM, Surveyor interviewed CNA N and asked her how often R51 left the facility with family. CNA N stated she would say it was at least once per week. On 5/7/26 at 7:44 AM, Surveyor interviewed NHA A and asked him if he was aware that R51 had admitted to the facility with prior use of illegal substances. NHA A stated he did not believe that staff were aware of that.On 5/7/26 at 8:41 AM, Surveyor interviewed NHA A and asked him why R51 had been ordered Narcan. NHA A stated that Narcan was ordered for R51 due to his substance use and to be proactive because he may use other substances that Narcan would be effective for.On 5/7/26 at 8:45 AM, Surveyor interviewed LPN C and asked her how often R51 left the facility with family. LPN C stated that R51 goes out with family at least twice per month, sometimes more often.On 5/7/26 at 8:49 AM, Surveyor interviewed RN O and asked her what she would be monitoring for someone who was using cocaine. RN O stated she would look for pinpoint pupils, euphoria, lethargy, hallucinating or delusions. Surveyor asked RN O if she would use Narcan for someone using cocaine. RN O stated yes, she would use Narcan if she suspected a resident had used drugs. Surveyor asked RN O if Narcan would be effective for someone using cocaine. RN O stated she had never administered Narcan, so she couldn't really tell whether it would be effective or not. Surveyor asked RN O if she had received education on smoking and illegal substance use. RN O stated yes, she had received training on both of these recently.On 5/7/26 at 8:54 AM, Surveyor interviewed CNA P and asked her how often R51 leaves the facility with family. CNA P stated that R51 leaves the facility at least once a week for sure. Surveyor asked CNA P what monitoring was being done for R51. CNA P stated that they check on him every hour to see if he needs anything and to make sure he is not getting up by himself. Surveyor asked CNA P if she had received any education on smoking and illegal substance use. CNA P stated yes, she had received education on smoking.On 5/7/26 at 10:30 AM, Surveyor interviewed R51 about smoking in the building. R51 confirmed that he had smoked crack cocaine once in his bathroom at the facility, and then the rest he went outside to smoke later on that same night in the smoking area on the facility premises. R51 stated that the police came the next day, but he couldn't remember what the officer said to him.A police report dated 4/6/26 at 12:30 PM was provided to Surveyor by the [NAME] County Police Department, which states, in part: A resident reported he was smoking crack cocaine. Said he got it while he was out with his nephew. PD Q (Police Deputy) responded to the call on 4/6/26 at 12:52 PM. [Resident Name] went to [location] in [town] with his nephew. [Resident Name] paid $50 for a bag of crack cocaine. [Resident Name] said he smoked some yesterday and flushed the rest this morning. When I told [Resident Name] not to buy more crack, [Resident Name] said, ?I probably will'.On 5/7/26 at 11:05 AM, Surveyor interviewed PD Q who stated that he was called to the facility and made contact with R51 on 4/6/26. PD Q stated (continued on next page)

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Elroy Health Services	307 Royall Ave Elroy, WI 53929

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	that R51 told him he said he paid $50 for a bag of crack cocaine while out with family. PD Q indicated that R51 claimed to have smoked some of it and flushed the rest of it down the toilet that morning. PD Q stated there was no illegal substance or paraphernalia when he came to the building. PD Q stated that R51 told him that he smokes crack pretty often while out with family and that he was very clear that he would do it again. PD Q stated that he didn't file a report because he didn't find any evidence of drugs at that point. PD Q stated that there were other substances found in his room including weed wax melt and a THC wafer that was confiscated by nursing home staff and disposed of. PD Q stated that he spoke with SS R (Social Services) who said that he confiscated those materials and had already destroyed them before PD Q arrived at the facility.