STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	655000	A. Building B. Wing	06/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guam Memorial Hospital Authority	449 N Sabana Dr Barrigada, GU 96913

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation, interview, record review, and policy review, the facility failed to implement a regular maintenance program to ensure bed systems, including bed rails, mattresses, and frames, were inspected for safety and potential entrapment hazards. The facility did not conduct routine assessments of mattress fit or measure potential entrapment zones in accordance with Food and Drug Administration (FDA) guidance. This had the potential to affect 14 of 19 sampled residents (Resident (R) R2, R3, R5, R8, R11, R12, R4, R9, R13, R22, R23, R25, R26 and R27) who used bed rails and had the potential to result in injury related to bed entrapment or bed system malfunction. Findings include: 1.Observation on 06/04/26 at 8:22 AM, R2 was in bed with 1/3 bed rails raised time (x) 3 (two rails at the head of his bed and one 1/3 rail at the foot of his bed. On 06/04/26 at 10:29 AM, 12:00 PM, 1:39 PM and 4:21 PM, R2 was in his bed with 1/3 bed rails raised x 2 at the head of his bed. On 06/05/26 at 9:49 AM, R2 was observed in his bed with two 1/3 bed rails at the head of his bed in the raised position. R2 stated he thought he had rails on his bed to keep him from falling out of bed. On 06/05/26 at 11:53 AM R2 was observed in bed with two 1/3 bed rails raised at the head of his bed. 2. Observation of R3 in bed with four 1/3 bed rails in the raised position at the head and foot of her bed on 06/01/26 at 12:45 PM, on 06/02/26 at 8:45 AM, 12:12 PM and 2:41 PM, on 06/03/26 at 8:40 AM and 1:44 PM, and on 06/04/26 at 10:30 AM, 12:01 PM and 1:39 PM. 3. Observation of R5 in bed with 1/3 bed rails in the raised position at the head of his bed on 06/01/26 at 12:40 PM, on 06/02/26 at 8:47 AM and 2:39 PM, on 06/03/26 at 8:38 AM and 1:33 PM, and on 06/04/26 at 8:36 AM, 10:28 AM and 1:37 PM with three 1/3 bed rails raised on his bed (two at the head of his bed and one at the foot of his bed). 4. Observation of R8 in bed with three 1/3 bed rails in the raised position on 06/01/26 at 10:48 AM, on 06/02/26 at 8:52 AM and 2:41 PM, on 06/03/26 at 8:40 AM and 1:21 PM and on 06/04/26 at 12:05 PM. 5. Observation of R11 in bed with four 1/3 bed rails in the raised position at the head and foot of her bed on 06/01/26 at 10:51 AM and with three 1/3 bed rails raised (two at the head of her bed and one at the foot of her bed) on at 06/01/26 at 1:05 PM, on 06/02/26 at 8:43 AM and 12:09 PM and on 06/04/26 at 11:07 AM. 6. Observation of R12 on 06/02/26 at 1:19 PM in bed with three 1/3 bed rails raised on her bed (two rails at the head of her bed on one rails at the foot of her bed). Observation of R12 on 06/04/26 at 10:26 AM, at 12:02PM, at 1:36PM and at 4:23PM of R12 in bed with two 1/3 bed rails raised at the head of her bed. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. Observations on 06/01/26 at 11:45 AM and 1:23 PM and 06/02/26 at 2:14 PM, R4 was in bed with bilateral upper bed rails in place. On 06/04/26 10:46 AM R4 was in the commons area in bed with four bed rails (two upper [or towards the head of the bed] half rails and two lower [towards the foot of the bed]. On 06/05/26 at 12:25 PM in his room with all four bed rails up with padding attached to the bed rails. 8. Observations on 06/01/26 at 11:28 AM and 1:45 PM, 06/02/26 at 2:01 PM, and 06/05/26 at 12:31 PM, R9 was in bed with bilateral upper half bed rails raised; and on 06/04/26 at 10:54 AM R9 was observed in bed with bilateral upper bed rails and one lower bed rail raised. 9. Observations on 06/01/26 at 1:08 PM, 06/02/26 at 2:08 PM, 06/04/26 at 10:39 AM, and 06/05/26 at 12:15 PM, R13 was in bed with bilateral upper bed rails in the raised position. 10. Observations on 06/01/26 at 11:06 AM and 1:04 PM, 06/02/26 at 9:27 AM and 1:56 PM, 06/04/26 at 10:31 AM, and 06/05/26 at 11:53 AM, R22 was in bed with bilateral upper bed rails raised. 11. Observations on 06/01/26 at 11:08 AM, 06/02/26 at 1:58 PM, 06/05/26 at 12:02 PM, R23 was in bed with bilateral upper bed rails raised; and 06/04/26 at 10:33 AM, R23 was in bed with bilateral upper bed rails and one lower bed rail raised. 12. Observations on 06/01/26 at 11:30 AM, 06/04/26 at 10:38 AM, 06/05/26 at 12:13PM, R25 was in bed with bilateral upper bed rails raised, and on 06/02/26 at 2:07 PM, R25 was in bed with bilateral upper bed rails and one lower bed rail raised. 13. Observation on 06/01/26 at 11:36 AM and 06/04/26 at 10:45 AM, R26 was in bed with bilateral upper bed rails raised. 14. Observation on 06/01/26 at 1:25 PM, 06/04/26 at 10:46 AM, and 06/05/29 at 12:29 PM, R27 was in bed with bilateral upper bed rails raised. During an interview and record review on 06/05/26 at 3:01 PM, the Maintenance Leader (ML) stated bed inspections, consisting of testing the electrical components and the functionality of the bed were assessed annually. The ML stated the facility was aware of the Food and Drug Administration (FDA) recommendations regarding bed rails. The ML stated, The rails come standard to the bed. They can go down – we test them. They are not supposed to locked down. The ML was asked if mattresses were tested to ensure they fit the bed frame properly to limit entrapment zones. The ML stated they were not testing for entrapment zones as the bed rails were built into the bed. After review of the facility-provided binder of maintenance inspections, the Maintenance Leader confirmed that entrapment measurements were not performed. He stated, We do maintenance. The rails are on the bed when the resident arrives . No, we do not do any measurements. On 06/05/26 at 3:40 PM, the ML returned with a folder and stated they had done the testing as per FDA recommendations in 2023 but none since. There was no evidence the facility implemented an ongoing and consistent process to evaluate bed systems for entrapment risks in accordance with FDA guidance. During an interview on 06/06/26 at 9:54 AM, the DON was asked to provide a list of all residents that have bed rails. The DON stated, All the residents have bed rails because they came on the bed. Review of the facility's policy titled Safe and Effective Bed Rail Use, revised 07/,2021, revealed: Policy: It is the policy of this facility to identify and reduce safety risks and hazards commonly (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	associated with bed rail use. A duo-faceted approach will be used to achieve sustainable quality outcomes, including 1) regular bed maintenance and 2) individual bed rail evaluations. In response to the requirement of providing for a safe, clean, comfortable, and homelike environment, the facility's regular maintenance program will include regular inspection of all bed systems (e.g., rails, frames, and mattresses, and operational components) to ensure they are clean, comfortable, and safe. The facility will also ensure individual resident bed rail evaluations are performed on a regular basis. It is the policy of this facility to conduct bed inspections.The facility will conduct regular bed inspections, utilizing an interdisciplinary, team-based approach (e.g., nursing and maintenance) to risk identification and prevention. The Director of Nursing and Maintenance Director (or qualified designees) will be responsible for completion of bed inspections on a regular basis. Background: .OVERVIEW OF THE U.S. FOOD AND DRUG ADMINISTRATION'S [FDA] POTENTIAL ZONES OF BED, The FDA provides dimensional recommendations for Zones 1-4, as 80% of reported entrapment cases have occurred in these zones. ZONE 1: Within the Rail, Any open space between the perimeters of the rail can present a risk of head entrapment. FDA recommended space: less than 4 3⁄4 ZONE 2: Under the Rail, Between the Rail Supports or Next to a Single Rail Support The gap under the rail between the mattress, may allow for dangerous head entrapment. FDA recommended space: less than 4 3⁄4 inch, ZONE 3: Between the Rail and the Mattress This area is the space between the inside surface of the bed rail and the mattress, and if too big it can cause a risk of head entrapment. FDA recommended space: less than 4 3⁄4 inches, ZONE 4: Under the Rail at the Ends of the Rail, A gap between the mattress and the lowermost portion of the rail poses a risk of neck entrapment. FDA recommended space is less than 2 3⁄8inches.ZONE 5: Between Split Bed Rails, When partial length head and split rails are used on the same side of the bed, the space between the rails may present a risk of either neck or chest entrapment. ZONE 6: Between the End of the Rail and the Side Edge of the Head or Foot Board A gap between the end of the bed rail and the side edge of the headboard or footboard can present the risk of resident entrapment. FDA recommended space is less than 2 5/8 inches. ZONE 7: Between the Head or Foot Board and the End of the Mattress When there is too large of a space between the inside surface of the headboard or footboard and the end of the mattress, the risk of head entrapment increases.