STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365936	(x2) multiple construction a. building b. wing	(X3) DATE SURVEY COMPLETED 03/19/2026

name of provider or supplier	street address, city, state, zip code
LIBERTY RETIREMENT COMMUNITY OF LIMA INC	**2440 BATON ROUGE AVENUE** **LIMA OH, 45805**

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F 0000	INITIAL COMMENTS ANNUAL SURVEY EXTENDED SURVEY COMPLAINT INVESTIGATION INCIDENT NUMBER 1335674 MASTER COMPLAINT NUMBER 2788347 COMPLAINT NUMBERS 2724849, 2698450, 2680979, 2621295, 2615090, 2575850, 2568764, and 1335680 ADMINISTRATOR: Amber Addair #8082 CERTIFIED BED CAPACITY: 60 CENSUS IN HOUSE: 47 The following deficiencies are based on the annual survey, extended survey and investigation of Master Complaint Number 2788347, Complaint Numbers 2724849, 2698450, 2680979, 2621295, 2615090, 2575850, 2568764, 1335680 and Incident Number 1335674 completed on 03/19/26.	F 0000		

laboratory director's or provider/supplier representative's signature	title	(x6) date
	AMBER.ADDAIR	04/13/2026

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.

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F 0580	Continued From page 1	F 0580		
F 0580 SS=D	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must 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- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) 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); (C) 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); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 0580	This plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid Requirements. Submission of this plan of correction does not constitute an agreement that the deficiencies actually exist, nor is it an admission that they existed. This submission is a good-faith expression of the facility's desire to fully comply with Medicare and Medicaid requirements. F580 Notify of changes The PoC will determine what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #24 continues to be monitored for blood pressure as ordered, and the physician, cardiologist, and resident have been notified of the ongoing results per ADON beginning 3-24-26. Resident #24 was assessed by the DON for any negative effects on 4-9-26, and none were identified. Resident # 51 is no longer in the facility. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken? All residents in the building who have a change in condition could be affected by this practice. A sweep of residents on 3-28-26 by Nursing managers identified that the MD and the responsible party had been called for all changes in conditions. The weekly Nutrition at Risk meeting results were called to the physician and family by the MDS nurse starting 3-24-26. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur The DON/Designee educated all nursing staff by 4-9-2026, to notify physicians and responsible parties of any	04/10/2026

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F 0580	Continued From page 2 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This STANDARD is not met as evidenced by:	F 0580	change in condition, including parameters set by the physician. Weekly/ monthly weights are discussed in the weekly nutrition at Risk meeting and MDS nurse/designee was trained by DON on 3-31-36 to notify significant changes to MD and family/resident. Corrective action will be monitored to ensure the deficient practice will not recur. During daily morning clinical and standdown the DON/designee reviews all progress notes, labs, and assessments and verifies that the physician and responsible part is notified of any change in condition, significant weight loss or gains and abnormal results identified with established parameters. DON/designee audit 5x w X 4 weeks with results submitted to QAPI committee weekly.If any concerns are identified with the audits the issue is immediately corrected (notifications completed) and parties involved reeducated.	

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F 0580	Continued From page 3 Based on record review, resident and staff interviews, and policy review, the facility failed to ensure staff notified the physician and family representatives of residents' changes in condition. This affected two (#24 and #51) of two residents reviewed for notification. The current census is 47. Findings include: 1. Record review for Resident #24 revealed the resident was admitted to the facility on 04/18/22. Diagnoses for Resident #24 include fracture of the pelvis, chronic pain, post-traumatic stress disorder, depression, epilepsy, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated 12/12/25 revealed the resident had intact cognition. Review of Resident #24's care plans dated 04/29/25 revealed a focus for cerebral vascular accident related to hypertension. Interventions include to monitor vital signs and notify medical doctor of significant abnormalities, give medications as ordered. Review of physician orders dated 11/21/25 revealed Resident #24 was to be administered clonidine 0.1 milligrams, (mg) tablet by mouth every 8 hours as needed for systolic blood pressure greater	F 0580		

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F 0580	Continued From page 4	F 0580		

than 170.

Review of Resident #24's vital signs dated from 11/2025 to 03/2026 revealed Resident #24 had on 02/27/26 a systolic blood pressure (SBP) of 171, on 02/22/26 SBP was 174, on 01/15/26 SBP was 206, and on 12/19/25 SBP was 219.

Review of Resident #24's progress notes dated from 12/01/2025 to 03/12/2026 revealed there was no documentation of any notification to the physician of Resident #24's blood pressure being out of normal limits on 01/15/26 or 12/19/25.

Interview on 03/09/26 at 9:00 A.M. and on 03/16/26 at 8:30 A.M. with Resident #24 revealed the resident stated he was concerned due to many times he felt his blood pressure was too high. Resident #24 stated staff are monitoring his blood pressure, but when he goes to see his cardiologist he is being told no one from the facility is reporting to the physician any abnormalities with his blood pressure.

Interview on 03/12/26 at 2:00 P.M. with Director of Nursing, (DON) verified there was no documentation in Resident #24's medical records of the facility notifying the primary physician or cardiologist of Resident #24's high blood pressures.

2. Review of the medical record for Resident #51 revealed an admission date of 05/14/24 with diagnoses including diabetes mellitus, Down's Syndrome,

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F 0580	Continued From page 5 Hirschsprung's disease, and morbid obesity. Resident #51 discharged to the hospital on 07/06/25 and did not return to the facility. Review of an annual Minimum Data Set (MDS) assessment, dated 05/18/25,indicated Resident #51 had severe cognitive impairment and was dependent upon staff for activities of daily living. Further review revealed a weight loss note dated 06/27/25 which stated Resident #51 had a significant weight loss. The note stated Resident #51's weight was 241 pounds on 02/05/25, 238 pounds on 04/02/25, and 183.7 pounds on 06/25/25. The medical record did not have documentation to support the facility notified the physician of Resident #51's significant weight loss. Interview on 03/16/26 at 10:34 A.M, with the Assistant Director of Nursing (ADON) #210 confirmed the medical record for Resident #51 did not have documentation supporting the facility notified the physician of the significant weight loss on 06/27/25. Review of the facility policy titled, "Nutrition (impaired)/Unplanned Weight Loss," revised September 2017, stated staff would report to the physician any significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake.	F 0580		

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F 0580	Continued From page 6 This deficiency represents non-compliance investigated under Complaint Number 2698450.	F 0580		

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F 0584	Continued From page 7	F 0584		
F 0584 SS=E	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 0584	F584 Safe/Clean/Comfortable/Homelike The PoC will what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 3 met with the care conference team on 3-25-26 to discuss plans to manage the resident's mattress pad when soiled and a plan to manage behaviors related to toileting assistance. Nursing staff are rounding, monitoring linen placed on the floor by the resident, and removing linen when providing care. These rounds began 3-20-26. Resident # 3 has improved, clean, comfortable /homelike as of 3-26-26. The mattress pad is being laundered by the facility as of 4-9-26. Resident #3 was assessed for any negative effects from this deficient practice and she made it very clear that she is fine and does not believe she has any odor. Resident has no infection control concerns as a result of soiled linen and odor in her room. The assessment was completed by Infection preventionist nurse by 4-9-26. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Residents affected by the odor on the 600 hall are a total of 17. The residents involved are (#2, #4, #9, #12, #13, #17, #21, #25, #33, #34, #35, #40, #42, #49 and all per interview state, they do not notice any pervasive odors. All 600 hall residents have been interviewed by the social services/designee and none are complaining of a pervasive odor as of 3-19-2026. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. Education for nursing and housekeeping to	04/10/2026

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F 0584	Continued From page 8 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This STANDARD is not met as evidenced by: Based on medical record review, census list review, observation, resident interview, staff interview, and review of facility policy, the facility failed to ensure residents were provided a clean and sanitary environment. This directly affected Resident #3 and potentially 14 additional	F 0584	provide a clean and sanitary environment, and odor control. was completed on 4-9-2026 by DON and the housekeeping director. The mattress cover will now be laundered in the facility laundry and rounds in place by nursing and housekeeping to prevent soiled linen on the floor and to frequently mop the floor. How the corrective action will be monitored to ensure the deficient practice will not recur. Daily round audits began 3-30-26 by housekeeping 5x a week x4 weeks by housekeeping director or designee, resident #3s room, and a random 5 rooms on the 600 hall for linens on the floor or soiled floors. Nursing rounds are routinely conducted throughout the 600 hall, monitoring for soiled linen, clothes on the floor and pervasive smells. CNA rounds are routine and ongoing audits beginning 4-9-26. The social worker begining 4-8-26 to interview 5 residents a day, 5 xs a week for 4 weeks, for complaints of odor. If concerns arise, the social worker will notify housekeeping and nursing managers to review what has caused the odors. If nursing or housekeeping audits reveal concerns, the room will be cleaned, and laundry pursued with staff reeducated. Results submitted to the weekly QAPI with further follow through. Random social service audits are completed daily, interviewing residents on the 600 hall 5x a week X 4 weeks	

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F 0584	Continued From page 9 residents (#2, #4, #9, #12, #13, #17, #21, #25, #33, #34, #35, #40, #42, #49) who resident on the same hall as Resident #3. The facility census was 47. Findings include: Review of the medical record revealed Resident #3 was admitted on 03/24/22. Diagnoses included acute and chronic respiratory failure with hypoxia, type two diabetes mellitus with hyperglycemia, and chronic kidney disease stage 3. Review of the Minimum Data Set (MDS), dated 02/02/26, revealed the resident was cognitively intact and required set-up/clean up assistance with toileting, showering, and personal hygiene. Review of the care plan, revised on 10/01/25, revealed Resident #3 has mixed bladder incontinence. Interventions include to check frequently and as required for incontinence (wash, rinse, and dry perineum), apply barrier cream, and change clothing as needed after incontinence episodes, resident does not wear briefs, preference- encouraged resident to have chux pad then open brief in chair while up during the day to help contain incontinent episodes, and patient to let staff know if she needs assistance with changing when soiled.	F 0584		

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F 0584	Continued From page 10 Observation on 03/09/26 during the initial tour revealed the 600 hall had a strong pervasive urine odor. Observation on 03/11/26 at 12:15 P.M. revealed upon entering the 600 hall there was a strong pervasive urine odor. Interview on 03/11/26 at 12:17 P.M. with Licensed Practical Nurse (LPN) #202 verified the odor was coming from Resident #3's room. Observation on 03/11/26 at 12:19 P.M. revealed Resident #3's room had a pile of laundry near the door. Consecutive interview with Resident #3 revealed every day she places soiled laundry on the floor near the door and an aide will collect them. Resident #3 stated the pile of laundry had been there since earlier this morning and when housekeeping came to clean additional soiled laundry in the room was added to the pile. Interview on 03/11/26 at 12:23 P.M. with Certified Nursing Assistant (CNA) #223 and CNA #282 verified the 600 hall was malodorous and verified the soiled clothing. CNA #223 and CNA #282 revealed there is a bagged soiled down comforter in Resident #3's room that she will not allow the facility to launder and is waiting for pick-up by a family member. Interview on 03/11/26 at 12:28 P.M. with CNA #256 verified the odor on the 600 hall, adding that it is always a problem.	F 0584		

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F 0584	Continued From page 11	F 0584		

CNA #256 revealed some residents on the hall have asked to have their door shut due to the odor. CNA #256 stated she did not know the soiled linen was on the floor and would collect it.

Interview on 03/11/26 at 12:35 P.M. with Resident #34 verified she likes her door shut and at times it is due to the odor in the hall.

Interview on 03/11/26 at 12:55 P.M. with CNA #256 verified when she collected the laundry from Resident #3's floor the laundry was saturated.

Review of the facility census list revealed 14 residents (#2, #4, #9, #12, #13, #17, #21, #25, #33, #34, #35, #40, #42, #49) resided on the same hall as Resident #3.

Review of the policy titled, "Homelike Environment," dated 2021, verified residents are provided with a safe, clean, comfortable, and homelike environment. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a homelike settings including pleasant, neutral scents.

This deficiency represents non-compliance investigated under Complaint Number 2568764 and 2615090.