(Of note: Weed wax melts can be highly concentrated form of cannabis (THC) used for dabbing and vaporization and a THC wafer is a wafer tablet that's fast-disintegrating and contains cannabis extract.)On 5/7/26 at 11:20 AM, Surveyor interviewed SS R about R51's possession of illegal substances and smoking in his room. SS R stated that he helped create the education that was provided to all staff, and that he was the one who contacted law enforcement. SS R indicated that when PD Q arrived at the facility, he escorted him to R51's room, where PD Q interviewed R51 privately. SS R stated that he was not present when PD Q searched R51's room, but PD Q told him that he did not find anything. Surveyor asked SS R about finding a weed wax melt and THC wafer in R51's room. SS R stated that he was not involved with the search of R51's room, and that he was under the understanding that everything had been turned into the nurse the night before. SS R stated that it was NHA A (Nursing Home Administrator) who searched R51's room. On 5/7/26 at 11:24 AM, Surveyor interviewed NHA A (Nursing Home Administrator) about the incident involving R51's possession of illegal substances and smoking in his room. NHA A stated that he went to R51's room and found an Altoids container and a glove, and that the Altoids container was empty but that it was wet and looked like it had been washed out. NHA A stated that he gave those materials to PD Q. NHA A stated that PD Q went down to R51's room, but that he was not present when PD Q searched R51's room. Surveyor asked NHA A why the police hadn't been contacted sooner. NHA A stated that he couldn't speak to that but, that [Town name] does not have their own police department and that [NAME] County is only in [Town name] on certain days. Surveyor asked NHA A about the weed wax melt and THC wafer. NHA A stated that he didn't confiscate anything else from R51's room but the Altoid's container and glove and had no knowledge of a weed wax melt and TCH wafer being found in R51's room. The failure to provide adequate supervision and protect residents from R51 smoking an illegal substance in the facility created a reasonable likelihood for serious harm, which created a finding of immediate jeopardy. The facility removed the jeopardy on 5/7/26 when it completed the following:Identified Resident continues to reside at the facility. Identified Resident. had his smoking materials removed from the room, Sound Physicians on call service updated, PCP (primary care provider) updated, CP (care plan) reviewed, behavioral contract completed, COC completed, Psychosocial evaluation recompleted, nicotine assessment completed, smoking acknowledgement form recompleted, Police contacted, recent behaviors reviewed for changes, recent progress notes reviewed for changes, monitoring orders placed, opioid care plan and hx/o substance use CP with interventions and monitoring, Dx updated. Started on 4/6/26.Current residents who have a hx/o (history of) substance use disorder and residents that smoke have the potential to be affected. Residents identified to smoke had new smoking acknowledgement forms completed which include re-education on not smoking in their rooms and a Nicotine assessment recompleted to ensure safe smoking. An ongoing audit was initiated on 4/7/26 to observe for safe smoking practices and no smoking materials in rooms. Residents identified to have a hx/o substance use disorder had their care plan revised to include monitor for s/sx of opioid overdose and stimulant use.Education/Training:Residents identified to smoke were re-educated on not smoking in their rooms and safe smoking practices, and storage of materials. This was completed on 4/6/26 with

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not immediately notify and consult with a resident's physician when there was a change in condition. This occurred for 2 of 5 Residents (R68 & R6) reviewed for notification of change in condition. On 10/26/25, R68 had a BP (Blood Pressure) of 68/52, was feeling dizzy and lightheaded. Throughout the night R68 had BPs readings of 80/40, 89/56, and 94/58. The next morning on 10/27/25 at 9:15 AM, R68 had a fall. The facility did not notify physician of change in condition throughout the night. On 3/5/26, the facility sent an e-Interact communication to the provider of R6's change of condition. The facility did not follow up with the provider regarding the change of condition to get any new orders or monitoring recommendations for R6 for several hours, after the change of condition was noted. This is evidenced by: The facility's policy, entitled Change in Condition of the Resident, dated 9/20/22, states, in part: . Policy: A facility should immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); or a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). Policy Explanation and Compliance Guidelines: When a resident presents with a possible change of condition, after a fall or other possible injury, trauma, or noted changes in mental or physical functioning: . 3. Notify resident's physician- Use INTERACT Change in Condition: When to report to the MD (medical doctor)/NP (nurse practitioner)/PA (physician assistant) as a guideline. a. Immediate notification: Immediate notification for any symptom, sign or apparent discomfort that is: i. Acute or sudden in onset, and: ii. A marked change (i.e., more severe) in relation to usual symptoms and signs, or iii. Unrelieved by measures already prescribed requires a phone call to the provider. Do not fax for issues requiring immediate notification. DOCUMENTATION: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Documentation needs to include, but is not limited to the following: 1. Description of change in condition noted and assessment or observation of findings. 