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the Food and Drug Administration (FDA) guidance, and policy review, the facility failed to ensure alternatives were attempted prior to the use of bed/side rails for 6 of 19 sampled residents (Resident (R) R2, R3, R5, R8, R11 and R12) reviewed for bed/side rails. This failure had the potential to increase the risk of resident accidental entrapment, suffocation, serious injury, or death. Findings include: 1. Review of R2's undated Patient Data located in the Electronic Medical Record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnosis of stroke-like symptoms. Review of R2's quarterly Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 04/23/26 and found in a folder kept at the nurse's desk, revealed a behavior interview for mental status (BIMS) score of 14 out of 15, which indicated the resident was cognitively intact. The MDS indicated that the resident was independent with moving about in his bed but refused to transfer in and out of bed during the assessment reference period. The MDS indicated bed rails were not in use for the resident. Review of R2's Doctor's Orders Report dated 06/03/26 and found in the EMR revealed no physician's orders for the resident's bed rails. Review of R2's comprehensive care plan did not address the resident's specific use of bed rails. There was no specific information on the care plan related to the reason for the resident's use of bed rails or the type and size of rails in use on the resident's bed. The care plan did not address the use of bed rails nor any specific safety interventions for a resident that used bed rails. Review of R2's Bed Rail Risk assessment dated [DATE] and found in the EMR indicated the bed rails were being utilized for mobility and for safety per request of the resident. The assessment indicated the resident was at risk for injury related to the use of bed rails due to dementia, altered sensation and the use of a pressure reducing mattress on the resident's bed. The assessment indicated the bed rails were integral to the resident's bed and were to be used. The assessment did not address attempted alternatives to the resident's use of bed rails. Review of R2's clinical record, including nurses' notes, and progress notes revealed no documented evidence any alternatives were attempted prior to the use of bed rails or that education on the risks of bed rails was provided to the resident or family. Observation on 06/04/26 at 8:22 AM, R2 was in bed with 1/3 bed rails raised times (x) 3 (two rails at the head of the bed and one 1/3 rail at the foot of the bed). The rails on R2's bed were noted to be part of the manufacturer's original bed design, and there were no mechanisms to prevent staff from raising the bed rails. Observation on 06/04/26 at 10:29 AM, 12:00 PM, 1:39 PM and 4:21 PM, R2 was in his bed with 1/3 bed rails raised x 2 at the head of his bed. On 06/05/26 at 9:49 AM, R2 was observed in bed, which had been pulled into the facility's courtyard (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with two 1/3 bedrails at the head of his bed in the raised position. R2 stated he thought he had rails on his bed to keep him from falling out of bed On 06/05/26 at 11:53 AM R2 was observed in his room in bed with two 1/3 bed rails raised at the head of his bed. R2 was observed on 06/06/26 at 9:00 AM, Certified Nurse Aide (CNA)8 confirmed the resident was in bed with two 1/3 bed rails raised at the head of his bed and stated the resident had bed rails on his bed because he was afraid of falling out of bed. On 06/06/26 at 9:22 AM, R2 was observed along with the Director of Nursing (DON) who confirmed both of R2's bed rails were raised at the head of his bed. The DON stated the resident used the bed rails to move around in the bed. The DON confirmed no alternatives had been attempted prior to R2's use of bilateral bed rails and stated the rails were integral to the bed. 2. Review of R3's undated Patient Data located in the EMR revealed the resident was admitted to the facility on [DATE] with diagnosis of history of stroke. Review of R3's quarterly MDS with an ARD of 05/12/26 and found in a folder kept at the nurse's desk, revealed a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. The MDS indicated the resident was independent with moving about in her bed and required partial to moderate assistance from staff to transfer in and out of bed. The MDS indicated bed rails were not in use for the resident. Review of R3's Doctor's Orders Report dated 06/03/26 and found in the EMR revealed no physician's orders for the resident's bed rails. Review of R3's Safety Risk for Injury Related to Use of Side Rails Care Plan dated 05/14/26 and found in the EMR revealed the rationale for the resident's use of bed rails was hyperkalemia (elevated potassium levels in the blood). There was no specific information on the care plan related to the reason for the resident's use of bed rails or the type and size of bed rails in use on the resident's bed. The care plan did not address the use of bed rails nor any specific safety interventions for a resident that used bed rails. Review of R3's Bed Rail Risk assessment dated [DATE] and found in the EMR indicated the bed rails were being utilized per request of the resident because the resident felt safer when all four of her bed rails were raised on her bed. The assessment indicated that the resident was at risk for injury related to physical or clinical condition that increased the risk for entrapment. The assessment indicated the use of all four 1/3 bed rails. The assessment did not address attempted alternatives to the resident's use of bed rails. Review of R3's clinical record, including nurses' notes, and progress notes revealed no documented evidence any alternatives were attempted prior to the use of bed rails or that education on the risks of bed rails was provided to the resident or family. Observations of R3 in bed with four 1/3 bed rails in the raised position at the head and foot of her bed on 06/01/26 at 12:45 PM, on 06/02/26 at 8:45 AM, 12:12 PM and 2:41 PM, on 06/03/26 at 8:40 AM and 1:44 PM, and on 06/04/26 at 10:30 AM, 12:01 PM and 1:39 PM. The rails on R3's bed were noted to be part of the manufacturer's original bed design, and there were no mechanisms to prevent staff (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from raising the bed rails. R3 was observed along with CNA8 on 06/06/26 at 9:00 AM, CNA8 confirmed R3 was in bed with four 1/3 bed rails raised at the head of her bed. CNA8 stated the resident requested four bed rails because they made her feel safe. R3 was observed with the DON on 06/06/26 at 9:20 AM, who confirmed all four of R3's bed rails raised at the head of her bed and stated the resident requested all four bed rails be raised on her bed. The DON confirmed no alternatives had been attempted prior to R3's use of bilateral bed rails and stated the rails were integral to the bed. 3. Review of R5's undated Patient Data located in the EMR revealed the resident was admitted to the facility on [DATE] with diagnosis of history of stroke. Review of R5's quarterly MDS with an ARD of 03/22/26 and found in a folder kept at the nurse's desk, revealed a BIMS score was unable to be completed due to the resident's poor cognition. The MDS indicated R5 had both short and long-term memory problems. The MDS indicated the resident was dependent upon staff to move about in bed and transfer in and out of bed. The MDS indicated bed rails were not in use for the resident. Review of R5's Doctor's Orders Report dated 06/03/26 and found in the EMR revealed no physician's orders for the resident's bed rails. Review of R5's Safety Care Plan dated 05/14/26 and found in the EMR indicated the resident was using bed rails per his request. There was no specific information on the care plan related to the reason for the resident's use of bed rails or the type and size of rails in use on the resident's bed. The care plan did not address the use of bed rails nor any specific safety interventions for a resident that used bed rails. Review of R5'sBed Rail Risk assessment dated [DATE] and found in the EMR, indicated the bed rails were being utilized for safety and mobility. The assessment indicated the resident was at risk for injury related to the use of bed rails due to dementia. The assessment indicated the bed rails were integral to the resident's bed and were to be used. The assessment did not address attempted alternatives to the resident's use of bed rails. Review of R5's clinical record, including nurses' notes, and progress notes revealed no documented