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F 0604	Continued From page 12	F 0604		
F 0604 SS=D	483.10(e)(1),483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed	F 0604	F604 Right to be free of physical restraints The PoC will what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 30 is free of restraint. Resident #30 was assessed by the DON for any negative effects from being placed at the table with the WC locked on one side on 3-17-26, with no negative outcomes. On 3-17-26, going forward, the residents' chair is not locked when sitting at the table. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken? Reviews of residents who resided on the same unit with a dementia diagnosis have the potential for the same practice. An audit of these residents done by the MDS nurse or DON began on 3-24-2026 and resulted in no evidence of restraint use. On-going, there will be a random sample of 5 residents five days a week for four weeks. The audits began 3/24/26, and if any concerns are noted, they will be immediately corrected and staff re-inserviced. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. On or by 4-9-2026 DON/designee educated nursing staff in "The right to be free of any physical restraints". Reminder notice for nursing staff placed at the nurses' station by the DON on 4-8-26 that no residents shall have their wheelchairs locked while sitting at the dining tables. How the corrective action will be monitored to ensure the deficient practice will not recur. An audit is in place to review residents on Florence for their wheelchairs that they are not being locked	04/10/2026

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name of provider or supplier **LIBERTY RETIREMENT COMMUNITY OF LIMA INC**	street address, city, state, zip code **2440 BATON ROUGE AVENUE** **LIMA OH, 45805**		

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F 0604	Continued From page 13 for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This STANDARD is not met as evidenced by: Based on medical record review, observation, staff interview, and review of facility policy, the facility failed to ensure residents were free from physical restraint. This affected one (#30) of one resident reviewed for phyiscal restraint. The facility census was 47. Findings include: Review of the medical record revealed Resident #30 revealed an admission date of 10/06/23. Diagnoses included unspecified dementia, hyperlipidemia, major depressive disorder recurrent, anxiety disorder, and cognitive communication deficit. Review of the Minimum Data Set (MDS) assessment, dated 02/02/26, revealed the resident is severely cognitively impaired and requires set-up/clean-up assistance	F 0604	when the residents are seated independently The auditor is the RN MDS nurse, The DON ensures the audits are being completed. The audits began 3/24/26, and if any concerns are noted, they will be immediately corrected and staff re-inserviced. A random sampling of 5 residents, 5 days a week X4 weeks, with results submitted weekly to QAPI meeting for the QAPI team to evaluate the success of if any further guidance is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365936	(x2) multiple construction a. building b. wing	(X3) DATE SURVEY COMPLETED 03/19/2026

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F 0604	Continued From page 14 with eating. Resident #30 is dependent for toileting, showering, and personal hygiene. Resident #30 had occasionally behaviors of physical aggression, verbal aggression, and other behaviors in addition to rejection of care and wandering. Observation on 03/11/26 at 10:34 A.M. revealed Resident #30 was alert in a wheelchair sitting at the dining room table. Resident #30’s wheelchair was locked on the left side. Observation on 03/11/26 at 11:49 A.M. revealed Resident #30 at the dining room table eating lunch at the same location as the previous observation. Resident #30’s wheelchair was noted to be locked on the left side. Interview on 03/11/26 at 2:22 P.M., with Certified Nursing Assistant (CNA) #279 verified Resident #30 is not able to lock or unlock her wheelchair. CNA #279 stated locking Resident #30’s wheelchair was to ensure she remained at the table and does not wander throughout the facility during meals. CNA #279 verified the staff are not supposed to lock the wheelchair. Review of the undated facility policy titled, "Abuse, Mistreatment, Neglect, Injuries of Unknown Source and Misappropriation of Resident Property," revealed the facility will not tolerate mistreatment, abuse, exploitation, or neglect of its residents or misappropriation of resident property by	F 0604		

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F 0604	Continued From page 15 anyone. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This deficiency represents non-compliance investigated under Complaint Number 2698450.	F 0604		

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F 0627	Continued From page 16	F 0627		
F 0627 SS=D	483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) Inappropriate Discharge §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay	F 0627	F627 Inappropriate Discharge The PoC will what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 53 no longer resides in the facility. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents residing in the facility have the potential to be discharged. Census of 47. There are currently no residents being discharged from the facility as of 3/25/26 sweep completed by nurse manager. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. DON/designee in-serviced nursing management staff and social worker completed on 4/9/2026 a post-discharge plan is developed for each resident prior to his or her transfer or discharge. This plan will be reviewed with the resident, and/or his or her family, at least twenty-four (24) hours before the resident's discharge or transfer from the facility. Nursing services is responsible for obtaining orders for discharge or transfer, as well as the recommended discharge services and equipment, preparing the discharge summary and post-discharge plan, and completing discharge notes in the medical record. How the corrective action will be monitored to ensure the deficient practice will not recur. An audit of all discharged residents for a proper discharge plan and documentation is in place 5x a week X4 weeks per DON/designee. If there are concerns identified with the discharge audit, the concern will be corrected at that time, and	04/10/2026

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F 0627	Continued From page 17 for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.	F 0627	the nurse involved will be educated in the area of improvement. Results are presented to QAPI team weekly to evaluate areas of improvement.	

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F 0627	Continued From page 18 (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.	F 0627		

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F 0627	Continued From page 19 §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a	F 0627		

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F 0627	Continued From page 20 composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as	F 0627		

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F 0627	Continued From page 21	F 0627		

needed, to reflect these changes.

(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.

(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.

(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.

(vi) Address the resident's goals of care and treatment preferences.

(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.

(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.

(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to

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F 0627	Continued From page 22 local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.	F 0627		

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F 0627	Continued From page 23 §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This STANDARD is not met as evidenced by: Based on review of medical records, staff interview, and review of facility policy, the facility failed to have documentation of a resident’s discharge disposition in the medical record. This affected one (#53) of three closed records reviewed for discharge. The census was 47. Findings include:	F 0627		

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F 0627	Continued From page 24 Review of Resident #53’s closed medical revealed and admission date of 09/27/24. Diagnoses listed included breast cancer, hypertension, major depressive disorder, and osteoarthritis. Resident #53 was discharged on 08/19/25. Review of a quarterly Minimum Data Set (MDS) assessment dated 08/08/25 revealed Resident #53 was cognitively intact. Further review of Resident #53’s closed medical record revealed no documentation of Resident #53’s discharge disposition. There was not a documented recapitulation of Resident #53’s stay and there weren’t any progress notes concerning discharge arrangements. Interview with the Director of Nursing (DON) on 03/11/26 at 3:05 P.M. confirmed there was not any documentation of Resident #53’s discharge disposition in her medical record. The DON confirmed there was not a documented recapitulation of stay or nursing notes about Resident #53 discharge disposition. A post-discharge plan was not documented. Review of the facility’s policy titled “Transfer or Discharge, Preparing a Resident for,” dated revised 2016,	F 0627		

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F 0627	Continued From page 25 revealed a post-discharge plan is developed for each resident prior to his or her transfer or discharge. This plan will be reviewed with the resident, and/or his or her family, at least twenty-four (24) hours before the resident's discharge or transfer from the facility. Nursing services is responsible for obtaining orders for discharge or transfer, as well as the recommended discharge services and equipment, preparing the discharge summary and post-discharge plan, and completing discharge note in the medical record.	F 0627		

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F 0628	Continued From page 26	F 0628		
F 0628 SS=D	483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) Discharge Process §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.	F 0628	F0628 Discharge Process The PoC will what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #56 is no longer in the facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Any of the 47 residents residing in the facility have the potential for this practice. The residents who have been recently transferred or discharged had the potential to be affected. A sweep of these residents over a month, completed by nurse managers on 3-25-26, residing in the facility, revealed that residents requiring transfer/discharge are documented in the record with proper information and have not been affected by ths practice What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. All nurses and the social worker were educated by DON/designee over a period completed by 4/9/2026. Education included facility transfers or discharges of a resident; the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. Notify the resident and the resident's representative(s) of the transfer or discharge, and the facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. How the corrective action will be monitored to ensure the deficient practice will not recur. DON/Designee audit that each transfer/discharge is properly documented in	04/10/2026

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F 0628	Continued From page 27 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as	F 0628	the resident's chart daily 5x a week X 4 weeks. The information for transfer and discharge includes an e-interact transfer form and bed hold form as well as notification of reason for transfer and significant other notification etc. Results of the audit will be presented to the QAPI team weekly. Audits are done in real time, and if there is a concern, the DON/designee corrects the issue and reeducates the staff involved. Audits in place to ensure discharge forms are done with any discharge by DON/admin and follow-up if missed/re-education for the social services as needed.	

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F 0628	Continued From page 28 practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is	F 0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365936	(x2) multiple construction a. building b. wing	(X3) DATE SURVEY COMPLETED 03/19/2026

name of provider or supplier	street address, city, state, zip code
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F 0628	Continued From page 29	F 0628		

Continued From page 29

transferred or discharged;

(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;

(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and

(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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F 0628	Continued From page 30 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that	F 0628		

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F 0628	Continued From page 31 specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary	F 0628		

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F 0628	Continued From page 32 that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to document a resident's discharge information in the medical records including appropriate information for a resident's discharge to a hospital. This affected one (#56) of six residents reviewed for discharges. The current census is 47. Findings include: Record review for Resident #56 revealed	F 0628		

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F 0628	Continued From page 33 the resident was admitted to the facility originally on 06/06/24, re-admitted after a hospital stay on 09/25/25 and discharged to the hospital on 11/11/25. Diagnoses for Resident #56 included chronic pain, end stage renal disease requiring hemodialysis, and heart disease. Review of Resident #56’s comprehensive Minimum Data Set (MDS)assessment dated 07/12/25 revealed the resident had mildly impaired cognition. Review of Resident #56’s family representative contact information revealed the resident’s first contact was his sister followed by another sister and as the 3rd contact his brother. Review of Resident #56’s progress notes dated 11/11/25 at 6:18 A.M., revealed the nurse found the resident at 3:45 A.M. to be unresponsive in his room. Cardio-Pulmonary Resuscitation was initiated with emergency services being notified. Per the note the staff attempted to notify the resident’s brother and then sister as the resident was being transferred to the hospital. The nurse documented a follow-up call with the receiving hospital informing the nurse the resident had passed away at 5:30 A.M. Further review of Resident #56’s medical records including uploaded documentation, progress notes, and evaluations documents revealed there was no documentation regarding the	F 0628		

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F 0628	Continued From page 34 resident’s transfer to the hospital. There was no further documentation of the resident’s representative being notified of the discharge in writing. No discharge/transfer summary was noted in the resident’s records. Interview on 03/17/26 at 9:00 A.M. with Social Worker (SW) #284 verified there was no discharge summary in Resident #56’s records. SW #284 stated the social worker was training at the time Resident #56 was discharged and was unaware of any family representative of the resident being notified by the facility of the resident’s transfer/discharge information and any collection of the resident’s belongings after the resident had passed. SW #284 verified there was no further documentation in the resident's records of any contact after the transfer date with the family regarding the discharge. Interview on 03/17/26 at 11:00 A.M., with the Assistant Director of Nursing, (ADON) #210 verified there was no discharge summary in Resident #56’s medical records. ADON #210 verified there was no evidence of the required documentation of the transfer included in the medical records for the resident.	F 0628		

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F 0656	Continued From page 35	F 0656		
F 0656 SS=D	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 0656	F656 Comprehensive Care Plans The PoC will what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 10 has a new care plan that contains a comprehensive person-centered care plan to address an ongoing rash and interventions in place to treat/prevent worsening of the rash per MDS nurse on 3-12-26. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. A review of all like residents with wounds supports that they all have care plans related to their wounds in place.Completed by MDS nurse on 3-24-26. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. Corporate nurse in-service the MDS nurse on 3-24-26 that the facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident issues. The care plan must be done immediately upon collecting the information. How the corrective action will be monitored to ensure the deficient practice will not recur.audits began on 3/25/26 by DON/designee. All residents with skin conditions will be audited weekly by the DON to ensure that there is a care plan in place to address the skin condition . DON is doing a weekly audit reviewing all skin conditions X4 weeks X 2 months. Findings submitted to weekly QAPI committee. If a concern is found during the audit correction will be done by the MDS nurse and further redirection and education done.	04/10/2026

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F 0656	Continued From page 36 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This STANDARD is not met as evidenced by: Based on review of the medical record, staff interview, and policy review, the facility failed to develop a comprehensive person care plan related to skin impairment. This affected one (#10) of three residents reviewed for skin breakdown. The facility census was 47.	F 0656		

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F 0656	Continued From page 37 Findings include: Review of the medical record for Resident #10 revealed an admission date of 09/04/25 with medical diagnoses of cerebral infarction with left hemiplegia, mood disorder, hypertension (HTN) and epilepsy. Review of a quarterly Minimum Data Set (MDS) assessment, dated 12/31/25, indicated Resident #10 had moderate cognitive impairment and required partial/moderate staff assistance with toilet hygiene, bathing and supervision with bed mobility and transfers. Review of the MDS revealed no skin issues were noted. Review of the medical record for Resident #10 revealed documentation on shower sheets dated 01/02/26, 01/07/26, 01/09/26, 01/16/26, 01/24/26, and 01/30/26 which stated Resident #10 was noted to have redness under bilateral breasts and to her groin area which had worsened. The shower sheets indicated lotion was applied. Review of documentation on shower sheet dated 02/04/26 stated redness still under her breasts, powder did not work, and had been this way for months; on 02/06/26, redness noted under breasts and groin area; and on 02/27/26, old redness noted to breasts, groin, and belly. Review of medical record for Resident	F 0656		

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F 0656	Continued From page 38 #10 revealed a Wound Nurse Practitioner (NP) note dated 02/25/26 stated was resident was seen for initial evaluation and management of rash below breasts, in groin, umbilicus, and buttocks. The note stated nursing reported erythema to areas and odor. Observation of rash revealed fungal dermatitis noted to right inferior breast 16 centimeter (cm) by 13 cm, left inferior breast 7 cm x 10 cm, periumbilical 3 cm by 3 cm, and bilateral groin and buttocks with no measurements noted. The note stated Resident #10 was diagnosed with extensive fungal dermatitis to skin folds and buttocks. Review of the medical record revealed no documentation to support the facility developed a comprehensive person-centered care plan which addressed Resident #10's ongoing rash. Interview on 03/12/26 at 9:21 A.M. with MDS Nurse #201 confirmed Resident #10's medical record did not contain a comprehensive person-centered care plan to address Resident #10's ongoing rash or interventions in place to treat/prevent worsening of the rash. Interview on 03/12/26 at 10:00 A.M. with the Director of Nursing (DON) stated the expectation is for staff to complete skin assessments for residents weekly and document in the medical record. Review of the undated facility policy titled, "Care Plan, comprehensive	F 0656		

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F 0656	Continued From page 39 person-centered,” stated a comprehensive person-centered CP that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.	F 0656		