3. Notification of provider- include date, time, what was conveyed, any orders received. INTERACT: VITAL SIGNS BP (blood pressure): Report Immediately: Systolic BP>200mmHg (milliliters of mercury high column of mercury) or <90 mmHg. Example 1: R68 admitted to the facility on [DATE] and has diagnoses that include displaced trimalleolar fracture of right lower leg (fracture of lower leg sections that form your ankle joint), hypertensive heart disease with heart failure (occurs when long term unmanaged high blood pressure forces the heart to work too hard causing the muscle to thicken and eventually become weak) and chronic atrial fibrillation (heart arrhythmia characterized by an irregular, often rapid heart caused by chaotic electrical signals in the heart's upper chambers). R68's Physicians Orders, dated for 10/01/25- 10/31/25 includes: *Blood Pressure parameter: update MD if systolic BP >160 or diastolic BP<60. 10/28/25. *Diuretics- Observe for the following: . hypotension. If any symptoms observed, document in progress note and notify physician. *Furosemide. 80 mg. two times a day. for systolic heart failure. *Lisinopril 20 mg twice a day. for hypertension. *Metoprolol Succinate ER. 12.5mg daily for rate control in atrial fibrillation *Ramipril 10 mg two times a day for hypertension R68's BP readings are as follows: 10/26/25 8:21 PM BP - 68/52 10/26/25 9:00 PM BP - 80/40 10/26/25 10:00 PM BP - 89/56 10/26/25 11:00 PM BP - 94/58 10/27/25 12:05 AM BP - 104/64 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/27/25 9:15 AM BP - 68/40 Of Note- There are 4 BPs obtained with the systolic under 90. According to INTERACT (facility standard of practice) the physician should have been notified immediately and not by fax. R68's Progress Notes include: On 10/24/25 at 1:43 PM, Note Text- R68 returned from an ortho (orthopedic) appointment yesterday. Weight bearing as tolerated in cast. had a syncopal episode while being casted. A medical emergency was called. R68 was evaluated by code team and found to be hypotensive. On 10/26/25 at 8:40 PM, Note Text: Resident feeling dizzy and lightheaded. Says he saw black. Nurse took BP 68/52. RN notified and she will assess. On 10/26/25 at 9:04 PM, Note Text: LPN (licensed practical nurse) reports BP of 68/52 pulse 67. Resident had been up in wheelchair since 4:00 PM with visitors. He states that this is longer time than he is used to being out of bed. While waiting to be put back in bed he complained of feeling lightheaded and started seeing black. He said that when put back into bed he instantly felt better, and LPN took his BP. He states that he did not lose consciousness. Resident is alert and oriented x 4. He answers questions appropriately. HOB (head of bed) is elevated. Skin is warm, dry, pink. Respirations are 18, regular with no accessory muscle use. O2 94% on room air. Manual BP at 9:00PM 80/40 with heart rate 70 and irregular. (History of A-fib). Resident states that he has been drinking fluids (including soda) throughout the day. (chart shows 720 mLs (milliliters) as of noon) . His medications include Lasix 80 mg (milligrams) twice a day, lisinopril, metoprolol succinate. Will continue to monitor. On 10/27/25 at 4:06 AM, Note Text: Resident was checked on by staff and vital signs taken 10:00 PM and 11:00 PM. Vital signs taken at 12:00 AM after resident used the bedpan were 104/64 heart rate 72 and irregular. Notes faxed to PCP (primary care physician). On 10/27/25 at 9:15 AM, SBAR (Situation, Background, Assessment and Response)-Change of Condition. Called to R68's room by CNA (certified nursing assistant) stating that R68 is on the floor. Assessment.: .R68 was sitting on his buttock with legs straight out in front of him. CNA and PT (Physical Therapy) stated they attempted to stand R68 with gait belt and walker from a sitting position on his bed and when he started to stand, his right leg (casted) started sliding and R68 was lowered to the floor. R68 stated that he felt dizzy and lightheaded while sitting on the floor. BP noted to be very weak and low at 70/46. Recommendations: Send R68 via ambulance to ER (emergency room) for evaluation. Surveyor asked NHA A (Nursing Home Administrator) for documentation of the actual time fax was sent to PCP regarding R68's low BPs on 10/26/25 and 10/27/25. NHA A provided the following documentation from clinic: Encounter Date: 10/27/25. Received a fax from [NAME] Health Services: On 10/27/25 at 4:06 AM, Resident was checked on by staff and vital signs taken 10:00 PM and 11:00 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM. Vital signs taken at 12:00 AM after