evidence any alternatives were attempted prior to the use of bed rails or that education on the risks of bed rails was provided to the resident or family. R5 was observed in bed with 1/3 bed rails in the raised position at the head of his bed on 06/01/26 at 12:40 PM, on 06/02/26 at 8:47 AM and 2:39 PM, on 06/03/26 at 8:38 AM and 1:33 PM, and on 06/04/26 at 8:36 AM, 10:28 AM and 1:37 PM with three 1/3 rails raised on his bed (two at the head of his bed and one at the foot of his bed). The rails on R5's bed were noted to be part of the manufacturer's original bed design, and there were no mechanisms to prevent staff from raising the bed rails. R5 was observed with CNA8 on 06/06/26 at 9:03 AM, who confirmed R5 was in bed with three 1/3 bed rails raised at the head and foot of his bed. CNA8 stated the resident had rails on his bed to move in bed because he was afraid of falling out of bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5 was observed with the DON on 06/06/26 at 9:23 AM who confirmed both of R5's rails were raised at the head of his bed, and one rail was raised at the foot of his bed. The DON stated the resident used the rails to move around in the bed. The DON stated she did not know why three rails were raised on R5's bed since he could not use rails at the foot of his bed for mobility. The DON confirmed no alternatives had been attempted prior to R5's use of bilateral bed rails and stated the rails were integral to the bed. 4. Review of R8's undated Patient Data located in the EMR revealed the resident was admitted to the facility on [DATE] with diagnoses of cellulitis and pressure sore to the sacrum. Review of R8's quarterly MDS with an ARD of 06/01/26 and found in a folder kept at the nurse's desk, revealed a BIMS assessment score of 15 out of 15, which indicated the resident was cognitively intact. The MDS functional abilities section was not complete, and the MDS did not indicate whether the resident was independent with moving about in his bed, transferring in and out of his bed or that he required assistance from staff for these tasks. The assessment indicated bed rails were not in use for the resident. Review of R8's Doctor's Orders Report dated 06/03/26 and found in the EMR revealed no physician's orders for the resident's bed rails. Review of R8's comprehensive care plan did not address the resident's specific use of bed rails. There was no specific information on the care plan related to the reason for the resident's use of bed rails or the type and size of rails in use on the resident's bed. The care plan did not address the use of bed rails nor any specific safety interventions for a resident that used bed rails. Review of R8's Bed Rail Risk assessment dated [DATE] and found in the EMR, indicated the bed rails were being utilized for safety and mobility. The assessment indicated the resident was at risk for injury related to the use of bed rails due to the need for the resident to get out of bed unsupervised. The assessment indicated the bed rails were integral to the resident's bed and were to be used. The assessment did not address attempted alternatives to the resident's use of bed rails. Review of R8's clinical record, including nurses' notes, and progress notes revealed no documented evidence any alternatives were attempted prior to the use of bed rails or that education on the risks of bed rails was provided to the resident or family. R8 was observed in bed with three 1/3 bed rails in the raised position on 06/01/26 at 10:48 AM, on 06/02/26 at 8:52 AM and 2:41 PM, on 06/03/26 at 8:40 AM and 1:21 PM and on 06/04/26 at 12:05 PM. The rails on R8's bed were noted to be part of the manufacturer's original bed design, and there were no mechanisms to prevent staff from raising the bed rails. R8 was observed in bed along with CNA8 on 06/06/26 at 9:01 AM, who confirmed two 1/3 bed rails were raised at the head of R8's bed and one 1/3 rail was raised at the foot of his bed. CNA 8 stated the resident had rails on his bed because he was afraid of falling out of bed. R8 was observed with the DON on 06/06/26 at 9:23 AM, who confirmed three rails were raised at the head and foot of R8's bed. The DON stated the resident used the rails to move around in the bed. The DON confirmed no alternatives had been attempted prior to R8's use of bilateral bed rails and stated the rails were integral to the bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of R11's undated Patient Data located in the EMR revealed the resident was admitted to the facility on [DATE] with diagnosis of history of femur fracture. Review of R11's admission MDS with an ARD of 04/01/26 and found in a folder kept at the nurse's desk, revealed a BIMS score of 14 out of 15, which indicated the resident was cognitively intact. The MDS indicated the resident was independent with moving about in bed and required partial to moderate assistance from staff to transfer in and out of bed. The MDS indicated bed rails were not in use for the resident. Review of R11's Doctor's Orders Report dated 06/03/26 and found in the EMR, revealed no physician's orders for the resident's bed rails. Review of R11's Use of Bed Rails Care Plan dated 05/18/26 and found in the EMR, indicated the resident was using bed rails because she was Coronavirus Disease (COVID) positive. There was no specific information on the care plan related to the reason for the resident's use of bed rails or the type and size of rails in use on the resident's bed. The care plan did not address the use of bed rails nor any specific safety interventions for a resident that used bed rails. Review of R11's Bed Rail Risk assessment dated [DATE] and found in the EMR, indicated the bed rails were being utilized for safety and mobility. The assessment indicated the resident was at risk for injury related to the use of bed rails due to physical or clinical condition, however the assessment indicated the bed rails were integral to the resident's bed and were to be used. The assessment did not address attempted alternatives to the resident's use of bed rails. Review of R11's clinical record, including nurses' notes, and progress notes revealed no documented evidence any alternatives were attempted prior to the use of bed rails or that education on the risks of bed rails was provided to the resident or family. R11 was observed in bed with four 1/3 bed rails in the raised position at the head and foot of her bed on 06/01/26 at 10:51 AM and with three 1/3 rails raised (two at the head of her bed and one at the foot of her bed) on at 06/01/26 at 1:05 PM, on 06/02/26 at 8:43 AM and 12:09 PM and on 06/04/26 at 11:07 AM. R11 was observed in bed along with CNA7 on 06/06/26 at 9:23 AM, who confirmed the resident was in bed with four 1/3 bed rails raised at the head and foot of her bed and stated the resident had bed rails on his bed to move in bed per her request. There were no mechanisms to prevent staff from raising the bed rails. R11 was observed in bed with the DON on 06/06/26 at 9:24 AM, who confirmed all four of R11's bed rails were raised at the head and foot of her bed. The DON stated the resident used the bed rails to move around in her bed, but that four rails should never be in the raised position on any resident's bed. The DON stated she did not know why all four bed rails were raised on R11's bed. The DON confirmed no alternatives had been attempted prior to R11's use of bilateral bed rails and that the rails were integral to the bed. 6. Review of R12's undated Patient Data located in the EMR revealed the resident was admitted to the facility on [DATE] with diagnosis of dementia. Review of R12's quarterly MDS with an ARD of 04/24/26 and found in a folder kept at the nurse's (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	desk, revealed a BIMS score of five out of 15, which indicated the resident was severely cognitively impaired. The MDS indicated the resident required partial to moderate assistance from staff to move around within her bed and to transfer in and out of bed. The MDS indicated bed rails were not in use for the resident. Review of R12's Doctor's Orders Report dated 06/03/26 and found in the EMR revealed no physician's orders for the resident's bed rails. Review of R12's Use of Side Rails Care Plan dated 12/18/24 and found in the EMR, indicated upper bed rails were in use on the resident's bed bilaterally. There was no specific information on the care plan related to the reason for the resident's use of bed rails or the type and size of rails in use on the resident's bed. The care plan did not address the use of bed rails nor any specific safety interventions for a resident that used bed rails. Review of R12's Bed Rail Risk assessment dated [DATE] and found in the EMR, indicated the bed rails were being utilized for safety and mobility. The assessment indicated the resident was at risk for injury related to the use of