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F 0679	Continued From page 40	F 0679		
F 0679 SS=D	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This STANDARD is not met as evidenced by: Based on medical record review, observations, staff interview, and policy review, the facility failed to provide activities to meet the resident's needs and cognitive capabilities. This affected one (#40) of three residents reviewed for activities. The facility census was 47. Findings include: Review of the medical record for Resident #40 revealed an admission date of 09/29/20 with medical diagnoses of cerebral palsy (CP), profound intellectual disabilities, seizures, hypertension, and dysphagia.	F 0679	F0679 activities The POC will what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 40 has a new activities plan based on her particular needs utilizing the comprehensive assessment , care plan and preferences were done on 3-18-26 by the activities director. The new activities plan was created by the actvities director on 3-18-26. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Residents identified with similar cognitive and physical delays have been screened for appropriate activity plans. Residents who are identified with intellectual disabilities by diagnosis or low BIM scores and have community and individual activities ongoing to meet their needs. Sweep done 3-19-26. The activity director did the sweep and there were no negative concerns during the sweep. What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur. The activities director was educated on 3-17-26 by administrator that the facility has an on-going program to support residents in their choice of activities, both facility sponsored groups and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community considering the residents level of functioning. How the corrective action will be monitored to ensure the deficient practice will not recur. Audits of proper activities began	04/10/2026

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F 0679	Continued From page 41 Review of an annual Minimum Data Set (MDS) assessment, dated 02/11/26, indicated Resident #40 had severe cognitive impairment and was dependent upon staff for all activities of daily living. Review of the medical record for Resident #40 revealed a care plan dated 01/23/24 that stated Resident #40 was dependent upon staff for emotional, physical, spiritual, creative, and community activities and social well-being related to CP and intellectual disabilities with a goal to maintain involvement in cognitive stimulation, and social activities as desired. Interventions included inviting Resident #40 to scheduled activities, to ensure the activities Resident #40 was attending were compatible with physical and mental capacities, adapted as needed, and compatible with individual needs and abilities. Further review revealed a care plan dated 01/23/24 which stated Resident #40 was dependent upon staff for emotional, physical, spiritual, creative, and community activities with a goal for Resident #40 to participate in room visit programming two to four times weekly. Interventions included monitor visits to determine length of a visit and provide sensory stimulating interventions. Review of an admission assessment note dated 02/04/26 included a quarterly activity note for Resident #40 which stated preferences and participating level this	F 0679	3-19-26 The administrator/designee is auditing for activities that meet the needs of the residents with cognitive and intellectual delays, utilizing proper activity programming weekly X 4 weeks. Results being submitted to the QAPI committee. Concerns identified from the audit will be addressed, and the activity director will be further directed in proper activities by the administrator or classes.	

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F 0679	Continued From page 42 quarter are group and one-on-one activities. The note stated Resident #40 responds to music and staff would do one-on-one and hand massages. Review of Resident #40's activity documentation for January 2026 revealed hand massages on 01/02/26, 01/14/26, 01/28/26 and 01/29/26. Further review of January activity documentation revealed Resident #40's activity on 01/05/26, 01/08/26, 01/09/26, and 01/27/26 was to be sitting up in the living room. Resident #40 was noted to participate with room visit on 01/16/26 and 01/23/26 and small chat on 01/27/26. No other activities were documented for Resident #40 in January 2026. Review of Resident #40's activity documentation for February 2026 revealed hand massages were done on 02/04/26, 02/11/26, 02/18/26, 02/20/26, and 02/25/26. The documentation indicated Resident #40 was up in the living room on 02/09/26 and 02/16/26 and had room visit on 02/03/26. An activity was documented on 02/13/26 for Valentine Day party and on 02/27/26 that Resident #40 was up in her room listening to music. No other activities were documented for Resident #40 in February. Lastly, review of Resident #40's activities for March 2026 revealed hand massages on 03/04/26, 03/11/26, room visit on 03/06/26, and up in the living room on 03/11/26 and 03/12/26. No other activities were documented. Observation on 03/09/26 from 12:15 P.M.	F 0679		

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F 0679	Continued From page 43 to 1:55 P.M. Resident #40 was observed sitting in a common area near the 400 Hall in front of a television. The observation revealed no staff interaction with Resident 40. Observation on 03/12/26 at 9:50 A.M. observed Resident #40 sitting in common area near the 400 Hall in front of the television. Other residents were observed sitting in the common area watching television. No staff were noted to be present. Interview on 03/12/26 at 10:08 A.M. with Activity Director (AD) #207 confirmed the activity documentation from 01/01/26 to 03/09/26 did not have support Resident #40 was offered or provided activities as care planned for the residents preferences and needs. AD #207 confirmed the activity provided on some days included up in the “living room” which was the common area near the 400 Hall, up in her room with music on the television, and hand massages. Review of the facility policy titled, “Activity,” dated November 2017, stated the facility provides, based on the comprehensive assessment, care plan, and preferences of each resident, an on-going program to support residents in their choice of activities, both facility sponsored groups and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial	F 0679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365936	a. building b. wing	03/19/2026

name of provider or supplier	street address, city, state, zip code
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F 0679	Continued From page 44 well-being of each resident, encouraging both independence and interaction in the community. This deficiency represents non-compliance investigated under Complaint Number 2698450.	F 0679		

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F 0684	Continued From page 45	F 0684		
F 0684 SS=D	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This STANDARD is not met as evidenced by: Based on medical record reviews, observation, and staff interviews, the facility failed to continually assess a surgical wound and schedule recommended follow up wound clinic appointments for Resident #02; failed to ensure accurate assessment of skin impairment and initiate treatment timely for a rash for Resident #10; and the facility failed to document the cause of wound injury/trauma area for Resident #51. This affected three (#02, #10, and #51) of four residents reviewed for skin assessments and treatments. The facility census was 47. Findings include:	F 0684	F684 Quality of Care The PoC will what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #2 wound is healed per wound nurse 4-31-26.No further follow-up wound clinic appointment was needed or scheduled. Resident #10 has a treatment for rash which was ordered by the wound CNP and written by the wound nurse this order was written 3/18/26 which is demonstrating improvement and resident #51 is no longer in the facility. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents in the facility have the potential for an identified practice census of 47. A sweep of residents to include any skin and wound conditions was done by 3-25-2026 by the wound nurse and certified wound nurse practitioner. The wound nurses look for any skin issues, and the wound nurse practitioner sees all residents with any skin concerns. (treatment order was in place, follow-up appointments with wound clinic had been scheduled), accurate assessments were in place, and the cause of wound injury/trauma had been The facility has no residents requiring treatment from an outside wound clinic; all current skin/ wound conditions have been described and measured. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. DON/designee in-service all nurses in proper management of skin and wound issues. The resident's wounds must be reported, documented, and the MD notified. The areas	04/10/2026

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F 0684	Continued From page 46 1. Review of the medical record for Resident #02 revealed an admission date of 09/15/25, with medical diagnoses of acute osteomyelitis, diabetes mellitus (DM), peripheral vascular disease (PVD), congestive heart failure (CHF) and anemia. Review of the medical record revealed Resident #02 discharged to hospital on 11/20/25, readmitted to the facility on 12/03/25, discharged to the hospital on 12/19/25, readmitted to the facility on 12/21/25, discharged to the hospital on 01/31/26 and readmitted to the hospital on 02/11/26. Review of the medical record for Resident #02 revealed a quarterly Minimum Data Set (MDS) assessment, dated 02/20/26, which indicated Resident #02 was cognitively intact and was dependent upon staff for toileting, bathing, and transfers, and required substantial/maximum staff assistance with bed mobility. The MDS did not contain documentation to support Resident #02 had a surgical wound. Review of the medical record for Resident #02 revealed a physician order dated 02/15/26 to cleanse the left heel with wound cleanser, pat dry, apply Oil Emulsion (petroleum gauze) to wound bed, cover with silicone bordered dressing to change three times per week and as needed. Review of the medical record for Resident	F 0684	must be assessed completely and described in progress notes with origin. Treatment order in place. Residents going to the wound clinic are expected to be measured in the facility and assessed by the wound nurse with proper documentation. Education includes the importance of scheduling follow-up appointments. This is an oversight by the wound care nurse. The in-service period is ongoing, ending 4-9-2026. Wound nurse and DON were in-serviced 3-26-26 by the corporate nurse this inservicing also includes the need to schedule follow-up appointments. How the corrective action will be monitored to ensure the deficient practice will not recur. Weekly audits 5x week for 4 weeks per wound nurse /designee for residents with wounds. The audit includes observation of the wound and documentation.to ensure wounds are being accurately and continually assessed and the cause of trauma is being documented. The daily audit of all shower sheets to identify any new skin concerns to ensure there is no skin issue that goes without being identified and treated, reported to MD and the responsible party. The daily shower sheet is are audited by the wound nurse, and the wound nurse reports findings from the daily audit sheets in the morning clinical meeting. Weekly assessment of skin for all residents per wound nurse/designee. The shower sheet audit is reported in the morning clinical meeting and if any issues are identified, the wound nurse immediately calls the CNP and educates caregivers. Audits for skin are 5X week, ongoing. Results submitted to the QAPI committee. any concerns corrected and reeducation completed. Wound	

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F 0684	Continued From page 47 #02 revealed an admission assessment dated 09/15/25 which stated Resident #02 had a DM ulcer to left heel. Review of admission assessment dated 12/03/25 stated Resident #02 had a pressure ulcer to left heel. Review of weekly skin observation dated 12/21/25 stated Resident #02 had surgical site to left heel, and admission assessment dated 02/11/26 did not have any documentation related to wound to left heel. Review of the weekly wound assessment dated 03/11/26 stated Resident #02 had a surgical site to left heel which measured 1 centimeter (cm) by 1 cm by 0.1cm. The assessment stated the left heel wound started as a DM ulcer on 09/15/25 and was debrided while Resident #02 was hospitalized from 11/20/25 to 12/03/25. The note stated the wound to Resident #02's left heel was now categorized as a surgical wound and had a moderate amount of serosanguinous drainage. Review of the medical record for Resident #02 revealed a Wound Clinic note dated 01/13/26 which stated Resident #02 had left heel wound for many months status post heel incision and drainage with skin graft and cerement G. The note stated the wound to the left heel was characterized as a pressure ulcer. Review of the medical record for Resident #02 revealed a physician order dated 02/15/26 to cleanse the left heel with wound cleanser, pat dry, apply Oil Emulsion (petroleum gauze) to wound	F 0684	clinic appointments are monitored by the wound nurse and schedule is reported in morning clinical. monitored weekly by DON.	

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F 0684	Continued From page 48 bed, cover with silicone bordered dressing to change three times per week and as needed. Review of the medical record for Resident #02 revealed wound physician note dated 03/04/26 revealed no documentation to support the facility addressed left heel wound. Interview on 03/11/26 at 2:50 P.M., with Outpatient Wound Registered Nurse (OWRN) #304 at the Wound Clinic stated Resident #02 was last seen at the Wound Clinic on 01/13/26 for evaluation of left heel pressure ulcer with surgical site which measured 2.4 cm by 2.1 cm by 0.05 cm with sutures in place. OWRN #304 stated the Wound Clinic called the facility on 03/05/26 and left a message for a return call to schedule a follow-up appointment for Resident #02 but had not heard back from the facility. Observation on 03/11/26 at 3:00 P.M., of Wound Nurse #246 completed wound care for Resident #02’s left heel. Wound Nurse #246 was observed to apply personal protective equipment (PPE) and removed the dressing dated 03/10/26 from Resident #02’s left heel. Resident #02’s left heel observed to have a 1 cm by 1 cm round wound with small amount of drainage noted. Wound bed was observed to be beefy red and surrounding skin was pink. No odors noted. Wound Nurse #246 was observed to completed dressing change as ordered and no	F 0684		

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F 0684	Continued From page 49 concerns with wound care or infection control observed. Interview on 03/11/26 at 3:05 P.M., with Wound Nurse #246 stated Resident #02 has had a wound to her left heel since admission on 09/15/25 and that the facility had not measured the left heel wound because the wound clinic was monitoring the wound. Wound Nurse #246 confirmed the facility completed treatments to left heel wound three times per week as ordered. Wound nurse #246 confirmed Resident #02 had not been seen by the wound clinic since 01/13/26 because of a hospitalization and a follow up appointment had not been made yet. Wound Nurse #246 confirmed Resident #02's left heel wound had not been measured from 01/13/26 until 03/11/26. 2. Review of the medical record for Resident #10 revealed an admission date of 09/04/25 with medical diagnoses of cerebral infarction with left hemiplegia, mood disorder, hypertension (HTN) and epilepsy. Review of the medical record for Resident #10 revealed a quarterly MDS assessment, dated 12/31/25, which indicated Resident #10 had moderate cognitive impairment and required partial/moderate staff assistance with toilet hygiene, bathing and supervision with bed mobility and transfers. Review of the MDS revealed no skin issues were noted.	F 0684		

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F 0684	Continued From page 50 Review of the medical record for Resident #10 revealed documentation on shower sheets dated 01/02/26, 01/07/26, 01/09/26, 01/16/26, 01/24/26, and 01/30/26 which stated Resident #10 was noted to have redness under bilateral breasts and to her groin area which had worsened. The shower sheets indicated lotion was applied. Review of documentation on shower sheet dated 02/04/26 stated redness still under her breasts, powder did not work, and had been this way for months, 02/06/26 redness noted under breasts and groin area, and on 02/27/26 old redness noted to breasts, groin, and belly. Review of the weekly skin assessments dated 01/06/26, 01/16/26, 01/27/26, 02/10/26, and 02/20/26 stated Resident #02 had no skin issues noted. Review of a weekly wound observation dated 02/25/26 revealed Resident #10 had fungal areas under right and left breasts, and belly button. The observation did not include measurements and stated no open areas were noted. Review of Resident #10"s physician orders revealed a physician order dated 12/31/25 for miconazole nitrate cream 2% to rash under breasts topically every shift for infection. The order was discontinued on 02/15/26 and a new order was written to cleanse under bilateral breasts with soap and water, rinse, pat dry, apply antifungal powder two times per day.	F 0684		