resident used the bedpan were 104/64 heart rate 72 and irregular. Notes faxed to PCP (primary care physician). On 10/26/25 at 9:04 PM, LPN reports BP of 66/52 pulse 67. Resident had been up in wheelchair since 4:00 PM with visitors. He states that this is longer time than he is used to being out of bed. While waiting to be put back in bed he complained of feeling lightheaded and started seeing black. He said that when put back into bed he instantly felt better, and LPN took his BP. He states that he did not lose consciousness. Resident is alert and oriented x 4. He answers questions appropriately. HOB (head of bed) is elevated. Skin is warm, dry, pink. Respirations are 18, regular with no accessory muscle use. O2 94% on room air. Manual BP at 9:00PM 80/40 with heart rate 70 and irregular. (History of A-fib). Resident states that he has been drinking fluids (including soda) throughout the day. (chart shows 720mLs (milliliters) as of noon) . His medications include Lasix 80 mg (milligrams) twice a day, lisinopril, metoprolol succinate. Will continue to monitor. Fax from NP, dated 10/27/25 at 9:15 AM, states, in part: . Reduce furosemide from 80 mg twice a day to 40 mg twice a day due to hypotension. On 5/6/26 at 11:21 AM, Surveyor interviewed ADON U (Assistant Director of Nursing) and asked if ADON U could recall back in November working with R68. Surveyor reviewed R68's progress notes with ADON U. Surveyor asked if ADON U had notified the physician on R68's BP of 68/52, lightheadedness, and seeing black on 10/26/25. ADON U indicated no. ADON U indicated she had informed the charge RN and that RN assessed R68. ADON U indicated she is unable to see a progress note indicating the physician was notified. Surveyor asked ADON U if a BP of 68/52 would be considered a change of condition that would need to be reported to the physician. ADON U indicated yes, it is reportable. ADON U indicated the facility uses eINTERACT for standards of practice and follows the parameters for vital signs in eINTERACT. Surveyor asked ADON U if R68's BP of 68/52 should have been reported to the physician. ADON U indicated yes, the nursing staff have been taught on off hours and weekends for a change of condition, the nursing staff are to use the Sound Physician, which is a tele visit where we interact with the physician by video. ADON U informed Surveyor to check with NHA A as he is able to run a Sounds Report for physician updates. On 5/6/26 at 12:04 PM, Surveyor asked NHA A for documentation to verify actual time physician notification occurred for R68's low BP. NHA A did provide the documentation. NHA A indicated the facility would have expected the MD to be notified immediately of R68's BP of 68/52, lightheadedness, and seeing black. NHA A indicated he would have expected a face-to-face notification over the Sounds iPad not by fax. On 5/6/26, at 1:24 PM, Surveyor interviewed MD T (Medical Doctor). Surveyor reviewed R68's change of condition with MD T starting with R68's ortho visit on 10/23/25 where he had a syncopal episode, and then a BP of 68/52, feeling lightheadedness, dizzy, and seeing black on 10/26/25 at 8:40 PM. On 10/26/25, at 9:00 PM R68 had a BP of 80/40. On 10/26/25, at 10:00 PM, R68 had a BP of 89/56. On 10/26/25, at 11:00 PM, R68 had a BP of 94/58. On 10/27/25, at 9:15 AM, R68 had a BP of 70/46 and a fall. MD T indicated with the event that had occurred during the ortho visit, MD T would think the facility would have been monitoring R68's BP. MD T indicated with a BP of 68/52 and the symptoms R68 was having, MD T would have expected a sounds physician notification. MD T indicated she would have expected some change to be made. MD T indicated the low BPs from the syncopal episode to the BP checks up to the fall would have warranted a call and a change to be made or sent to the ER. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Name] updated and he will be going to meet her at the hospital. On 3/5/26 at 1:35 PM, Resident left via ambulance at this time. R6's hospital Discharge summary, dated [DATE], states the following, in part: . Principal Diagnosis: Acute on chronic respiratory failure with hypoxia.Active Hospital Problems: Acute on chronic respiratory failure with hypoxia, Hypercapnic respiratory failure, Acute kidney injury, COPD, Chronic diastolic heart failure, metabolic encephalopathy, Stage 3b Chronic kidney disease. Summary of admission: . Patient is somnolent, awakens to voice and denies pain but otherwise doesn't participate in history. Per report pt (patient) was less alert last night and then worse this morning. Minimal intake this morning and no urine output overnight or this morning. Her oxygen levels were noted to be 80% on 4 L (liters) and was started on a nonrebreather, subsequently put on BiPAP for a few hours which was removed prior to transport. Hospital Course: [Resident Name] was