bed rails due to dementia and physical or clinical condition (left knee contracture), however the assessment indicated the bed rails were integral to the resident's bed and were to be used. The assessment did not address attempted alternatives to the resident's use of bed rails. Review of R12's clinical record, including nurses' notes, and progress notes revealed no documented evidence any alternatives were attempted prior to the use of bed rails or that education on the risks of bed rails was provided to the resident or family. Observation on 06/02/26 at 1:19 PM, R12 was in bed with three 1/3 rails raised on her bed (two rails at the head of her bed and one rail at the foot of her bed). Observation on 06/04/26 at 10:26 AM, at 12:02 PM, and at 4:23 PM, R12 was in bed with two 1/3 bed rails raised at the head of her bed, and there were no mechanisms to prevent staff from raising the bed rails. R12 was observed in bed with CNA7 on 06/06/26 at 9:26 AM, in bed with two 1/3 rails raised at the head of her bed. CNA7 stated R12 had bed rails raised on her bed to assist with mobility in bed and because she was afraid to fall out of bed. R12 was observed with the DON on 06/06/26 at 9:27 AM, who confirmed both of R12's bed rails were raised at the head of her bed and stated the resident used the bed rails to move around in the bed. The DON confirmed no alternatives had been attempted prior to R12's use of bilateral bed rails and stated the bed rails were integral to the bed. Review of the facility's policy titled Safe and Effective Bed Rail Use revised 07/2021, revealed, Purpose: The objective of the bed rail use policy is to determine if resident use is safe and appropriate. The interdisciplinary team will use data collected from regular bed inspections and individual bed rail evaluations to bolster care planning and positive resident outcomes. The bed rail use policy will be reviewed annually or more frequently as needed and will be integrated into the facility Quality Assurance and Performance Improvement program (QAPI). Policy: It is the policy of this facility to identify and reduce safety risks and hazards commonly associated with bed rail use. A duo-faceted approach will be used to achieve sustainable quality outcomes, including 1) regular bed (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	maintenance and 2) individual bed rail evaluations.the facility's regular maintenance program will include regular inspection of all bed systems (e.g., rails, frames, and mattresses, and operational components) to ensure they are clean, comfortable, and safe. The facility will also ensure individual resident bed rail evaluations are performed on a regular basis. Individual bed rail evaluations will include data collection analysis and determination of potential alternatives to bed rail use. When bed rail(s) are deemed necessary and appropriate, the facility will provide education to resident or resident's representative pertaining to the risk and benefits of bed rail use. The facility's priority is to ensure safe and appropriate bed rail use.Rationale for Completing Bed Rail Risk Assessment.BOX 2: alternatives to bedrails.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to advise one of five residents (R12) reviewed for unnecessary medications of the risks and benefits for psychotropic medication use. This failure had the potential to affect the care provision, discharge planning, and/or informed consent for psychotropic medications. Findings include: Review of R12's undated Patient Data located in the EMR revealed the resident was admitted to the facility on [DATE] with diagnoses of dementia and Failure to Thrive. Review of R12's quarterly Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 04/24/26 and found in a folder kept at the nurse's desk revealed a Brief interview of mental status (BMS) score of five out of 15, which indicated the resident was severely cognitively impaired. Review of R12's Doctor's Orders Report dated 06/03/26and d in the EMR revealed an order, with an initial order date of 05/30/26, for Quetiapine (an antipsychotic medication) 25 milligram (mg) once daily at bedtime. There was no diagnosis for the Quetiapine order in the EMR. Review of R12's Medication Administration Records (MARs) dated 06/01/26 through 06/06/26 and found in the Medication Administration Book on the medication cart, revealed the resident received the Quetiapine per physician's order. Review of R12's EMR revealed no documentation to indicate informed consent had been obtained for the administration of the resident's antipsychotic medication. During an interview on 06/06/26 at 1:19 PM, the DON stated she was not aware informed consent was to be obtained for the administration of any psychotropic medication. The facility's policy related to informed consent for the administration of psychotropic medication was requested on 06/05/26 at 4:00 PM. The survey team was provided with a facility policy related to the administration of psychotropic medication prior to survey exit; however, the policy did not address informed consent for the administration of the medication.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on interview, record review, observation and document review, the facility failed to ensure appropriate sized incontinence products were available for one (Resident (R) 13) of 19 residents in the survey sample. This failure had the potential to negatively affect R13's dignity and skin integrity. Findings include:During an interview on 06/01/26 at 1:08 PM, R13 queried if the facility had any large size briefs as the mediums briefs did not fit. The request was passed on to the Director of Nursing (DON) on 06/01/26 at 1:30 PM. During a follow-up interview and observation on 06/04/26 at 10:39 AM regarding whether large briefs had been provided, R13 stated, No and asked if he could show what was being used. R13 lowered the sheet to show an incontinence brief under him attached to an absorbent bed pad (also known as chux) tucked in over the top of the groin area. R13 stated, this has been going on for a while now. Review of R13's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/14/26 and found in a folder kept at the nurse's desk revealed a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15, indicative of being cognitively intact. Observation of the Clean Utility Room on 06/04/26 at 10:57 AM with Registered Nurse (RN) 3 revealed two bags of medium sized briefs and stacks of chux. RN3 stated, There's another supply room in the back.With RN3 on 06/04/26 at 11:01 AM observation of the back supply room, RN3 stated, This is the PAR level room and confirmed the presence of four large plastic bags each containing ten packages of Dr. P medium briefs. RN3 stated, the room next to the PAR level room was the CSR room where we have the charges [charge items]. RN3 clarified items like gauze, abdominal dressings (ABD) pads, and kerlix were in this room and that there are no briefs in there.During an interview on 06/04/2026 at 11:00 AM regarding brief sizes, the DON stated, They normally have them, but CSR is out. A request was made for the last delivery invoice for small and large sized briefs. During an interview on 06/05/26 at 11:30 AM, Certified Nurse Aide (CNA) 6 stated an awareness that they have had medium sized briefs for the past couple of months. When asked who was to be advised if out of stock of something. CNA6 stated, Actually, someone is assigned to do the inventory for the supplies [named three names, one per shift] then they advise the [NAME] Clerk to order supplies. When asked who instructed the CNAs to use a chux along with a brief. CNA6 stated, It's used to extend. I guess it's a practice for the CNAs, I guess nobody instructed. At least we can close the diaper. CNA6 stated that the chux supports the skin for no skin tears and extra absorption.During an interview on 06/05/26 at 11:12 AM, the Administrative Officer (AO) stated, Yes, those are the inventories. The AO confirmed she had been told that it was January when they had the large size. A policy regarding the sizing of briefs, inventories, and who was to be advised of stock inventories was requested and not provided prior to survey exit on 06/06/26.Review of the facility provided brief inventories documentation revealed the last supply of large incontinence briefs was documented on 02/02/26.A follow-up interview on 06/05/26 at 12:15 PM, R13 stated large briefs had now been provided. R13 stated, he hasn't had them since February. R13 stated that he had advised his therapist who told the charge nurse and the head nurse. He was just told they were out of stock. R13 stated that the bed pad was uncomfortable, it was embarrassing and undignified to have it [brief] be so small and not fit. It's embarrassing to have to wear a diaper anyway, then to have it fit like a speedo and have something tucked in that was uncomfortable. It just is not right. During an interview on 06/05/26 at 5:12 PM, the Medical Director stated, Yes of course they should have appropriate sizes. We shouldn't deny anyone their rights. They have a right to have their size.During an interview on 06/06/26 at 1:30 PM, the DON stated, Different sizes should be available. Lately, only providing the medium. They [hospital] said they stopped ordering anything but the mediums. The DON stated, I called the day before and was told they only had medium and when I followed up, they sent over large briefs.