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F 0684	Continued From page 51 Review revealed an order dated 02/25/26 apply antifungal cream to buttocks, 02/26/26 Diflucan (antifungal medication) 150 milligram (mg) one tablet by mouth daily for four days. and on 03/01/26 Benadryl 25 mg one tablet every eight hours as needed for itching. Review of medical record for Resident #10 revealed a Wound Nurse Practitioner (NP) note dated 02/25/26 which stated was seen for initial evaluation and management of rash below breasts, in groin, umbilicus, and buttocks. The note stated nursing reported erythema to areas and odor. Observation of rash revealed fungal dermatitis noted to right inferior breast 16 cm by 13 cm, left inferior breast 7 cm x 10 cm, periumbilical 3 cm by 3 cm, and bilateral groin and buttocks with no measurements noted. The note stated Resident #10 was diagnosed with extensive fungal dermatitis to skin folds and buttocks and an order was give for antifungal powder to skin folds and antifungal cream to buttocks, Diflucan 150 mg daily for five days. Review of the medical record for Resident #10 revealed a nurses note dated 03/02/26 at 7:02 P.M. which stated Resident #10's significant other requested to take Resident #10 to Urgent Care due to excoriation under breasts and new rash covering extremities and torso. Review of a nurse's note dated 03/02/26 at 9:53 A.M. stated Resident #10 returned to the facility with new orders for Keflex	F 0684		

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F 0684	Continued From page 52 (antibiotic) and Diflucan for a fungal infection of the skin and candidal intertrigo. Review of the medical record for Resident #10 revealed an Urgent Care note dated 03/02/26 which stated resident presented with complaints of rash under bilateral breasts, umbilical area, under stomach, arms, and abdomen. The note stated examination of skin revealed rash was macular, papular, and purpuric with areas of erythema and excoriation under bilateral breasts, lower abdomen, and umbilical was sloughing. The note stated an order for Keflex and Diflucan were given. Review of Resident #10's physician orders dated 03/02/26, for fluconazole (Diflucan) 150 mg one tablet by mouth one day per week on Tuesdays, and an order dated 03/11/26 ketoconazole external cream 2% apply under breasts and groin topical every shift. Review of the medical record revealed no documentation to support the facility administered Keflex as ordered by Urgent care on 03/02/26. Interview on 03/11/26 at 10:52 A.M. with Licensed Practical Nurse (LPN) #202 stated Resident #10’s areas started as yeast areas under her breasts but have gotten worse. LPN #202 stated Resident #10 did not complain of pain but frequent itching.	F 0684		

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F 0684	Continued From page 53 Interview and observation on 03/12/26 at 11:55 A.M., with Resident #10 stated the rash under her breasts, to her groin, and on her belly have been present for a long time and hasn't improved. Resident #10 stated the areas are very itchy but were not causing her pain. Observation of Resident #10's abdomen revealed red rash noted under bilateral breasts extending down her abdomen and scattered over her back. Rash appeared dry and no drainage noted. Interview on 03/12/26 at 9:13 A.M. with the Director of Nursing (DON) confirmed the weekly skin assessments completed in January 2026 and February 2026 did not contain documentation to support Resident #10 had a rash under bilateral breasts, groin area, or umbilical area until wound observation assessment was completed on 02/25/26. DON also confirmed that the medical record had no documentation to support a treatment was initiated for the rash to Resident #10's groin or umbilical area until 02/25/26. DON also confirmed the facility did not complete a comprehensive skin evaluation for Resident #10's rash until the resident was seen by Wound NP on 02/25/26. DON also confirmed the Keflex was not administered as ordered by Urgent Care. 3. Review of the medical record for Resident #51 revealed an admission date of 05/14/24 with DM, Down's Syndrome, Hirschsprung's disease, and morbid	F 0684		

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F 0684	Continued From page 54 obesity. Resident #51 discharged to the hospital on 07/06/25 and did not return to the facility. Review of the medical record for Resident #51 revealed an annual Minimum Data Set (MDS) assessment, dated 05/18/25, which indicated Resident #51 had severe cognitive impairment and was dependent upon staff for activities of daily living. The MDS indicated Resident #51 had an indwelling catheter. Review of the medical record for Resident #51 revealed a Wound NP note dated 06/02/25 stated Resident #51 had a non-pressure wound left sacrum, trauma/injury 3 cm by 0.2 cm with moderate serous exudate and 10% slough present. Further review revealed a Wound NP note dated 07/01/25 revealed Resident #01 continued with non-pressure to left sacrum, full thickness trauma which measured 0.5 cm by 0.5 cm by 0.2 cm with 10% slough and surgical debridement completed. Review of the medical record for Resident #51 revealed a physician order dated 06/17/25 to cleanse sacral wound with wound cleanser or normal saline, apply calcium alginate, and cover with bordered gauze daily and as needed. Review of the medical record revealed treatments were completed as ordered. Interview on 03/16/26 at 9:01 A.M. with MDS Nurse #201 confirmed the medical	F 0684		

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F 0684	Continued From page 55 record did not have documentation to support what caused the trauma or what type of trauma was to Resident #51's sacrum. MDS Nurse #201 stated she was not able to determine what type of trauma Resident #51 had to his sacrum. This deficiency represents non-compliance investigated under Complaint Number 2568764 , 2615090 and 1335680.	F 0684		

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F 0689	Continued From page 56	F 0689		
F 0689 SS=E	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This STANDARD is not met as evidenced by: Based on medical record review, observation, resident interview, staff interview, resident food list review, and review of facility policy, the facility failed to ensure resident meals were free from choking hazards. This affected Resident #34 with the potential to affect an additional seven (#3, #4, #8, #15, #21, #41, and #46) residents who were served soup. In addition, the facility failed to ensure the facility followed the fall policy and provided documentation of the fall in the medical record. This affected one (#6) of seven residents reviewed for falls. The facility census was 47. Findings include:	F 0689	F0689 Free of Accident Hazards/Supervision/Devices The PoC will what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #34 per the interview with the resident by the administrator, she found that the bone in her soup, but the resident stated she had not been harmed by it, she had not eaten it, and would prefer that type of soup. Residents #3, #4, #8, #15, #21, #41, and #46 all were served the same chicken soup on the day of the survey, but per social services, all of those residents did not see any bones in their soup and didn't choke or have any negative effects from the soup. No other resident in the facility received chicken soup that day.no other residents had potential to be affected by this deficient practice n 3/10/26 Resident #6 was sent to the hospital post fall and a nurse wrote an IDT note written upon return 12/2/25 with interventions. She has healed s/p fall at this time. The PA stated on 4-9-26 that the resident's injuries from fall are currently healed. Falls sweep was conducted by DON and Adon going back a week. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All facility residents have the potential for falls. A sweep of falls post survey on March 26,2026 has identified that all residents that have fallen have documentation, interventions, and post-fall follow-up. The potential to be affected by the deficient practice was no one else other than the affected resident and the additional seven who had been served soup that day; no other residents had the potential	04/10/2026

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F 0689	Continued From page 57 1. Review of the medical record revealed Resident #34 was admitted on 04/29/25. Diagnoses included chronic obstructive pulmonary disease, heart failure, type two diabetes mellitus without complications, hypothyroidism, and major depressive disorder. Review of the Minimum Data Set (MDS) assessment, dated 12/07/25, revealed the resident was cognitively intact and set-up/clean-up for eating. Observation on 03/10/26 at 12:13 P.M. of Resident #34 ate lunch in her room with the door closed. Observation of the completed lunch meal revealed an approximate two inch chicken bone in the soup bowl. Subsequent interview with Resident #34 verified having chicken noodle soup and finding a chicken bone in the soup while eating. Interview on 03/10/26 at 12:29 P.M. with Cook #212 verified there was an approximate two inch chicken bone in Resident #34's soup bowl. Interview on 03/10/26 at 12:31 P.M. with Dietary Manager #226 revealed there was left over fried chicken from a recent meal and dietary staff deboned the chicken for the soup. Review of a facility provide resident list	F 0689	to be affected by the deficient practice on 3-10-26 per the dietary manager. As of 3-10-26 shredded chicken has been purchased, and the dietary manager has been monitoring for bones in the shredded chicken with each meal a day 5x days a week X4 weeks. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. DON/designee in-serviced all nurse to write the post-fall nurse's notes to include head-to-toe assessment of the resident, the position observed, from bed or chair, in room, bathroom, etc, and what the resident was doing, transferring from bed to chair, attempting to walk to the bathroom, etc. Describe any injury observed; skin tears, laceration, bruising, swelling, limited range of motion, suspected fractures. The in-service was completed 4-9-2026.Fall investigation to include witness statements and root cause analysis as well as IDT note. Dietary manager did an in-service for her kitchen staff to verify that the food will be prepared in a form to accommodate resident allergies, intolerances, and personal, religious, and cultural preferences based on reasonable efforts. Provided food and drink will be nutritious, palatable, attractive, and at a safe and appetizing temperature to meet individual needs. And a decision made only shredded chicken has been purchased on 3-33-26 for chicken soup and checked by DM/designee for chicken bones before preparation. How the corrective action will be monitored to ensure the deficient practice will not recur. The dietary manager/designee has an audit of food quality and presentation 5x a week x 4	

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F 0689	Continued From page 58 revealed on 03/10/26 eight (#3, #4, #8, #15, #21, #34, #41, and #46) were served chicken noodle soup for lunch. Review of policy titled, "Purpose and Objectives of the Food and Nutrition Services Department", date 2021, verified the food will be prepared in a form to accommodate resident allergies, intolerances, and personal, religious, and cultural preferences based on reasonable efforts. Provided food and drink will be nutritious, palatable, attractive, and at a safe and appetizing temperature to meet individual needs. 2. Review of Resident #6's medical record revealed an admission date of 01/25/22. Diagnoses listed included chronic respiratory failure, obstructive sleep apnea, delusional disorders, and anxiety. Review of a quarterly Minimum Data Set (MDS) dated 02/02/25 revealed Resident #6 was cognitively intact and had two or more falls. Review of interdisciplinary team (IDT) notes dated 11/17/25 at 10:48 A.M., revealed a fall investigation was completed with interventions being reviewed. The note did not include any time or date of a fall, Resident #6's condition after the fall, or staff involved. Review of IDT notes dated 11/19/2025 10:48 A.M., revealed a fall investigation was completed with interventions being	F 0689	weeks, including monitoring shredded chicken for bones to ensure the food is safe to eat. Submit findings to the weekly QAPI Committee. DON/designee audit all falls daily 5X a week X4 weeks falls documentation written description of fall root cause analysis idt note with intervention and post-fall note to ensure there are no repeat falls or inuries.. Findings are submitted to the weekly QAPI committee if concerns are found, a follow-up investigation is completed, and further education is done for nurses involved.	

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F 0689	Continued From page 59 reviewed. The note did not include any time or date of any fall, Resident #6's condition after the fall, or staff involved. Review of nurse's notes revealed no documentation of falls related to the IDT notes on 11/17/25 and 11/19/25. Review of Risk Management documents revealed Resident #6 had an unwitnessed fall on 11/14/25 and on 11/17/25. On the bottom of each Risk Management page, a statement was printed "Privileged and Confidential - Not part of the Medical Record - Do not Copy." Interview with the Director of Nursing (DON) on 03/11/26 at 3:05 P.M. confirmed no documentation in nursing notes related to IDT notes dated 11/17/25 and 11/19/25. The DON stated those falls were documented in Risk Management and would not be able to be seen in the electronic medical record. During an interview on 03/16/2026 at 9:05 A.M., with the Assistant Director of Nursing (ADON) #210 confirmed per the facility's fall policy, a nurse should document a resident's fall in the nurse's notes. Review of the facility's policy titled "Resident Falls", dated revised May 2023, revealed the nurse's notes should include head to toe assessment of the resident, the position observed, from bed or chair, in room, bathroom, etc, and what	F 0689		

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F 0689	Continued From page 60 the resident was doing; transferring from bed to chair, attempting to walk to the bathroom, etc. Describe any injury observed; skin tear, laceration, bruising, swelling, limited range of motion, suspected fracture. This deficiency represents non-compliance investigated under Complaint Number 2698450 and 2568764.	F 0689		

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F 0690	Continued From page 61	F 0690		
F 0690 SS=D	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 0690	F690 Bowel/Bladder Incontinence, Catheter, UTI The PoC will what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #51 is no longer in the facility. How you will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken? Residents residing in the facility with indwelling catheters may be affected by the same practice. There are currently 7 residents with catheters in the building. All seven have been assessed on 4-2-26 for symptoms of UTI,by the infection preventionist and none have current symptoms of UTI 4-2-26. At the time of assessments, there were no concerns What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. DON/designee educated the nursing staff on or before 4-9-2026 about the necessary care and treatment of catheter care to prevent catheter-associated urinary tract infections (UTI). This education includes symptoms of UTI. Nurses and STNAs were educated to identify and report a change in a resident's baseline mental, behavioral, or physical status to a nurse and a medical doctor. The nurse would assess the resident's condition based on the information reported. Staff were inserviced on symptoms of UTI. Emergency care for the residents would be provided if appropriate and /or necessary, the physician would be notified if warranted, emergency services would be contacted for transport if warranted, and the party responsible would be notified of a change in mediation or treatment or if the resident was transferred for acute	04/10/2026

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F 0690	Continued From page 62 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This STANDARD is not met as evidenced by: Based on the medical record review, hospital report review, staff interview and policy reviews, the facility failed to ensure the necessary care and treatment was provided when a resident with a urinary catheter displayed symptoms of a urinary tract infection (UTI). This affected one (#51) out of two residents reviewed for care and treatment of urinary catheters. The facility census was 47. Findings include: Review of the medical record for Resident #51 revealed an admission date of 05/14/24 with medical diagnoses of diabetes mellitus, down's syndrome, Hirschsprung's disease, and obstructive and reflex uropathy. Review of the medical record revealed Resident #51	F 0690	care . Monitor closely for medications ordered. The facility will ensure that the deficient practice does not recur. How the corrective action will be monitored to ensure the deficient practice will not recur. Audits of residents all 7 residents with catheters are being audited weekly by DON/ or designee. If there are more catheters in place they will be added to the number of residents with catheters being audited. The DON/designee will audit for care and signs of infection by observation of the resident, interview with the resident and reviewing progress notes. audit started 4-1-2026 and are ongoing 5xaweek for 4 weeks. Results are supplied to the QAPI team weekly. If concerns are identified, the MD will be notified and staff reeducated in the process of assessing for uti and care and treatment to prevent UTIs.	