admitted with acute on chronic hypercapnic respiratory failure, metabolic encephalopathy and AKI (Acute Kidney Injury). CXR (chest x-ray) and BNP (B-type natriuretic peptide test to determine heart failure) suggested fluid overload. She was placed on BIPAP (Bilevel Positive Airway Pressure machines - noninvasive ventilators used to treat breathing difficulties) and given IV diuretics. IV antibiotics were started for concern of possible CAP (community acquired pneumonia). It was felt that her confusion was likely multifactorial including the hypercapnia, high dosed Seroquel, and AKI. On 5/7/26 at 2:39 PM, Surveyor interviewed RN Y (Registered Nurse) about resident changes in condition. RN Y stated a change in condition would include if a resident was not eating, restless, a change in vital signs, a fever, or changes in behavior. Surveyor asked RN Y how she would notify the physician of a change in condition. RN Y stated that she was instructed to use the Sounds communication system on the computer, but personally she would try to call the physician. On 5/7/26 at 2:42 PM, Surveyor interviewed RN Z about resident changes in condition. RN Z stated that a change of condition would be fatigue, changes in mentation, and vital signs out of parameter. Surveyor asked RN Z how she would notify the physician of a change in condition. RN Z stated she would call the physician and also contact her supervisor. On 5/7/26 at 2:47 PM, Surveyor interviewed LPN AA (Licensed Practical Nurse) about resident changes in condition. LPN AA stated that a change of condition would be anything out of the normal. Surveyor asked LPN AA how she would notify the physician of a change in condition. LPN AA stated she would call them if she felt like it was a situation that couldn't be waited on. On 5/7/26 at 2:51 PM, Surveyor interviewed RN O about R6's change in condition. RN O stated that the CNA (Certified Nursing Assistant) had called her to R6's room and when she went in to assess her, she noted that R6 was difficult to rouse and had taken her oxygen tubing off. RN O stated that she replaced the oxygen on R6 and took her pulse oximetry, noting that R6's O2 sats were in the mid to low 80's range. RN O stated that PA X (Physician Assistant) was in the facility that day and told her to increase R6's oxygen liters to 4, which she did. RN O stated she gave R6 her nebulizer treatment which didn't help any, so PA X told her to get a nonrebreather mask for R6. RN O stated that R6's oxygen levels continued to go down, so PA X told her to send R6 out to the hospital. Surveyor asked RN O about physician notification for changes in condition. RN O stated that she used the e-Interact tool because that would give them a paper trail of notifying the provider. RN O indicated that if she felt it was an emergency, she would use her nursing judgment and send someone out before contacting the physician. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/26 at 2:52 PM, Surveyor interviewed LPN C about R6's change in condition. LPN C stated that R6 tends to take her oxygen off, and on that day, they couldn't get her oxygen level up and she was kind of out of it. LPN C stated that they increased R6's liters of oxygen, but PA X was in the facility and made the decision to send her out. On 5/7/26 at 2:57 PM, Surveyor interviewed PA X (Physician Assistant) and asked what her expectation for notification was if a resident has a change of condition. PA X stated that it would depend on the timeline, and if it was outside of office hours of 8:00 AM to 4:30 PM they would have had to use the Sounds (telehealth on call doc service). PA X stated that during office hours they could either contact the clinic or use Sounds. PA X indicated, however, that if someone was critical, she would expect the staff to use their nursing judgment to send them to the hospital without contacting the physician first. On 5/7/25 at 3:11 PM, Surveyor interviewed VPS E (Vice President of Success) about physician notification and R6's change in condition. VPS E stated that sending a fax to the physician would not be appropriate in that situation, and that the staff should have called the doctor to follow up.