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review the facility failed to ensure require Notification of Medicare Non-Coverage (NOMNC advisements were provided to two of three residents (Resident (R) 29 and R30) to ensure that residents were give two days in advance notice of Medicare A services ending. This failure had the potential for residents to incur unauthorized expenses and/or forfeit the time granted for an appeal to Medicare. Findings include:1. Review of R29's facility provided Patient Data revealed an admission date of 01/19/26 with diagnosis of post-surgical right femur fracture. Review of the facility provided NOMNC worksheet indicated for R29 the Medicare A services start date was 01/19/26 with the last covered day of services was 02/02/26. Review of the facility provided NOMNC form showed the last covered day noted was 02/02/26 and that R29 signed the form on 02/02/26. During an interview on 06/06/26 at 2:59PM, the Hospital Utilization Specialist ([NAME]) confirmed the NOMNC was to be issued two days in advance of the last covered day and confirmed for R29 that it was not provided two days prior to the last day of Medicare A services end date. 2. Review of R30's facility provided Patient Data revealed an admission date of 04/12/26 with diagnosis of oxygen dependence. Review of the facility's provided NOMNC worksheet indicated for R30 the start date of Medicare A services and the last covered day of Medicare A services was 04/12/26. Review of the facility provided NOMNC form showed the last covered day was 04/12/26 and R30 signed that she did not consent, along with a facility representative signature dated 04/21/26. During an interview on 06/06/26 at 3:09 PM, the [NAME] stated that R30 was transferred to the skilled nursing facility because of the typhoon and needing hospital beds [NAME] confirmed that R30 required no skilled care and that the NOMNC was signed on 04/21/26 which was nine days after the end of the service date. Review of the facility's policy titled Skilled Nursing Facility ABN/NOMNC effective date 11/10/2022, revealed: .III. Policy. 1. Skilled Nursing Facility may issue Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) . to Medicare fee-for service inpatients if they plan to hold the patient financially liable. These notices may be issued during admission or at any point during an [sic] skilled nursing stay if it is determined that the care the patient is receiving, or is about to receive, is not covered because it is:.b. Custodial care (not a covered level of care) (S1862(a)(9) of the Act) . B. The Notice of Medicare Non-Coverage (NOMNC) (CMS-10123). 1. Must be delivered at least two calendar days before Medicare covered services end or the second to the last day of service if care is not being provided daily.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to ensure two Residents (R)2 and R12) out of five residents reviewed for unnecessary medication was free from potential chemical restraints. The facility's failure to ensure residents were free from unnecessary chemical restraints created the potential for this and other residents to receive medication that is not necessary or desired related to their psychiatric/mental health care. Findings include: 1.Review of R2's undated Patient Data located in the Electronic Medical Record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnoses of stroke-like symptoms and type 2 diabetes. Review of R2's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/23/26 and found in a folder kept at the nurse's desk revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident was cognitively intact. The MDS indicated that the resident was receiving an antidepressant medication daily and that the resident did not exhibit any behaviors during the assessment reference period. Review of R2's Doctor's Orders Report dated 06/03/26 and found in the EMR revealed an order, with an initial order date of 05/30/26, for the resident to receive Trazadone (an antidepressant medication) 25 milligrams (MG) three times daily. There was no diagnosis or rationale for the resident's Trazadone order. Review of R2's Medication Administration Records (MARs) dated 06/01/26 through 06/06/26 and found in the Medication Administration Book on the medication cart revealed the resident was receiving his Trazadone per physician's orders. The MARs revealed agitation was being monitored related to the administration of the medication. There was no documentation of side effect tracking related to the Trazadone in the resident's record. Review of R2's Coping Care Plan dated 08/15/25 and found in the EMR revealed nothing specific related to the administration of antidepressant medication. Review of R2's EMR revealed no documentation to indicate any attempt had been made by the facility to address the resident's agitation with the use of non-pharmaceutical methods prior to initiating the Trazadone order for. 2.Review of R12's undated Patient Data located in the EMR revealed the resident was admitted to the facility on [DATE] with diagnoses of dementia and Failure to Thrive. Review of R12's quarterly MDS with an ARD of 04/24/26 and found in a folder kept at the nurse's desk revealed a BIMS score of five out of 15, which indicated the resident was severely cognitively impaired. The MDS indicated the resident was receiving antipsychotic medication daily and did not exhibit any behaviors during the assessment reference period. Review of R12's Doctor's Orders Report dated 06/03/26 and found in the EMR revealed an order, with an initial order date of 05/30/26, for the resident to receive Quetiapine (an antipsychotic medication) 25 mg once daily at bedtime. There was no diagnosis associated with the Quetiapine order. Review of R12's MARs dated 06/01/26 through 06/06/26 and found in the Medication Administration Book on the medication cart revealed the resident received the Quetiapine per physician's orders. The MARs revealed the resident was being monitored for confusion related to the administration of the medication, however, there was no documentation of tracking side effect related to the usage of Quetiapine. Review of R12's Antipsychotic Medication Use Care Plan dated 08/08/24 and found in the EMR indicated the resident was receiving Quetiapine related to minor outbursts. Interventions included monitor side effects related to the use of the medication and monitor the resident's behaviors related to the administration of the medication. No specific behaviors related to the administration of the Quetiapine were indicated in the plan of care. Review of R12's EMR revealed no documentation to indicate any attempt had been made by the facility to address the resident's minor behavioral disturbance by non-pharmaceutical methods prior to initiating the order for Quetiapine. During an interview on 06/06/26 at 1:19 PM, the Director of Nursing (DON) confirmed specific behaviors and side effects related to the administration of psychotropic medications were expected to be monitored, non-pharmacological interventions should be attempted prior to the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration of psychotropic medication, and a clear diagnosis/rationale was expected to be in place for each psychotropic medication ordered for a resident. Review of the facility's policy titled, Psychotropic Medication Use dated 02/2016 revealed, Residents of the facility who are prescribed psychotropic medication, such as antipsychotic, antidepressants, etc. will be monitored.Attending physicians must indicate that a psychotropic medication is necessary to treat a specific condition/behavior.Licensed nurses will be aware of potential side effects of psychotropic medications and report any side effects to the resident's attending physician.Attempts for non-pharmacological interventions must be clearly documented in the resident's chart.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure a comprehensive admission Minimum Data Set (MDS) assessment was completed within the time frame required by the RAI Manual for one of 19 sampled residents (Resident (R) 21). This failure had the potential for inaccurate or incomplete care planning and/or provision of care to the resident, and/or inaccurate reimbursement for services.During the tour of the facility, R21 was observed in his room on 06/01/26 at 11:02AM. Review of the facility provided resident matrix document did not indicated that R21 was a new admission admitted within the past 30 days. Review of the facility provided Patient Data sheet revealed R21 was admitted to the facility on [DATE]. During an interview on 06/03/26 at 3:45PM when inquiring about a list of names that needed MDS assessment reviews, the MDS Coordinator (MDSC) provided a note that indicated that R21's admission (comprehensive) MDS with an assessment reference date (ARD) of 04/21/26 was still incomplete. During the interview, the MDSC stated she used the RAI manual as a reference. Review of the RAI Manual dated October 2025 page 5-1 revealed: Transmitting Data: Providers must transmit all sections of the MDS 3.0 required for their State-specific instrument, including the Care Area Assessment (CAA) Summary (Section V) and all tracking or correction information. Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirements. Care plans are not required to be transmitted. Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 [MDS section] + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B [MDS section] + 14 days).