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F 0690	Continued From page 63 was discharged from the facility on 07/06/25 to hospital for evaluation of ongoing right abdominal pain and was admitted to the hospital with peptic ulcer disease, cholecystitis and UTI. Review of Resident #51's annual Minimum Data Set (MDS) assessment, dated 05/18/25, indicated Resident #51 had severe cognitive impairment and was dependent upon staff for activities of daily living. The MDS indicated Resident #51 had an indwelling catheter. Review Resident #51's physician order dated 02/15/25 revealed an order for 16 French catheter to straight drain and catheter care every shift and as needed. Review of Resident #51's nurse's note, dated 04/09/25 at 2:27 P.M., documented the nurse noted purulent drainage from the catheter site when cleaning and a small amount of grey greenish drainage from the catheter. The note stated Resident #51 complained of pain "where he peed". Review of Resident #51's physician orders revealed an order dated 04/11/25	F 0690		

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F 0690	Continued From page 64 for urinalysis (UA) with reflex culture. Review of the laboratory report dated 04/11/25 for a UA showed yellow and turbid (appears cloudy, hazy, or murky rather than transparent, often indicating the presence of substances like bacteria, pus, blood, or crystals) urine and positive for the presence of Hemoglobin, nitrates, white and red blood cells. Urine culture was ordered. Review of Resident 51's physician progress note dated 04/14/25 revealed the resident was seen for UA concerning UTI, starting antibiotic and no other complaints. Review of Resident #51's nurse's note dated 04/16/25, documented Resident #51's indwelling catheter was changed per monthly schedule. Review of the laboratory report for Resident #51 revealed UA culture result dated 04/16/25 was positive for greater than 100,000 pseudomonas and noted on the paper copy of the culture results was a handwritten physician order for Bactrim Double Strength (DS) two times per day	F 0690		

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F 0690	Continued From page 65 for seven days. The undated note had an illegible physician or Nurse Practitioner (NP) signature. Review Resident #51's physician notes dated 04/22/25 and 04/30/25 revealed no documentation to support urinary status were addressed. Review Resident #51's medication administration record (MAR) for April 2025 revealed no documentation to support the facility administered the Bactrim or any other antibiotic. Review of the monthly Nurse Practitioner (NP) note, dated 05/19/25, revealed no documentation to support urinary status was addressed. Review of a nurse's note dated 05/23/25 at 5:30 A.M, documented Resident #51 yelled out that he couldn't pee. The note documented that the nurse observed Resident #51's catheter had no output, his abdomen was distended and hard upon palpation, and the Certified Nurse Assistant (CNA) reported Resident #51 had not had any urine output the entire shift. The note stated the nurse removed	F 0690		

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F 0690	Continued From page 66 the old foley catheter and Resident #51 had large green foul-smelling discharge come from the penis. The note continued to state a new indwelling catheter was inserted under sterile technique and 500 cubic centimeters (cc) of dark odorous urine was returned. The note indicated a culture was collected. Review of Resident #51's medical record revealed no documentation of the physician being notified of the resident displaying symptoms of a potential UTI or having decrease urinary output. Review of Resident #51's physician orders revealed an order dated 05/23/25 for culture of genital. There were no orders to obtain laboratory work for the urinary tract infection symptoms. Review of the laboratory report for Resident #51 revealed the 05/23/25 genital culture came back with normal flora. Review of Resident #51's medical record revealed no documentation of the doctor being notified of the symptoms on 05/23/25 or the resident being transferred	F 0690		

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F 0690	Continued From page 67 to the hospital or the reason for the transfer on 05/28/25. Review of Resident #51's Emergency Room notes dated 05/28/25 documented Resident #51 was diagnosed with atypical pneumonia, UTI, and gastroesophageal reflux disease and ordered Levofloxacin 500 mg one tablet by mouth daily for 10 days. Review of Resident #51's nurses note dated 05/28/25 documented Resident #51 arrived back to the facility by emergency medical transport and Resident #51 had been diagnosed with UTI, pneumonia, and acid reflux. Review of Resident #51's physician order revealed an entry order dated 05/29/25 for Levofloxacin 500 milligram (mg) one tablet by mouth at bedtime for 10 days. Review of May 2025 MAR revealed the Levofloxacin was started on 05/29/25 given for the ten days. Review of Resident #51's nurse's note	F 0690		

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F 0690	Continued From page 68 dated 06/11/25, documented resident's mom had concerns with resident's care. The note stated mom was going to have evaluation done for Hospice or palliative care. Stated the physician was notified and orders for UA, Complete Blood Count (CBC) and ultrasound (US) of right abdomen and medication changes noted. UA was obtained on 06/14/25 and culture returned on 06/16/25 which showed Methicillin- Resistant Staphylococcus Aureus (MRSA). Review of the laboratory report dated 06/11/25 for a UA showed yellow excessive turbid (appears cloudy, hazy, or murky rather than transparent, often indicating the presence of substances like bacteria, pus, blood, or crystals) urine and positive for the presence of Hemoglobin, nitrates, white and red blood cells. Urine culture was ordered. Review of the laboratory report dated 06/14/16 revealed the presence of MRSA and resistant to certain medications and susceptible to others. Review of the physician orders revealed order dated 06/27/25 for Macrobid 100 milligram (mg) one capsule by mouth two times per day for seven days. The	F 0690		

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F 0690	Continued From page 69 medication was administered. Interview on 03/17/26 at 11:10 A.M. with MDS Nurse #201 confirmed the facility staff did not administer Bactrim as ordered in April 2025 for UTI. MDS Nurse #201 confirmed the facility did not obtain orders for repeat UA's to be completed in April or May 2025. MDS Nurse #201 confirmed there is no evidence of the physician being notified of the symptoms of the UTI or that the facility did not request an order for an UA to be done when resident was showing signs and symptoms of a possible UTI on 05/23/25. MDS Nurse #201 confirmed Resident #51 was diagnosed with UTI at the hospital on 05/28/25. Review of the facility policy titled, "Urinary Catheter Care," revised September 2014 stated the purpose was to prevent catheter-associated urinary tract infections (UTI). stated the staff were to observe the residents' urine level for noticeable increases or decreases. Stated if the levels stay the same, or increases rapidly, report it to the physician or supervisor. Review of the facility policy titled, "Change of Condition" dated May 2017 stated staff	F 0690		

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F 0690	Continued From page 70 are expected to identify and report a change in a resident's baseline mental, behavioral, or physical status to a nurse. The nurse would assess the resident's condition based on the information reported. Emergency care for the resident would be provided if appropriate and /or necessary, the physician would be notified if warranted, emergency services would be contacted for transport if warranted, and the responsible party would be notified of a change in mediation or treatment or if the resident was transferred for acute care. This deficiency represents non-compliance investigated under Complaint Number 2615090 and 2575850.	F 0690		

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F 0695	Continued From page 71	F 0695		
F 0695 SS=J	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This STANDARD is not met as evidenced by: Based on observation, record review, Emergency Medical Services (EMS) report review, hospital documentation review, death certificate review, resident interview, staff interview, review of facility's policy for "Cardio-Pulmonary Resuscitation (CPR)", and review of facility's policy and procedure for "In Case of Decannulation", the facility failed to ensure the necessary life-sustaining respiratory services were provided to residents who required invasive mechanical ventilation via tracheostomy (a hole in the front of the neck and into the windpipe) cannula. This resulted in Immediate Jeopardy and serious life-threatening harm on 10/05/25 at 1:40 A.M., when Resident #54 was found unresponsive without a pulse, with the	F 0695	F695 On 10/05/25, Resident #54 was transferred to the hospital. On 10/05/25 at 6:00 A.M., Respiratory Therapist Manager (RTM) #242 verbally in-serviced both agency nurses, LPN #288 and LPN #302. Both nurses returned demonstration and reviewed printed policies and procedures in the agency binder after the incident occurred. This education included suctioning (both open and closed), how to measure the placement of the suction catheter, decannulation, how to use Ambu-bag and the competency checklist for respiratory nursing care for residents on ventilators and residents who have tracheostomy and the location of crash carts and Automated External Defibrillator (AED). On 10/07/25, CCO #300 and former Human Resource Manager (HRM) #303 in-serviced RNs and LPNs on Respiratory policies, CPR, supplemental oxygen, Trach and Decannulation. Policies and procedures were sent to all nurses via text message for immediate review. There was no documentation of receipt of the text to the staff. On 10/07/25, CCO #300 and former HRM #303, in-serviced CNAs on personal care for residents with tracheostomies. Policies and procedures were sent to all CNAs via text for immediate review. There was no documentation of receipt of the text to the staff.. On 03/12/26 at 10:30 A.M., the Administrator and CCO #300 educated RTM #242 on the facility's requirements for nurses training for ventilator dependent residents, supplemental oxygen, tracheostomy care and emergency procedures. On 03/12/26 at 10:30 A.M., RTM #242 implemented an education binder to track and audit all facility and agency	04/10/2026

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F 0695	Continued From page 72 tracheostomy cannula dislodged, and had been without oxygen for an unknown period of time. Staff were not trained in regards to reinserting the cannula or the procedure required to provide life-saving measures. Consequently, lifesaving CPR was not properly performed when Resident #54 was not provided with supplemental oxygen or re-cannulated timely, was transferred to the hospital and subsequently passed away three days later from an anoxic brain injury secondary to hypoxic respiratory failure. This affected one (Resident #54) of four residents reviewed for tracheostomy care. The facility identified two current residents with tracheostomies. The facility census was 47. On 03/12/26 at 12:13 P.M., the Administrator, the Director of Nursing (DON) and Chief Compliance Officer (CCO) #300 was notified Immediate Jeopardy began on 10/05/25 at 1:40 A.M. , when the an agency nurse, Licensed Practical Nurse (LPN) #288, was alerted by Certified Nurse Aide (CNA) #265 that while she was providing care for Resident #54 the tracheostomy (trach) had become de-cannulated and was no longer in place in the resident's trachea. LPN #288 went to assess Resident #54 and found the resident unresponsive with the tracheostomy cannula lying on her chest. LPN #288 attempted to place the tracheostomy cannula back into Resident	F 0695	staff education documents. Beginning on 03/12/26 at 10:30 A.M., RTM #242 or designated Respiratory Therapist will train agency nursing staff on ventilator dependent residents care plans, protocols for tracheostomy care and emergency procedures for ventilator dependent and/or trach residents prior to providing care to residents. Competency checklist to be completed by Respiratory Therapist. This is a new standard practice going forward without an end date. On 03/12/26 at 10:45 A.M., RTM #242 re-educated and completed check-off on Competency Checklist for Respiratory Care for Nursing, Decannulation and Emergency Procedures for Registered Nurses (RNs) and LPNs. Education/Training included verbal, return demonstration and printed procedures. This was completed on 03/13/26. On 03/12/26 at 12:30 P.M., a Quality Assurance (QA) meeting was held immediately following notification of Immediate Jeopardy. This included CCO #300, the Administrator, LNHA, DON, Assistant DON, Minimum Data Set (MDS) Nurse, RTM #242, Infection Preventionist/Wound Nurse, Scheduler, Business Office Manager, Social Services, Activity Director, Maintenance Director, Dietary Manager, Therapy Manager, Housekeeping/Laundry Supervisor who met to discuss the 10/05/26 incident, education needed, policies and procedures to put into place. Beginning on 03/12/26 at 12:45 P.M., RTM #242 will complete a respiratory assessment for all at risk residents and ensure that residents are provided with respiratory care by trained staff. Completed by	

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F 0695	Continued From page 73 #54's trachea and was unsuccessful. LPN #288 instructed CNA #265 to call Respiratory Therapist (RT) #236 for instruction and to call for Emergency Services (911). LPN #288 was unable to obtain a pulse on Resident #54 and began chest compression but did not apply any supplemental oxygen to the resident, who required mechanical ventilation to breathe. On 10/05/25 at 1:51 A.M., 11 minutes after the resident was found to be de-cannulated, unresponsive and without a pulse, RT #236 arrived at the facility along with Emergency Medical Services (EMS) and was able to re-cannulate the resident. After re-cannulating Resident #54's tracheostomy, RT #236 prepared the Ambu-bag (a hand-held, self-inflating device used to provide positive pressure ventilation to patients who are not breathing) with oxygen and began to supply oxygen to Resident #54 via the tracheostomy cannula. EMS assumed CPR chest compressions from LPN #288 and was able to reconnect the ventilator to Resident #54 and transport her to the hospital. While EMS was able to adequately ventilate Resident #54, the resident continued to require CPR measures at the hospital. Once a pulse was obtained, the resident was admitted to the Intensive Care Unit but was found to be non-reactive and in a vegetative state. Resident #54 passed away three days later, on 10/08/25, with the cause of death determined as anoxic brain injury (brain deprived of oxygen causing rapid	F 0695	03/13/26 at 4:00 P.M. Beginning on 03/12/26 at 1:30 P.M., the Director of Nursing (DON) and RTM #242, uploaded the acknowledgement procedure electronically to the Clipboard staffing agency to notify agency employees that our facility has vent/trach residents that require care outside of normal routine care. Agency staff must be trained by an RT on ventilator dependent resident care plans, protocols for tracheostomy care and emergency procedures for ventilator dependent residents and read and sign the Agency Nurse Binder at the nurse's station before starting their shift. This training will include verbal, return demonstration and printed procedures. Acknowledgement must be signed before the facility job positing applications will allow agency staff to pick up a shift at facility. DON verified posting on 03/13/26 at 8:05 P.M. On 03/12/26 at 3:00 P.M., RTM #242 completed Competency checklist and decannulation training for tracheostomy residents with Liberty Dialysis nurses. Training included verbal, return demonstration and printed procedures for respiratory needs of residents with tracheostomies. Completed on 03/12/26. Beginning on 03/12/26, LPN Scheduler #255, DON, and RTM #242 will attempt to schedule at least one facility licensed nurse trained by respiratory therapist per shift. LPN Scheduler #255 will notify DON and RTM #242 of any shifts that do not have a facility nurse trained by RT. In the unplanned event the facility would have two agency nurses working, the facility will have RT coverage or another licensed facility nurse in the facility who has completed training with a Respiratory	