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interview the facility did not provide the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) and the Notice of Medicare Non-Coverage (NOMNC); thus, did not provide the notice of Medicare services ending and the accurate potential financial liability to residents whose Medicare coverage was ending for 1 of 3 residents reviewed (R48).R48 was receiving Medicare A benefits. R48 was not provided with the NOMNC and SNFABN form thus not being provided with the accurate financial liability. Evidenced by:The facility's policy titled Advance Beneficiary Notice dated 5/12/25 states in part .5. To ensure that the resident, or representative, has enough time to make a decision whether or not to receive the services in question and assume financial responsibility, the notice shall be provided at least two days before the end of a Medicare covered Part A stay or when all of Part B therapies are ending. The notices must nit be provided while the resident/ representative is under duress or in an emergency situation.R48's Medicare coverage ended on 4/22/26. R48 or their representative was not provided with a NOMNC or SNF ABN form. R48 was not informed of his entire potential liability and reason for ending of benefits prior to the benefits ending. Notice was provided to R48's representative on 4/27/26.On 5/5/26 at 3:51 PM, Surveyor interviewed MDS (Minimum Data Set) Coordinator D . Surveyor asked MDS Coordinator D what the process is for handing out beneficiary notices, MDS Coordinator D stated that they are provided to the resident or their representative two days prior to their last covered day. Surveyor asked MDS Coordinator D about R48's notices being late, MDS Coordinator D stated that R48's notices got missed and were not provided prior to their last covered day. Surveyor asked MDS Coordinator D if the notices should have been provided to R48's representative prior to 4/22/26, MDS Coordinator D stated yes.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **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 is unable to carry out activities of daily living (ADLs) receives the necessary services to maintain good nutrition, grooming, personal and oral hygiene for 1 of 16 sampled Residents (R7).R7 reported that facility staff do not assist with shaving, despite R7 having their own shaver. R7 noted to have approximately 1/4 facial hair on their chin.Evidenced by:The facility's policy titled Activities of Daily Living (ADLS) dated 7/26/22 states in part .3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.R7 was admitted to the facility on [DATE] with diagnoses that include bipolar disorder (a mental health condition characterized by significant mood swings, including manic (or hypomanic) episodes and depressive episodes), dementia, polyneuropathy (nerve disease caused by damage to many nerves, often due to conditions like diabetes or alcohol overuse), and radiculopathy (condition caused by the compression of a spinal nerve root, leading to symptoms such as pain, numbness, and tingling along the affected nerve).R7's most recent MDS (Minimum Data Set) dated 5/5/26 states that R7 has a BIMS (Brief Interview of Mental Status) of 15 out of 15, indicating that R7 is cognitively intact. R7's MDS also states that R7 is dependent on staff for showering/bathing and personal hygiene.R7's care plan dated 2/5/19 states in part .Focus: ADL self care deficit as evidenced by: related to: physical limitations, bipolar disorder, osteoarthritis, chronic pain to BLE (Bilateral Lower Extremities). Goal: Will be clean, dressed, and well groomed daily to promote dignity and psychosocial wellbeing. Interventions/Tasks: .Encourage and assist to shower or bathe as desired and as needed.It is important to note that neither R7's care plan nor R7's CNA (Certified Nursing Assistant) Kardex addresses R7's personal hygiene/grooming.On 5/7/26 at 12:39 AM, Surveyor interviewed R7. Surveyor noted that R7 had facial hair on their chin that was approximately 1/4 long. Surveyor asked R7 how they feel about having the whiskers on their chin, R7 stated that they don't like them and that they even have their own shaver on the dresser. Surveyor observed an electric shaver on R7's dresser. Surveyor asked R7 if they ask the staff to shave them, R7 stated yes, but if they forget to ask, staff doesn't do it.On 5/7/26 at 12:46 PM, Surveyor interviewed CNA S. Surveyor asked CNA S if they provided cares for R7 this morning, CNA S stated yes. Surveyor asked CNA S how often they shave R7, CNA S stated that they forget about it. Surveyor asked CNA S if they noticed R7's whiskers on their chin this morning, CNA S stated no and asked Surveyor if they are long. Surveyor reported that R7's facial hair is approximately 1/4 long.On 5/7/26 at 2:11 PM, Surveyor interviewed VPS E (Vice President of Success). Surveyor asked VPS E how often they would expect resident to be shaved, VPS E stated that for female residents, they want to consider their dignity and appearance and should shave residents accordingly. Surveyor asked VPS E if a resident asks to be shaved, should staff be completing that request, VPS E stated yes.