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure the Minimum Data Set (MDS) assessments were transmitted within the timeframes specified in the RAI manual for nine of 19 residents (Resident (R)1, R4, R7, R9, R22, R27, R2, R3 and R12) MDSs reviewed during the survey. This failure had the potential for inaccurate or incomplete care planning and/or provision to the resident, the resident being discharged may not be able to receive services elsewhere because Medicare was not aware of the discharge status, and/or a lack of appropriate payment for services to the facility. Findings include: 1.Review of R1's facility provided undated Patient Data revealed an admission date of 01/20/26. Review of the validation report provided by the MDS Coordinator (MDSC) revealed a quarterly MDS with an assessment reference date (ARD) of 04/27/26 found in a folder kept at the nurse's desk, was not transmitted until 06/02/26. 2. Review of R4's facility provided undated Patient Data revealed an admission date of 05/27/26. Review of the validation report provided by the MDSC showed a discharge return anticipated MDS with an ARD of 05/04/26 found in a folder kept at the nurse's desk was not transmitted until 06/02/26. 3. Review of R7 facility provided undated Patient Data revealed a facility admission date of 01/15/26. Review of the validation report provided by the MDSC showed a quarterly MDS with an ARD of 04/22/26 found in a folder kept at the nurse's desk was not transmitted until 06/02/26. 4.Review of R9's facility provided undated Patient Data revealed an admission date of 10/23/24. Review of the validation report provided by the MDSC showed a quarterly MDS with an ARD of 04/20/26 found in a folder kept at the nurse's desk was not transmitted until 06/02/26. 5. Review of R22's facility provided undated Patient Data revealed an admission date of 04/12/26. Review of the validation report provided by the MDSC revealed an admission MDS with an ARD of 04/19/21 found in a folder kept at the nurse's desk was not transmitted until 06/02/26. 6. Review of R27's facility provided undated Patient Data revealed an admission date of 04/13/26. Review of the validation report provided by the MDSC revealed an admission MDS with an ARD of 04/20/26 and found in a folder kept at the nurse's desk was not transmitted until 06/03/26. 7.Review of R2's undated Patient Data located in the Electronic Medical Record (EMR), revealed the resident was admitted to the facility on [DATE]. Review of R2's quarterly MDS with an ARD of 04/23/26 found in a folder kept at the nurse's desk was not transmitted until 06/02/26. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8.Review of R3's undated Patient Data located in the EMR revealed the resident was admitted to the facility on [DATE]. Review of R3's quarterly MDS with an ARD of 05/12/26 found in a folder kept at the nurse's desk was not transmitted until 06/02/26. 9. Review of R12's undated Patient Data located in the EMR revealed the resident was admitted to the facility on [DATE]. Review of R12's quarterly MDS with an ARD of 04/24/26 found in a folder kept at the nurse's desk was not transmitted until 06/02/26. Review of the facility's MDS Submitter Final Validation Report dated 06/03/26 provided by the MDSC indicated for R1, R4, R7, R9, R22, R27, R2, R3 and R12's, Record Submitted Late: The submission date was more than 14 days after the assessment. During an interview on 06/03/26 at 10:13 AM, the MDSC confirmed MDS Assessments were expected to be transmitted within 14 days of assessment completion. During an interview on 06/06/26 at 1:19 PM, the Director of Nursing (DON) confirmed MDS assessments were expected to be transmitted timely. During an interview on 06/03/26 at 4:02 PM, the MDSC confirmed all the assessments were submitted late and that she used the RAI Manual as a reference. Review of the October 2025 RAI Manual page 5-1 revealed: Transmitting Data: Providers must transmit all sections of the MDS 3.0 required for their State-specific instrument, including the Care Area Assessment (CAA) Summary (Section V) and all tracking or correction information. Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirements. Care plans are not required to be transmitted. Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 [MDS section] + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B [MDS section] + 14 days). Tracking Information Transmission: For Entry and Death in Facility tracking records, information must be transmitted within 14 days of the Event Date (A1600 [MDS section] + 14 days for Entry records and A2000 [MDS section] + 14 days for Death in Facility records).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessments for one of 19 residents (Resident (R) 12) reviewed. The MDS did not accurately reflect the resident's receipt of antipsychotic medication during the look-back period. This failure had the potential to result in inaccurate information being used for care planning an clinical decision-making. Findings include: Review of R12's undated Patient Data located in the Electronic Medical Record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnoses of dementia and Failure to Thrive. Review of R12's Doctor's Orders Report revealed an order, with an initial order date of 07/18/25, for the resident to receive Quetiapine (an antipsychotic medication) 25 milligram (mg) once daily at bedtime. Review of R12's quarterly MDS with an Assessment Reference Date (ARD) of 01/24/26 and found in a folder kept at the nurse's desk, indicated a Brief Interview for Mental Status (BIMS) score of five out of 15, which indicated the resident was severely cognitively impaired. The MDS indicated the resident was not receiving an antipsychotic medication. Review of R12's Medication Administration Record/Treatment Administration Record (MAR/TAR) for 01/2026 revealed R12 received Quetiapine daily during the seven day look-back period (01/17/26 through 01/24/26) for the 01/24/26 quarterly MDS. During an interview on 06/03/26 at 10:13 AM, the MDS Coordinator (MDSC) confirmed R12's quarterly MDS was inaccurate related to the administration of an antipsychotic medication for the resident. During an interview on 06/06/26 at 1:19 PM, the Director of Nursing (DON) confirmed MDS assessments were expected to be accurate.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure Pre admission Screening and Resident Review (PASARR) Level 1 evaluation was completed for one (Residents (R)12) out of one resident reviewed for PASARR. The facility's failure to ensure the appropriate PASARR assessment was completed created the potential for residents to have unmet psychological/psychiatric needs while residing in the facility. Findings include:Review of R12's undated Patient Data located in the Electronic Medical Record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnosis of dementia. Review of R12's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/24/26 and found in a folder kept at the nurse's desk revealed a Brief Interview for Mental Status (BIMS) score of five out of 15, which indicated the resident was severely cognitively impaired. Review of R12's EMR revealed no documentation that the PASARR Screening Level 1 had been completed prior to R12's admission to the facility, or at any time during the resident's admission, to ensure psychiatric services were not needed. During an interview on 6/03/26 at 3:48 PM, the Director of Nursing (DON) confirmed she was responsible for ensuring PASARR Level 1 evaluations were completed for each resident in the facility. She confirmed she was not able to locate R12's PASARR Level 1 Screening. The DON stated that each resident was expected to have a PASARR Level 1 screening in place prior to admission to the facility and then again with any change in psychiatric status or the addition of psychiatric medication to the resident's plan of care. The facility's policy regarding PASARR assessment was requested of the DON by the survey team on 06/05/26 at 4:00 PM and was not received prior to survey exit on 06/06/26.