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F 0695	Continued From page 74 cell death within minute), secondary to hypoxic (a dangerous condition where tissue receives insufficient oxygen to maintain homeostasis) respiratory failure. Immediate Jeopardy was removed on 03/13/26, when the facility implemented the following corrective actions: On 10/05/25, Resident #54 was transferred to the hospital. On 10/05/25 at 6:00 A.M., Respiratory Therapist Manager (RTM) #242 verbally in-serviced both agency nurses, LPN #288 and LPN #302. Both nurses returned demonstration and reviewed printed policies and procedures in the agency binder after the incident occurred. This education included suctioning (both open and closed), how to measure the placement of the suction catheter, decannulation, how to use Ambu-bag and the competency checklist for respiratory nursing care for residents on ventilators and residents who have tracheostomy and the location of crash carts and Automated External Defibrillator (AED). On 10/07/25, CCO #300 and former Human Resource Manager (HRM) #303 in-serviced RNs and LPNs on Respiratory policies, CPR, supplemental oxygen, Trach and Decannulation. Policies and procedures were sent to all nurses via text message for immediate review. There	F 0695	Therapist for the duration of the shift. This will be ongoing practice, unless there are no residents with vents/traches in the facility. Any resident who has a tracheostomy or ventilator needs to be considered for admission will not be admitted to the facility until an RT is present in facility. No ventilator or tracheostomy residents will be admitted off-hour or on the weekends if RT is not available. Beginning on 03/12/26, the DON or designated nurse manager and RTM #242 or designated Respiratory Therapist will monitor schedule daily to ensure scheduling compliance with RTs and agency staff. Beginning on 03/13/26, the RTM #242 or designated Respiratory Therapist will monitor agency education binder daily to ensure all education documents are completed. This will be ongoing. Beginning on 03/13/26, the DON or designated nurse manager will audit the education binder weekly to ensure that a Respiratory Therapist has trained all facility and agency staff. This will be ongoing. Beginning on 03/19/26 at 1:45 P.M, during the monthly Quality Assurance and Performance Improvement (QAPI) meeting with the Medical Director, a review of correction plan to ensure the training has been completed for all RNs, LPNs, agency and will be ongoing as needed. This will be reviewed at the quarterly QAPI meeting starting May 2026 and ongoing if the facility has residents that are ventilator dependent or have tracheostomy. Respiratory Department will provide additional training as needed outside of the regularly scheduled trainings. Beginning 04/01/26 and ongoing monthly, RTM #242 or the designated Respiratory	

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F 0695	Continued From page 75 was no documentation of receipt of the text to the staff. On 10/07/25, CCO #300 and former HRM #303, in-serviced CNAs on personal care for residents with tracheostomies. Policies and procedures were sent to all CNAs via text for immediate review. There was no documentation of receipt of the text to the staff.. On 03/12/26 at 10:30 A.M., the Administrator and CCO #300 educated RTM #242 on the facility's requirements for nurses training for ventilator dependent residents, supplemental oxygen, tracheostomy care and emergency procedures. On 03/12/26 at 10:30 A.M., RTM #242 implemented an education binder to track and audit all facility and agency staff education documents. Beginning on 03/12/26 at 10:30 A.M., RTM #242 or designated Respiratory Therapist will train agency nursing staff on ventilator dependent residents care plans, protocols for tracheostomy care and emergency procedures for ventilator dependent and/or trach residents prior to providing care to residents. Competency checklist to be completed by Respiratory Therapist. This is a new standard practice going forward without an end date. On 03/12/26 at 10:45 A.M., RTM #242 re-educated and completed check-off on	F 0695	Therapist will attend the monthly nurse and CNA meetings to provide ongoing education, review competency checklist and to ensure that all staff are knowledgeable of policies and procedures related to residents on life sustaining mechanical devices and/or requiring CPR. This training will include verbal, return demonstration and printed procedures.	

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F 0695	Continued From page 76 Competency Checklist for Respiratory Care for Nursing, Decannulation and Emergency Procedures for Registered Nurses (RNs) and LPNs. Education/Training included verbal, return demonstration and printed procedures. This was completed on 03/13/26. On 03/12/26 at 12:30 P.M., a Quality Assurance (QA) meeting was held immediately following notification of Immediate Jeopardy. This included CCO #300, the Administrator, LNHA, DON, Assistant DON, Minimum Data Set (MDS) Nurse, RTM #242, Infection Preventionist/Wound Nurse, Scheduler, Business Office Manager, Social Services, Activity Director, Maintenance Director, Dietary Manager, Therapy Manager, Housekeeping/Laundry Supervisor who met to discuss the 10/05/26 incident, education needed, policies and procedures to put into place. Beginning on 03/12/26 at 12:45 P.M., RTM #242 will complete a respiratory assessment for all at risk residents and ensure that residents are provided with respiratory care by trained staff. Completed by 03/13/26 at 4:00 P.M. Beginning on 03/12/26 at 1:30 P.M., the Director of Nursing (DON) and RTM #242, uploaded the acknowledgement procedure electronically to the Clipboard staffing agency to notify agency employees that our facility has vent/trach residents that require care outside of	F 0695		

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F 0695	Continued From page 77 normal routine care. Agency staff must be trained by an RT on ventilator dependent resident care plans, protocols for tracheostomy care and emergency procedures for ventilator dependent residents and read and sign the Agency Nurse Binder at the nurse's station before starting their shift. This training will include verbal, return demonstration and printed procedures. Acknowledgement must be signed before the facility job positing applications will allow agency staff to pick up a shift at facility. DON verified posting on 03/13/26 at 8:05 P.M. On 03/12/26 at 3:00 P.M., RTM #242 completed Competency checklist and decannulation training for tracheostomy residents with Liberty Dialysis nurses. Training included verbal, return demonstration and printed procedures for respiratory needs of residents with tracheostomies. Completed on 03/12/26. Beginning on 03/12/26, LPN Scheduler #255, DON, and RTM #242 will attempt to schedule at least one facility licensed nurse trained by respiratory therapist per shift. LPN Scheduler #255 will notify DON and RTM #242 of any shifts that do not have a facility nurse trained by RT. In the unplanned event the facility would have two agency nurses working, the facility will have RT coverage or another licensed facility nurse in the facility who has completed training with a Respiratory Therapist for the duration of the shift. This will be ongoing practice, unless there are	F 0695		

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F 0695	Continued From page 78 no residents with vents/traches in the facility. Any resident who has a tracheostomy or ventilator needs to be considered for admission will not be admitted to the facility until an RT is present in facility. No ventilator or tracheostomy residents will be admitted off-hour or on the weekends if RT is not available. Beginning on 03/12/26, the DON or designated nurse manager and RTM #242 or designated Respiratory Therapist will monitor schedule daily to ensure scheduling compliance with RTs and agency staff. Beginning on 03/13/26, the RTM #242 or designated Respiratory Therapist will monitor agency education binder daily to ensure all education documents are completed. This will be ongoing. Beginning on 03/13/26, the DON or designated nurse manager will audit the education binder weekly to ensure that a Respiratory Therapist has trained all facility and agency staff. This will be ongoing. Beginning on 03/19/26 at 1:45 P.M, during the monthly Quality Assurance and Performance Improvement (QAPI) meeting with the Medical Director, a review of correction plan to ensure the training has been completed for all RNs, LPNs, agency and will be ongoing as needed. This will be reviewed at the	F 0695		

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F 0695	Continued From page 79 quarterly QAPI meeting starting May 2026 and ongoing if the facility has residents that are ventilator dependent or have tracheostomy. Respiratory Department will provide additional training as needed outside of the regularly scheduled trainings. Beginning 04/01/26 and ongoing monthly, RTM #242 or the designated Respiratory Therapist will attend the monthly nurse and CNA meetings to provide ongoing education, review competency checklist and to ensure that all staff are knowledgeable of policies and procedures related to residents on life sustaining mechanical devices and/or requiring CPR. This training will include verbal, return demonstration and printed procedures. Although the Immediate Jeopardy was removed on 03/13/26, the deficiency remains at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include:	F 0695		

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F 0695	Continued From page 80 Record review revealed Resident #54 was admitted on 04/25/25 and was discharged on 10/08/25. Diagnoses included acute and chronic respiratory failure, dependence of a ventilator, obstructive sleep apnea, pulmonary hypertension, and malnutrition. Review of Resident #54's Minimum Data Set (MDS) comprehensive quarterly assessment dated 09/24/25 revealed the resident had intact cognition, no behaviors, and was receiving invasive ventilation via a tracheostomy cannula. Review of Resident #54's physician orders dated 04/25/25 revealed she was a Full Code, with a size 16 Shiley cannula with ventilator settings of Assist Control (AC) Respiratory Rate (RR) 12, Positive End-Expiratory Pressure (PEEP) 6, Tidal Volume (Vt) 400, and oxygen titrate to keep saturation at 90 percent. Review of Resident #54's care plans dated 04/28/25 revealed a focus for tracheostomy related to respiratory failure. Interventions included ensure trach ties are secured at all times, monitor and document restlessness and agitation, monitor respiratory rate, ventilator setting	F 0695		

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F 0695	Continued From page 81 per order with oxygen via the tracheostomy/ventilator. Cannula (tube) out procedure: keep extra trach cannula and obturator (a structure that blocks or closes an opening) at the bedside, if cannula is coughed out, open stoma with hemostat. If cannula cannot be reinserted, monitor/document for signs of respiratory distress, if able to breathe spontaneously elevate head of bed 45 degrees, stay with resident and obtain medical help immediately. Review of the Emergency Medical Service (EMS) care report dated 10/05/25, revealed a call was reported as received from the facility at 1:44 A.M. EMS was dispatched to the facility, at 1:48 A.M. The EMS arrived at the facility at 1:49 A.M. and arrived at Resident #54’s room. At 1:49 A.M., EMS documented the resident’s tracheostomy cannula came out, facility staff were able to replace the trach cannula, and Resident #54 was loaded onto a cot and transported to the hospital. Per the EMS care report the staff at the facility were unable to provide any history or information about Resident #54 and no packet containing information was transferred with the patient to the hospital. EMS documented staff reported it was unknown how long the tracheostomy cannula was out of place.	F 0695		

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F 0695	Continued From page 82 Review of the hospital documentation dated 10/05/25 at 2:09 A.M. revealed Resident #54 arrived at the emergency room by EMS transport. Resident #54 was evaluated for cardiac arrest secondary to hypoxic respiratory failure. Resident #54 had her trach (cannula) pulled out for an undisclosed amount of time. Per the hospital documentation the trach was replace and EMS did Advanced Cardiac Life Support (ACLS) with compression and ventilation prior to arrival. Upon arrival Resident #54 was in asystole (without a heartbeat) and required additional ACLS CPR measures to obtain a cardiac rhythm. Review of the “Medical Decision Making” section of the report ACLS algorithm was followed to initiate chest compression and medication to stabilize resident. Initial blood gas tests showed the resident had respiratory acidosis (lower than normal blood pH caused by hypoventilation) and it was anticipated that the hypoxic respiratory failure caused cardiac arrest. The hospital physician documented “given a clear story of trach dislodgement the focus on respiratory failure as a primary cause for the cardiac arrest”. Review of Resident #54’s progress notes dated 10/05/25, entered at 3:36 A.M. for care at 1:15 A.M., revealed LPN #288 documented this nurse was located at the nurse’s station at time of incident. LPN #288 was alerted by CNA #265,	F 0695		

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F 0695	Continued From page 83 Resident#54's trach had dislodged from the trachea while giving the resident care. LPN #288 immediately attempted to "reinforce" the tracheostomy cannula back into the trachea. LPN #288 simultaneously instructed the CNA #265 to call emergency service, and RT #236 for assistance, while attempting replacement of the cannula. RT stated she would come STAT (immediately). LPN #288 immediately began chest compression while awaiting the arrival of assistance. RT #236 arrived in eight to ten minutes along with EMS. RT #236 was able to locate the trach pathway and successfully reinsert the tracheal cannula back into trachea, as EMS was establishing vitals. Resident #54 was transferred out to the hospital. LPN #288 faxed over resident's medication summary and profile to hospital. LPN #288 contacted resident's husband with no answer, left voicemails, and notification of transfer. DON notified, LPN #288 awaiting report from hospital. Review of Resident #54's critical care note dated 10/05/25 at 6:51 A.M., revealed the Assessment and Plan section included cardiac arrest likely secondary to hypoxic respiratory failure after resident was found unresponsive at the facility for an unknown period of time and found to have dislodged trach. Concern for anoxic brain injury secondary to the cardiac arrest as the resident is not	F 0695		

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F 0695	Continued From page 84	F 0695		

responding at this time with no withdrawal from pain.