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 1 of 2 residents (R43) reviewed for transportation for medical appointments. R43 had a medical appointment scheduled for 5/4/26 and the facility failed to arrange transportation. Evidenced by: The facility does not have a transportation policy. R43 was admitted to the facility on [DATE] with diagnoses that include cognitive communication deficit (a condition where cognitive impairments disrupt a person's ability to communicate effectively, despite intact language or speech abilities), cirrhosis of liver (a complication of long-term inflammation of the liver. It results in the replacement of healthy liver tissue with scar tissue, called fibrosis), alcohol abuse, and hepatitis C (a liver disease caused by the hepatitis C virus).R43's most recent MDS (Minimum Data Set) dated 4/30/36 states that R43 has a BIMS (Brief Interview of Mental Status) of 14 out of 15, indicating that R43 is cognitively intact.On 5/5/26 at 10:23 AM, Surveyor interviewed R43. R43 reported that they were supposed to have a medical appointment yesterday (5/4/26) and their ride never showed up. Surveyor observed a sticky note on R43's bedside table that stated 5/4 at 10:45 [Facility Name] general surgery consult [City Name, Physician's Name]. R43 reported to Surveyor that they threatened to leave the facility after they failed to set up transportation to their appointment.Surveyor requested a list of all appointments from 5/1/26-5/6/26. The list provided stated that R43 had an appointment on 5/4/26 at 10:45 AM and states was missed due to not having transportation, [Transportation Company's Name] was contacted and did not respond.On 5/6/26 at 4:24 PM, Surveyor interviewed Scheduler V. Surveyor asked Scheduler V what the process is for scheduling transportation for appointments, Scheduler V stated that depending on their insurance, they call different transportation companies to arrange transportation. Surveyor asked Scheduler V what type of transportation had been arranged for R43's appointment on 5/4/26, Scheduler V stated they had gotten ahold of [Transportation Company Name] and they were unable to do it, and the other transportation company cannot provide transportation on Mondays. Surveyor asked Scheduler V if the facility has a transportation van, Scheduler V stated yes but if a resident does not have Medicaid, the facility will not get reimbursed for the ride. Surveyor asked Scheduler V what type of insurance R43 had, Scheduler V stated R43 had Medicaid pending. Surveyor asked Scheduler V when they were made aware that R43 did not have transportation to their appointment, Scheduler V stated Monday morning. Surveyor asked Scheduler V if they had tried to schedule R43 with another transportation company, Scheduler V stated no. Scheduler V reported to Surveyor that the facility's transportation van was recently in the shop for repairs.On 5/7/26 at 9:00 AM, Surveyor interviewed BOM W (Business Office Manager). Surveyor asked BOM W what R43's payor source was on admission, BOM W stated that it was Medicaid pending. Surveyor asked BOM W if Medicaid will back date and cover costs incurred, BOM W stated yes. Surveyor asked BOM W if Medicaid would cover the cost of transportation to appointments, BOM W stated yes. Surveyor asked BOM W what happens when a resident needs transportation to an appointment and doesn't have a payor source, BOM W stated that the facility will set the resident up with transportation and the facility will absorb the cost or the resident will pay privately, and then when Medicaid is approved, the facility can bill for the transportation. On 5/7/26 at 9:32 AM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A what the expectation is for scheduling transportation for residents' appointments, NHA A stated that they should be scheduled timely and that the facility should be following up with the transportation company. Surveyor asked NHA A when the facility's transportation van had gotten out of the shop, NHA A reported that they weren't sure but would look into it. Surveyor asked if R43 should have been taken to their appointment using the facility's transportation van, NHA A stated that they were not (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sure when R43's payor source was approved.It is important to note that NHA A provided surveyor with an email stating that the facility's transportation van was in the shop from 4/16/26- 4/30/26.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that it was free of medication error rates of 5% or greater. There were 2 errors out of 39 opportunities that affected 2 out of 5 residents (R54 & R46) included in the medication pass task, which resulted in an error rate of 5.13%.R54's orders include levothyroxine daily at 5:30 AM. Staff administered R54's levothyroxine at 8:09 AM. Staff administered R54's levothyroxine and calcium at the same. Staff administered R54's levothyroxine at the wrong time and against manufacturer's directions not to administer with Calcium.Staff administered R46's levothyroxine at 7:46 AM. The order is to administer levothyroxine at 6:00 AM. Staff administered this medication late.Evidenced by:The facility policy entitled Medication Administration, dated 