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, observation, interview, and policy review, the facility failed to ensure two of 19 residents (Resident (R) R4 and R22) had comprehensive person-centered care plans for each resident, with measurable objectives and timeframes to meet the resident's medical, nursing, mental, and/or psychosocial needs as identified during a comprehensive assessment. This failure had the potential to affect the care and/or quality of life experienced by the resident while at the facility. Findings include:1. Review of R4's facility provided undated Patient Data revealed a readmission date of 05/27/26 with diagnoses of history of cerebral vascular accident (stroke), fever from urinary tract infection, and bedbound.Observations of R4 on 06/01/26 at 11:45 AM and 1:23 PM; and 06/02/26 at 2:14 PM in bed with bilateral upper half rails in the up position with blue pads wrapped around them; and on 06/05/26 at 12:25 in bed with all four bed rails in the up position with the blue padding attached to all four rails.Observation on 06/06/26 at 9:12 AM with the Director of Nursing (DON) revealed R4 in bed with all four rails in the up position with blue padding attached on the interior of the rail.Review of the facility provided Care Plan revealed the use of R4's bed rails was not care planned. During an interview on 06/06/26 at 1:20 PM, the DON stated an expectation that Bed rail use should be care planned.2. Review of R22's facility provided undated Patient Data revealed an admission date of 04/12/26 with diagnoses of depression and undiagnosed mental disability. Observations on 06/02/26 at 10:58 AM, 06/02/26 at 1:56 PM, 06/04/26 at 10:31 AM, and 06/05/26 at 11:53 AM revealed R22 in bed. Review of R22's facility provided Activity Assessment revealed, Interventions: 1:1 [one to one] activity: conversation, exercise and music therapy, group activity: bingo social, outdoor sunshine/ socialization. Frequency: Resident will be seen 5 to 7x [times] / week for 1:1/group activity. Review of R22's facility provided Care Plan did not reveal any personalized activity care plan based on the assessment. During an interview on 06/06/26 at 1:38 PM, the DON confirmed activities should be care planned. Review of the facility's policy titled Comprehensive Care Plans reviewed 02/2016 revealed:Purpose: To ensure that resident will receive a comprehensive care plan so that resident will be in a best possible, physical, mental, psychological well-being.Policy: A facility must develop a comprehensive care plan for each resident that includes measurable objective and timetables to meet a resident's medical, nursing, mental, and psychological needs that are identified on a comprehensive assessment.The services that are to be furnished to attain or maintain the resident highest possible, physical, mental, and psychological well-being. A comprehensive care plan should develop after the comprehensive assessment. Must be prepared by the other disciplinary team that includes physician, and registered nurse with responsibility for the resident and other appropriate staff in discipline. Procedures: The facility must use the result of the assessment to develop, review and revise the comprehensive care plan.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to ensure routine dental services were provided for one (Resident (R)5) out of two residents reviewed for dental services in the sample of 19 residents. The facility's failure to ensure dental services were provided for R5 created the potential for the resident to experience complications and/or pain related poor dentition. Findings include: Review of R5's undated Patient Data located in the Electronic Medical Record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnosis of history of stroke. Review of R5's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/22/26 and found in a folder kept at the nurse's desk revealed a Brief Interview for Mental Status (BIMS) score that was not able to be completed due to the resident's poor cognition. The MDS indicated no oral or dental problems. Review of R5's Doctor's Orders Report dated 06/03/26 and found in the EMR revealed no physician's orders for the resident to see an oral health professional. Review of R5's Dental Care Care (sic) Plan dated 06/15/25 and found in the EMR indicated the resident was expected to maintain good oral health. Interventions included, Referral to oral health professional. Review of R5's EMR revealed no documentation to indicate the resident had been seen by a dentist/oral health professional for routine dental care since his admission to the facility on [DATE]. During an interview on 06/03/26 at 2:58 PM, the Social Services Director (SSD) stated that all residents were to be offered/receive routine dental services at least every six months as part of their plan of care. The SSD confirmed R5 had not been offered routine dental services since his admission on [DATE]. During an interview on 06/03/26 at 3:57 PM, the Director of Nursing (DON) confirmed R5 did not have a physician order to receive routine dental care. She stated her expectation was that all residents should be offered routine dental care at least once every six months. Review of the facility's policy titled Dental Services dated 02/2016 revealed, [The Facility] must provide or obtain from outside resources routine or emergency dental services to meet the need of each resident.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and policy review, the facility failed to ensure residents were assessed for influenza and pneumococcal vaccination status and offered and/or provided indicated vaccines, or that refusal, contraindication, or prior vaccination status was documented, for 1 of 5 residents (Resident (R) 19) reviewed for vaccinations. This failure had the potential to increase the risk for R19 to contract influenza and/or pneumococcal disease and experience adverse health outcomes. Findings include:Review of R19's undated Patient Data located in the Electronic Medical Record (EMR), revealed the resident was admitted to the facility on [DATE] and was over the age of 65 at the time of admission. Review of R19's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/21/26 and found in a folder kept at the nurse's desk, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated the resident was moderately cognitively impaired. Review of R19's Immunization Records dated 06/04/26 and located in the EMR revealed no documentation the facility assessed, offered, or provided influenza or pneumococcal vaccines, nor documented refusal, contraindication, or prior vaccination status. During an interview on 06/04/26 at 2:57 PM, the Infection Preventionist (IP) indicated influenza and pneumococcal vaccines were to be offered upon admission to the facility or at the hospital prior to transfer to the facility. The IP confirmed that there was no documentation of R19 influenza and pneumococcal immunization status. The IP stated she was not sure how R19's immunization status had been missed upon admission to the facility. During an interview on 06/06/26 at 1:19 PM, the Director of Nursing (DON) confirmed influenza and pneumococcal immunizations were expected to be offered and administered prior to or upon admission to the facility and that it was the facility's responsibility to ensure this was done. Review of the facility's policy titled, Administering Pneumococcal Vaccine dated 04/2023 indicated, Upon admission, the assigned licensed nurse will assess every resident for inclusion in the high-risk target group. The criteria for inclusion in this group is as follows: Previously unvaccinated adults age [AGE] years and older.Upon one week of admission, the resident or authorized resident representative will be given a copy of the Vaccine Information Sheet (VIS). Review of the facility's policy titled, Administering Influenza Vaccine dated 04/2023 indicated, Vaccination will be administered by the licensed nurse as a standing order for those individuals who are assessed and are determined to meet the criteria for high-risk target groups.Upon admission, the assigned licensed nurse will assess every resident for inclusion in the high-risk target group. The criteria for inclusion in this group is as follows:Persons aged > 50 years ˆ Have any condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretion or that can increase the risk for aspiration .Upon one week of admission, the resident or authorized resident representative will be given a copy of the Vaccine Information Sheet (VIS).