Review of Respiratory Care Note dated 10/05/25 at 2:22 P.M., documented by RT #236, called by facility at 1:40 A.M, because the ventilator was alarming and the tracheostomy “looked weird”. It was noted Resident #54 was completely decannulated. Trach was easily replaced and the resident was back on the ventilator. Resident #54 was very dusky, letting the ventilator carry her with a faint pulse. EMS was unable to get a blood pressure. EMS transferred the resident to gurney and to hospital.

Review of Resident #54’s death certificate dated 10/08/25 revealed the primary cause of death was anoxic brain injury secondary to cardiac arrest and hypoxic respiratory failure.

During an interview on 03/09/26 at 9:37 A.M., Resident #24 stated he knew of a resident on a ventilator who had passed away due to the staff working not being trained on how to take care of residents on ventilators. Resident #24 said he heard a commotion one night and it was the EMS and staff talking about how the nurse who assigned to residents on ventilators did not know how to care for them properly. Resident #24 stated he

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F 0695	Continued From page 85 knew there were no respiratory therapists in the building at night. During an interview on 03/09/26 at 1:25 P.M., RT #236 stated she worked in the facility on 10/04/25 from 6:00 P.M. to 12:00 A.M. On 10/04/25 around 11:00 P.M. she provided nighttime respiratory care for Resident #54 which included trach care, ventilator checks, and oxygen checks. RT #236 stated at the time she provided the care Resident #54 was in no distress, the trach was in place, the resident had no secretions, and her oxygen level was around 98 percent. RT #236 stated prior to her clocking out at 12:00 A.M. She asked LPN #288 if she was comfortable caring for Resident #54, as she was an agency nurse who had not worked on the unit before. RT #236 stated LPN #288 had told her, “I am good” and RT#236 left the facility. RT #236 stated on 10/05/25 early in the morning she was called by agency nurse LPN #288 and was told Resident #54’s trach “looked weird”. RT #236 stated she asked the nurse simple questions about Resident #54’s respiratory status and the only answers LPN #288 gave was saying “I don’t know”. RT #236 stated she told the nurse to call 911 and she would be coming into the facility immediately. RT #236 stated on the phone she asked LPN #288 if the resident had a pulse, was breathing, and what happened to the trach, the only answer LPN #288 gave her	F 0695		

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F 0695	Continued From page 86 was, “I don’t know”. RT #236 stated when she arrived at the facility the EMS were coming into the building. RT #236 stated she led the EMS to the resident’s room and reached the resident at 1:51 A.M. RT #236 stated LPN #288 was doing chest compression but was not providing any oxygen via the Ambu-bag or by any other means. RT #236 stated she was able to reinsert the trach cannula and she herself got the Ambu-bag out of the basket located on the vent, in the room. RT #236 stated she hooked it up to the oxygen tank, attached it to Resident #54 and started to supplement the oxygen via the Ambu-bag through the trach. RT #236 stated while she was preparing the Ambu-bag, EMS took over chest compressions and was asking LPN #288 questions about the resident in which LPN #288 kept answering, “I don’t know where anything is for this resident”. RT #236 stated she assisted the EMS with transferring the resident to a gurney and she hooked up the ventilator and assisted EMS to transfer the resident out of the facility on the ventilator. RT #236 stated she then went back to talk to the LPN #288 about the incident, but LPN #288 continued to tell her she did not know where anything was and how to care for the resident’s trach when they become dislodged. During an interview on 03/10/26 at 10:00 A.M., CCO #300 revealed after the	F 0695		

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F 0695	Continued From page 87 10/05/25 incident with Resident #54 the CCO #300 did send education to the former Human Resource Manager #303 to have all facility nurses review the policies and procedures for tracheostomy care. CCO #300 stated she did not require signatures for the education, so she was unsure who received the education. During an interview on 03/11/26 at 9:33 A.M., agency nurse LPN #288 stated she had not worked in the facility with the ventilator residents prior to 10/04/25. LPN #288 stated upon her arrival at the facility, on 10/04/25, from 6:00 P.M. to 6:00 A.M. shift, she was not oriented to the unit, received no resident orientation regarding care plans, and did not receive education or orientation on location of emergency equipment including the crash cart and emergency supplies in Resident #54's room. LPN #288 stated she had no experience in re-cannulating tracheostomy cannulas after they became dislodged and received no education from the facility on what to do if decannulation happens. LPN #288 stated she was led to believe by staff there would be a respiratory therapist in the building for the whole shift. LPN #288 stated on 10/04/25, she administered nighttime medications, sometime around 11:00 P.M. to Resident #54 and the resident was in no distress. LPN #288 stated she could not recall having any conversation	F 0695		

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F 0695	Continued From page 88 with RT #236 prior to RT #236 leaving for her shift. LPN #288 stated she could not recall the ventilator alarming but stated in the early morning CNA #265 came to her at the nurse's station and said, "Resident #54's trach came out". LPN #288 stated she immediately ran to the resident's room and found her trach laying on her chest. LPN #288 stated she tried to reinsert the trach into the resident's trachea but could not get the cannula back in. LPN #288 stated she then told the CNA #236 to call RT #236 and put her on speaker phone. LPN #288 stated she also told the CNA #236 to call for the other agency LPN #302 and 911, when she noticed Resident #54 was not breathing and was not responding to her. LPN #288 stated she continued to attempt to reinsert the trach cannula and then she started chest compressions on the resident when she could not obtain a pulse. LPN #288 stated it was a short time later RT #236 came back into the facility to the resident's room with EMS and RT #236 took over care of the resident by reinserting the trach cannula and then getting the Ambu-bag hooked up to oxygen. LPN #288 verified at no time from the time she found Resident #54 with her cannula out to the time RT #236 arrived at the resident's bedside was LPN #288 able to supply any oxygen to Resident #54. Per LPN #288 she did not know where the crash cart or the Ambu-bag was in the facility. LPN #288 verified she did have a current CPR certification at the time of the incident.	F 0695		

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F 0695	Continued From page 89 During an interview on 03/11/26 at 2:57 P.M., Respiratory Therapy Manager (RTM) #242 stated respiratory therapists are scheduled for all day shifts from 6:00 A.M. to 6:00 P.M. and some night shifts but due to census may not be scheduled for a whole 12-hour shift, 6:00 P.M. to 6:00 A.M. RTM #242 stated on 10/04/25, RT #236 was told to clock out at 12:00 A.M. per the schedule. RTM #242 stated it was the facility's unwritten protocol for the RT to ask the nurses working on nightshift if they were comfortable taking care of the ventilated residents prior to the RT leaving the facility. RTM #242 stated it was reported to her LPN #288 told RT #236 she was fine taking care of Resident #54 when RT #236 left the facility. RTM #242 verified there was no official training for agency nurses on caring for residents with tracheostomy on the ventilators but stated it was in the care plans on what to do if the resident becomes decannulated. During an observation on 03/10/26 at 8:28 A.M. Resident #08 was dependent on a ventilator supplying support via a tracheostomy cannula. There was an Ambu-bag, extra suction wand, extra tracheostomy cannula, and emergency supplies located in a grey basket attached to the resident's ventilator.	F 0695		

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F 0695	Continued From page 90 During an observation on 03/10/26 at 8:40 A.M, a crash cart was located outside of Resident #08’s room in the hallway, painted red and clearly visible from the hallway on both sides. Emergency supplies were observed on the crash cart including an Ambu-bag, oxygen tank, suction wands, and emergency tubing. Review of the facility policy titled "Emergency Procedures – Cardio-Pulmonary Resuscitation”, revised February 2018, revealed when a resident is found unresponsive assess for absence of breathing. If a cardiac arrest is likely the rescuer will begin CPR. Following the initial assessment begin with chest compressions, after 30 chest compressions provide 2 breaths via the Ambu-bag or manually with a CPR shield. All rescuers trained in CPR should provide ventilations with a compression to ventilation ratio of 30:2. Review of the policy titled, “In Case of Decannulation”, undated, the policy stated call 911 and call for a crash cart. Attempt to re-insert trach or establish an airway by covering the stoma with gauze and tape, in the gray basket on vent cart. Put on appropriate oxygen device if	F 0695		

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F 0695	Continued From page 91 spontaneously breathing (in bag with spare trach on vent cart). If no spontaneous breaths begin Ambu-bag with face mask at 15 liters of oxygen with 100% O2 (oxygen), located in each room with a ventilator/trach on the vent stand and tank is already turned on, turn flow liter to 15. Check all vitals, if no pulse, begin compression and continue CPR unless indicated otherwise. This deficiency represents noncompliance investigated under Complaint Numbers 2724849, 2698450, 2615090, and 1335680.	F 0695		

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F 0712	Continued From page 92	F 0712		
F 0712 SS=D	483.30(c)(1)-(4) Physician Visits-Frequency/Timeliness/Alt NPP §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This STANDARD is not met as evidenced by: Based on review of medical records and	F 0712	Physician Visits-Frequency/Timeliness/Alt NPP The PoC will what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 28 has been seen by the facility physician on 3-18-2026. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken A sweep of new admissions to the facility has been completed by 4-1-26 by the ADON and the physician has seen all new admissions within the first 30 days of admission. The sweep included the last 30 days audit of residents that they have been seen by the physician. all have been seen. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. DON/designee has in-serviced nursing management and nurses that they must ensure residents are assessed by a physician within the first 30 days after admission. Inservice completed on 3-31-2026.Medical director was in serviced that he will need to see new admissions within 30 days of admission on 3-18-26 by the DON. How the corrective action will be monitored to ensure the deficient practice will not recur. DON/designee is auditing new admissions for compliance with physician visit within 30 days weekly x 2 months and submitted to the weekly QAPI committee. The audits began 3-31-26. If any concerns are noted, the MD will be alerted to come in to see the resident in a timely. The audits will alert the adon that the time limit is approaching.	04/10/2026

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F 0712	Continued From page 93 staff interview, the facility failed to ensure residents were assessed by a physician within the first 30 days after admission. This affected one (#28) of three residents reviewed for physician visits. The census was 47. Findings include: Review of Resident #28 medical record revealed an admission date of 06/25/25. Diagnoses listed included end stage renal disease, sexual dysfunction, major depressive disorder, and liver cirrhosis. Review of a quarterly Minimum data Set (MDS) revealed Resident #28 was cognitively intact and received dialysis. Further review of Resident #28’s medical record revealed the first documented physician assessment was on 12/10/25. Resident #28 had been assessed by a nurse practitioner (NP) and physician (PA) assistant prior to 12/10/25. Interview with MDS Nurse #201 on 03/16/26 at 2:15 P.M. confirmed Resident #28 had not been assessed within the first 30 days by a physician. The first time Resident #28 was assessed by a physician at the facility was 12/10/25.	F 0712		

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F 0755	Continued From page 94	F 0755		
F 0755 SS=E	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of	F 0755	F755 Pharmacy Srvcs/Procedures/Pharmacist/Records The PoC will what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident 22 is receiving ophthalmic drops per order with a 5-minute wait time between drops. An assessment of resident #22 was completed on 4-9-26 by the infection preventionist with no negative effects. The order was written to remind the nurses to wait 5 min between medication administration. the order was rewritten on 3/31/26 by unit manager. Resident #24 was audited on 3-31-26 by the DON and continues to receive clonidine as prescribed related to BP parameters. Resident #24 was assessed for negative effects on 4-9-26 by the infection preventionist, and none were identified How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All the residents in the facility that have eye gtt orders, there are 3 and have bp with parameters, there are 3, have the potential for this practice. A sweep of all residents with eye gtts was done 3/29/26 by nurse manager and a sweep of BP with established parameters completed 3/29/26 by the DON. These residents are in compliance with med pass. The eye gtt orders have been reviewed and written to include proper sequence of administration by MDS and ADON . Residents who have established medication parameters for blood pressure medication could also be affected by this practice but have been educated and are currently being audited for compliance What measures will be put into	04/10/2026

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F 0755	Continued From page 95 records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This STANDARD is not met as evidenced by: Based on medical record review, observation, staff interview, review of manufacturer instructions, and review of facility policy the facility failed to administer medications per physician order and administer ophthalmic drugs as recommended. This affected two (#22 and #24) of four residents reviewed for medication administration. The facility census was 47. Findings include: 1. Review of the medical record revealed Resident #22 was admitted on 09/18/25. Diagnoses included unspecified dementia moderate without behavioral disturbance, essential hypertension, chronic kidney disease, mixed hyperlipidemia, unspecified glaucoma. Review of the MDS assessment, dated	F 0755	place or what systemic changes you will make to ensure that the deficient practice does not recur. DON/designee in-service all nurses in eye gtt sequencing and leave the insert with the medication to review. Additionally, nurses were in- serviced to monitor the MAR for identified parameters and follow the guidance and document. This in-service was completed 4-9-2026 How the corrective action will be monitored to ensure the deficient practice will not recur. On 3/29/26 DON/designee are auditing all residents with eye gtts 3X a week X 4 weeks for observation of medication administration with 5 min between multiple eye gtts. All of the residents with BP parameters are being audited by observation of administration and MAR 3x a week by the DON for medicating residents according to BP parameters all to ensure administration of residents with multiple eye drops will be administered at least five minutes between medicated eye drops and medication was administered according to BP parameters). Results are presented to QAPI committee weekly. If the audit reveals concerns, the nursing will be reeducated post audit.	