1/26, states, in part: . POLICY: Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so.PROCEDURES: Medication Preparation: .3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. Compare the medication and dosage schedule on the resident's MAR (Medication Administration Record) with the medication label.Medication Administration:1. Medications are administered in accordance with written orders of the prescriber.3. The timing of medication administration must align with manufacturer specifications.14. routine medications are administered according to the established medication administration schedule for the nursing care center.Example 1:R54 was admitted to the facility on [DATE] and has diagnoses that include hypothyroidism (where an underactive thyroid gland fails to produce enough hormones, causing bodily functions to slow down) and age-related osteoporosis (a condition where bones lose density and strength causing fragile bones and a high fracture rate).R54's Comprehensive Minimum Data Set (MDS) Assessment, dated 5/5/26 shows R54 has a Brief Interview of Mental Status (BIMS) score of 12, indicating R54 has moderate cognitive impairment.R54's Physicians Orders, dated 5/06/26, states, in part: . Calcium 600 + D3 Oral Tablet 600-400 MG (Milligrams)- Unit (Calcium Carbonate-Cholecalciferol). Give 1 tablet by mouth in the morning for supplement. Start Date: 4/23/25.Levothyroxine Sodium Tablet 150 MCG (Micrograms). Give 1 tablet by mouth one time a day for low thyroid hormone. Start Date: 4/23/25.R54's May 2026 MAR, states, in part: . Calcium 600 +D3 Oral Tablet 600-400 MG-UNIT. Give 1 tablet by mouth in the morning for supplement at AM 7. Start Date: 4/23/25.Levothyroxine Sodium Tablet 150 MCG. Give 1 tablet by mouth one time a day for low thyroid hormone at 5:30AM. Start Date: 4/23/25.According to Mayo Clinic, https://www.mayoclinic.org, administering levothyroxine with calcium carbonate may cause an increased risk of certain side effects.According to drugs.com, https://www.drugs.com, levothyroxine and calcium carbonate should be administered 4 hours apart. Taking levothyroxine and calcium carbonate together can affect your thyroid level and make levothyroxine less effective.On 5/06/26 at 7:59 AM, Surveyor observed LPN C (Licensed Practical Nurse) administer R54's Levothyroxine 150 mcg and Calcium 600 +D3 600mg/400unit at the same time.On 5/16/26 at 10:10 AM, Surveyor interviewed LPN C. Surveyor asked when R54's levothyroxine should be given. LPN C indicated at 6:00 AM. Surveyor reviewed with LPN C that LPN C administered R54's levothyroxine and calcium at 8:09 AM. Surveyor asked if levothyroxine and calcium should be administered together. LPN C indicated no. Surveyor asked LPN C if R54 received her levothyroxine late. LPN C indicated yes, and LPN C indicated she did not get to R54 when she was supposed to. Example 2:R46 was admitted to the facility on [DATE] and has diagnoses that include hypothyroidism (where an underactive thyroid gland fails to produce enough hormones, causing bodily functions to slow down).R46's Quarterly Minimum Data Set (MDS) Assessment, dated 3/30/26 shows R46 has a Brief Interview of Mental Status (BIMS) score of 03, indicating R46 has severe cognitive impairment.R46's Physicians Orders, dated 5/06/26, states, in part: . Levothyroxine Sodium Tablet 75 MCG (micrograms). Give 1 tablet by (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mouth one time a day related to HYPOTHYROIDISM. Start Date: 7/22/20.R46's May 2026 MAR (Medication Administration Record) states, in part: . Levothyroxine Sodium Tablet 75 MCG. Give 1 tablet by mouth one time a day related to HYPOTHYROIDISM. at 06:00. Start Date: 7/22/20.On 5/6/26 at 7:46 AM, Surveyor observed LPN C administer R46's Levothyroxine 75 mcg.On 5/06/26 at 10:10 AM, Surveyor interviewed LPN C and asked what time R46's Levothyroxine is ordered to be administered. LPN C indicated 6:00 AM. LPN C indicated she administered R46's levothyroxine late. LPN C indicated there is an hour before and an hour after the ordered time that the medication can be administered. LPN C indicated if a medication is ordered on the MAR for AM, the nurse has from 6:00 AM until 10:00 AM to administer the medication. LPN C indicated she administered R46's levothyroxine late due to so much going on this morning.On 5/6/26 at 4:19 PM, Surveyor interviewed VPS E (Vice President of Success). Surveyor informed VPS E of observation of LPN C administering R54's levothyroxine with calcium at 8:09 AM. VPS E indicated levothyroxine, and calcium should not be administered together. VPS E indicated the levothyroxine administered late and with calcium would be a medication error. Surveyor informed VPS E of observation of LPN C administering R46's levothyroxine at 7:46 AM. VPS E indicated the medication was administered late and considered a medication error.