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure residents were assessed for COVID-19 vaccination status and offered and/or provided the COVID-19 vaccine, or that refusal, contraindication, or prior vaccination status was documented for two of five residents (Resident (R) 13 and R19) reviewed for vaccinations out of a total sample of 19. This failure had the potential to increase the risk of COVID-19 infection and serious illness. Findings include: Findings include: 1. Review of R13's facility provided undated Patient Data revealed an admission date of 09/07/25. Review of R13's quarterly MDS with an Assessment Reference Date (ARD) of 03/14/26 and found in a folder kept at the nurse's desk revealed a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15, indicative of being cognitively intact. Review of the Infection Preventionist (IP) Nurses Note dated 09/17/25 at 3:55 PM provided by the IP revealed, COVID-l9 VACCINATION: Offered and educated resident on the importance, significance, and common side effects of the vaccine. He agreed to receive the vaccine when available. Review of R13's entire clinical record revealed no documentation to indicate the vaccine was administered following the resident's agreement, nor was there documentation of refusal, contraindication, or prior vaccination status. During an interview on 06/04/26 at 5:15 PM, the IP confirmed there was no record R13 had received the COVID vaccine. During an interview on 06/06/26 at 1:27 PM, the Director of Nursing (DON) stated, Upon admission, verify if the resident had it or not. If not, we will educate on the vaccine and offer it within a week of admission. The DON confirmed R13 should have received whichever COVID vaccine he was due for. 2. Review of R19's undated Patient Data located in the Electronic Medical Record (EMR) revealed the resident was admitted to the facility on [DATE]. Review of R19's admission MDS with an ARD of 04/21/26 and found in a folder kept at the nurse's desk, revealed a BIMS score of 12 out of 15, which indicated the resident was moderately cognitively impaired. Review of R19's Immunization Records dated 06/04/26 and located in the EMR revealed no documentation the facility assessed, offered, or provided the COVID-19 vaccine, nor documented refusal, contraindication, or prior vaccination status. During an interview on 06/04/26 at 2:57 PM, the IP indicated COVID vaccines were to be offered to the resident upon admission to the facility or at the hospital prior to transfer to the facility. The IP stated she was not sure how R19's immunization status had been missed upon admission to the facility. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/06/26 at 1:19 PM, the DON confirmed COVID immunizations were expected to be offered and administered or documented as refused prior to or upon admission to the facility and that it was the facility's responsibility to ensure this was done. Review of the facility's policy titled Protocol for Provision of COVID-19 Vaccination for SNF Residents dated 02/2022, revealed, Purpose: The COVID-19 vaccination has been shown in clinical trials to prevent hospitalizations and deaths. This protocol provides the process for ensuring provision of COVID-19 vaccination for residents that opt-in for vaccination. By executing this, the Skilled Nursing Facility (SNF) will be protecting part of the community population who are the most vulnerable.

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F 0837 Level of Harm - Potential for minimal harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on interview, document review, policy review and review of the Guam Code Annotated (GCA), the facility failed to ensure its governing body appointed a Licensed Nursing Home Administrator (LNHA) who was licensed and responsible for the management of the facility, reporting and being accountable to the governing body. This failure had the potential to result in ineffective oversight and lack of accountability and to affect all the residents of the facility. Findings include: During an interview during entrance conference on 06/01/26 at 10:06 AM with the Director of Nursing (DON), the Administrative Officer (AO), and Medical Director, the DON confirmed she was the Acting Administrator and did not have an Administrator's licensed. Review of the file provided on 06/02/26 by the Hospital Quality, Patient Safety and Regulatory Compliance Administrator (QPSRCA) revealed a LNHA job posting was done in January 2025 with one qualified applicant. The file included that the Board of Trustees Human Resources Subcommittee had the LNHA opening topic on their agenda for 01/13/25, 02/10/26, 03/17/26, 04/28/26 and 05/13/26 Board of Trustee meetings. During an interview on 06/06/26 at 4:40 PM, the QPSRCA confirmed the LNHA position opening was also included on the facility's Quality Assurance agenda. Review of the facility's policy titled Governing Body, reviewed 11/2023 revealed, Policy: The facility must have a governing body that is legally responsible for establishing andimplementing policies regarding the management and operation of the Skilled Nursing Unit.Procedures: The governing body appoints the Administrator that is responsible for the management of the facility. Review of the GCA Chapter 15 Nursing Home Administrators located at https://guamcourts.gov included under S 15102. Administrator's License Required, No nursing home shall operate except under the supervision of a nursing home administrator, and no person shall be a nursing home administrator unless he is the holder of a sufficient nursing home administrator's license issued pursuant to this Chapter.

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F 0844 Level of Harm - Potential for minimal harm Residents Affected - Many	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. Based on interview, the facility failed to present a Disclosure of Ownership during the extended survey. This failure could affect the accuracy of records for Centers of Medicare and Medicaid Services (CMS) and has the potential to affect all of the residents in the facility. Findings include:On 06/04/26 at 10:18 AM, the Disclosure of Ownership document was requested from the Administrative Officer (AO). During the exit conference on 06/06/26 at 6:00 PM, the AO stated the department that would complete and provide the Disclosure of Ownership document was closed and the document would be emailed on Monday. As of 06/10/26 at 5:30 AM the Disclosure of Ownership document has not been provided by the facility.