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F 0755	Continued From page 96 02/26/26, revealed the resident was severely cognitively impaired. Review of physician order, dated 11/29/25, revealed an order for brimodidine tartrate ophthalmic solution 0.1% with instructions to instill one drop in both eyes two times a day for eye drop. Review of physician order, dated 01/27/26, revealed an order for dorzolamide hci-timolol mal ophthalmic solution 2-0.5% with instructions to instill one drop in both eyes two times a day for glaucoma. Review of brimonidone tartrate ophthalmic solution manufacturer instructions, no revised date, revealed if more than one topical ophthalmic drug is being used, the products should be administered at least five minutes apart. Review of dorzolamide hydrochloride ophthalmic solution manufacturer instructions, no revised date, revealed if more than one topical ophthalmic drug is being used, the drugs should be administered at least five minutes apart. Interview on 03/11/26 at 11:48 A.M. with Licensed Practical Nurse (LPN) #202 revealed she does not know if she is supposed to wait five minutes between giving eye drops. LPN #202 stated she does not wait and no one when training her waited in between eye drop applications.	F 0755		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0755	Continued From page 97 Observation on 03/11/26 at 11:50 A.M. of LPN #202 provide Resident #22 with brimonidone tartrate ophthalmic solution and immediate after administered the dorzolamide hydrochloride ophthalmic solution. Interview on 03/11/26 at 11:53 A.M. with LPN #202 verified she did not wait five minutes between eye drop solutions. 2. Record review for Resident #24 revealed the resident was admitted to the facility on 04/18/22. Diagnoses for Resident #24 include fracture of the pelvis, chronic pain, post-traumatic stress disorder, depression, epilepsy, and hypertension. Review of the MDS assessment dated 12/12/25 comprehensive quarterly assessment revealed the resident had intact cognition. Review of Resident #24's care plans dated 04/29/25 revealed a focus for cerebral vascular accident related to hypertension. Interventions include to monitor vital signs and notify physician of significant abnormalities, and administer medications as ordered. Review of physician orders dated 11/21/25 revealed Resident #24 was to be administered clonidine (anti-hypertensive medication) 0.1 milligrams, (mg) tablet by mouth every 8 hours as needed for	F 0755		

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F 0755	Continued From page 98	F 0755		

systolic blood pressure (SBP) greater than 170.

Review of Resident #24's Medication Administration Records (MAR) dated December 2025 revealed documentation the resident's SBP on 12/19/25 was 219, no documentation of the resident receiving the as needed clonidine medication was noted in the MAR. On 01/15/26 the SBP was documented as 206 with no documentation of the clonidine administered. On 02/06/26 the resident's SBP was documented as 183 with no documentation of clonidine administered. On 02/17/26 the SBP was documented as 172 with no documentation of clonidine administered. On 02/27/26 the SBP was documented as 175 with a notation the blood pressure was out of normal limits and 'see notes' in the MAR, no documentation of the administration of the clonidine was in the MAR for 02/27/26.

Further review of Resident #24's progress notes revealed there to be no documentation for the administration of the as needed clonidine medication in the progress notes dating from December 2025 to February 2026.

Interview on 03/09/26 at 9:00 A.M. and on 03/16/26 at 8:30 A.M. with Resident #24 revealed the resident stated he was concerned due to many times he felt his blood pressure was too high. Resident #24 stated staff are monitoring his blood

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F 0755	Continued From page 99	F 0755		

pressure, but when he goes to see his cardiologist he is being told no one from the facility is reporting to the physician any abnormalities with his blood pressure. Resident #24 stated he could not recall receiving any medications for his high blood pressure being administered.

Interview on 03/11/26 at 3:50 P.M. with the DON #264 verified there was no documentation of Resident #24 receiving his as need blood pressure medications in the medical records for the dated of 12/19/25, 01/15/26, 02/06/26, 02/17/26, and no notations for the ‘see notes’ on 02/27/26.

Review of the facility policy titled, “Pharmacy Services Policy”, dated 06/21/17, revealed a pharmaceutical service is available to provide residents with prescription and non-prescription medications, infusion therapy products and related equipment, supplies and services.

This deficiency represents non-compliance under Complaint Numbers 2568764, 2615090, and 2621295.

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F 0756	Continued From page 100	F 0756		
F 0756 SS=D	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been	F 0756	F756 Drug Regimen Review. The PoC will what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #2 recommendation for a change in magnesium order was not needed as the antibiotic that was a conflict is no longer ordered.MD notified 3/31/26. Resident #4 MD stated a dose reduction for amitriptyline is contraindicated and will not make a change at this time for fear of worsening of condition MD order 4/1/26. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Like residents, are residents in the facility who are reviewed by the pharmacy consultant. A sweep of the pharmacy recommendations in coordination with the medical director resulted in all recommendations have been reviewed and signed off on 3-26-26.The sweep went back to February 2026.conducted by ADON. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur. DON and ADON in-service by corporate nurses to obtain follow-up to the pharmacy recommendations in a timely manner. Also, in-service to assist MD when the resident has a psychiatrist or counselor. In-service was done on 3-27-26. MD inservice by ADON on 4/1/26 to complete pharmacy recomendations timely . How the corrective action will be monitored to ensure the deficient practice will not recur. DON is auditing, starting 4/1/26, for completed responses with signatures from MD and nurses, follow-up to ensure all recommendations are responded to by MD	04/10/2026

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F 0756	Continued From page 101 reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This STANDARD is not met as evidenced by: Based on medical record review, staff interviews, and policy review, the facility failed to ensure an appropriate and timely response to the pharmacist drug regimen reviews. This affected two (#02 and #04) residents out of the five residents reviewed for pharmacy reviews. The facility census was 47. Findings include: 1. Review of the medical record for Resident #02 revealed an admission date of 09/15/25 with medical diagnoses of	F 0756	within a week after receiving recommendations,and the pharmacy recomentations are written. monthly X2, and submitting findings to QAPI committee. If concerns are noted, DON will approach MD and ADON to correct the issue and to prevent further issues.	

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F 0756	Continued From page 102 acute osteomyelitis, diabetes mellitus (DM), peripheral vascular disease (PVD), congestive heart failure (CHF) and anemia. Review of the medical record for Resident #02 revealed a quarterly Minimum Data Set (MDS) assessment, dated 02/20/26, which indicated Resident #02 was cognitively intact and was dependent upon staff for toileting, bathing, and transfers, and required substantial/maximum staff assistance with bed mobility. Review of the medical record for Resident #02 revealed a pharmacy recommendation dated 12/09/25 to adjust the administration time of the Doxycycline (antibiotic) from the magnesium oxide and ferrous sulfate so that they are separated from each other by at least two hours for best absorption of both medications. Review of the pharmacy recommendation revealed a physician signature and was dated 12/10/25. Review of the medical record for Resident #02 revealed the December 2025 Medication Administration Record (MAR) which revealed Resident #02 received Doxycycline 100 milligram (mg) one tablet by mouth two times per day at 8:00 A.M. and 8:00 P.M., magnesium oxide 400 mg one tablet by mouth daily at 8:00 A.M., and Ferrous Sulfate 325 mg one tablet by mouth at 12:00 P.M. Review of the MAR revealed no documentation to support the	F 0756		

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F 0756	Continued From page 103 administration times were changed for magnesium sulfate. Interview on 03/12/26 at 9:32 A.M. with Director of Nursing (DON) confirmed Resident #02's pharmacy recommendation was reviewed by the physician on 12/10/25 and that the facility staff had not changed the times for magnesium oxide administration as per pharmacy recommendations and physician order. 2. Review of the medical record revealed Resident #4 was admitted on 07/01/25. Diagnoses included type two diabetes mellitus without complications, anxiety disorder, major depressive disorder, schizoid personality disorder, paraplegia, and malignant neoplasm of unspecified female breast. Review of the MDS assessment, dated 01/08/26, revealed the resident was cognitively intact. Review of the pharmacy recommendations, dated 01/27/26, revealed a gradual dose reduction trial for amitriptyline (antidepressant). Physician response was documented on 01/28/26 with dose reduction contraindicated due to additional attempts would likely cause increased distressed behavior with the word "psych" written. Additional handwritten note stated, "she is not psych, please advise."	F 0756		

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F 0756	Continued From page 104	F 0756		

Review of the pharmacy recommendations, dated 01/27/26, revealed a recommendation to address the two as needed medication orders for Lorazepam (anti-anxiety). Physician response was documented with no date that renewed the duration of therapy for 14 days with a handwritten not, "the resident was stable on hospice and psych". Additional handwritten note, stated “not psych please advise.”

Interview on 03/12/26 at 3:35 P.M. with the Director of Nursing verified there had been no additional physician follow-up for Resident #4’s January 2026 pharmacy recommendations.

Review of policy titled,"Medication Regimen Review", dated November 2017, verified physician recommendations are distributed to the appropriate physician within two working days. The physician reviews the medication regimen review within 30 days and documents the report has been reviewed and what action has been taken to address it. If there is no change, the physician documents their rationale. New orders are transcribed by a nurse and forwarded to the pharmacy.

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F 0757	Continued From page 105	F 0757		
F 0757 SS=D	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 0757	F757 Unnecessary drugs The PoC will what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 39 has been reviewed by physician on March 14, 2026, for ongoing use of antibiotic with justification of use to prevent UTI. Resident # 40 as of Feb 22, 2026, is no longer receiving this antibiotic. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Residents in the facility who have antibiotics without stop dates being used as a prophylactic treatment would be like residents. The sweep completed by the infection preventionist on 3/25/26 of current residents did not identify such residents. Any residents receiving antibiotics require documentation of the reason for antibiotic use. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. Inservice for nurse managers and licensed nurses to follow the antibiotic stewardship protocol a. Drug name; b. Dose; c. Frequency of administration; d. Duration of treatment: (1) Start and stop date; or (2) Number of days of therapy; route of administration; and f. Indications for use. The policy also stated that when the nurse calls a physician/prescriber to communicate a suspected infection, he/she would have the following info: when symptoms first observed, the resident's hydration status, current medication list, and the infection type. Inservice per DON/designee and completed by 4-9-2026. Residents with antibiotics ordered must have reason for the antibiotic	04/10/2026

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F 0757	Continued From page 106 This STANDARD is not met as evidenced by: Based on review of medical records, staff interviews, and review of facility policy, the facility failed to have a justified use of an antibiotic. This affected two (#39and #40) of two residents reviewed for antibotics. The census was 47. Findings include: 1. Review of Resident #39's medical record revealed an admission date of 09/06/22. Diagnoses listed included hemiplegia, type two diabetes mellitus, bladder dysfunction, and hypertension. Review of a quarterly Minimum Data Set (MDS) assessment dated 01/02/26 revealed Resident #39 was cognitively intact, had an indwelling urinary catheter, and had received an antibiotic. Review of physician orders revealed an order dated 07/23/25 for Cephalexin (antibiotic) oral tablet 500 milligrams (mg) give one tablet two times a day for prevention of infection. The end date was indefinite. A pharmacy note attached to the order was "please clarify a stop date." Review of medication administration	F 0757	identified. How the corrective action will be monitored to ensure the deficient practice will not recur. Daily audit of orders for antibiotics without stop dates began 3/25/26 by infection preventionist all antibiotic orders and will be audited weekly x 4 weeks by DON/designee to ensure all antibiotics have automatic stop dates Results are submitted to QAPI committee weekly. Concerns identified will be corrected at the time of audit, and education of nurses will be done to remind them that we need to have a stop date for any antibiotics ordered.	

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F 0757	Continued From page 107 records (MAR) revealed Cephalexin was administered 07/24/25 through 03/11/26. Further review of Resident #39's medical record revealed no documentation of a justified extended use of Cephalexin. The facility was unable to provide any laboratory results related to the use of Cephalexin. Resident #53 did not currently have a urinary tract infection (UTI). Interview with Infection Preventionist (IP) #246 on 03/12/26 at 7:55 A.M. confirmed Resident #39's Cephalexin had been ordered since 07/23/25 and should have been addressed for it's continual use. IP #246 stated Resident #39's Cephalexin did not come up on an ordered antibiotic list and was unaware until concerns were raised during the survey. IP #246 had called Resident #39's urology office and confirmed they had not ordered Cephalexin for continual use and were unaware Resident #39 was being administered Cephalexin. IP #246 confirmed there was not a justified use documented for the continual use of Cephalexin for Resident #39. 2. Review of the medical record for Resident #40 revealed an admission date of 09/29/20 with medical diagnoses of cerebral palsy, profound intellectual disabilities, seizures, hypertension, and dysphagia. Review of an annual Minimum Data Set	F 0757		

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F 0757	Continued From page 108 (MDS) assessment, dated 02/11/26, indicated Resident #40 had severe cognitive impairment and was dependent upon staff for all activities of daily living. Review of Resident #40's nurses note dated 02/12/26 stated Nurse Practitioner (NP) here to see resident and new order for Cefdinir (antibiotic) 250 milligram per five milliliter(ml). Review of the medical record revealed no documentation to support any abnormal urinary signs and symptoms or any test results for the use of the antibiotic. Review of physician orders for Resident #40 dated 02/12/26 for Cefdinir suspension 250 mg per five ml to give six ml by mouth two times per day for urinary tract infection for 10 days. Review of the medical record revealed the medication was administered as ordered. Interview on 03/12/26 at 8:13 A.M. with Infection Preventionist (IP) #246 confirmed the medical record for Resident #40 did not have any documentation to support the use of the antibiotic as treatment for UTI. IP #246 confirmed that a urine culture was not obtained prior to use of the antibiotic. Review of the facility's policy titled "Antibiotic Stewardship" dated revised December 2016, revealed the purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. If an antibiotic is indicated,	F 0757		

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F 0757	Continued From page 109 prescribers will provide complete antibiotic orders including the following elements: a. Drug name; b. Dose; c. Frequency of administration; d. Duration of treatment: (1) Start and stop date; or (2) Number of days of therapy; e. Route of administration; and f. Indications for use. The policy also stated that when the nurse calls a physician/prescriber to communicate a suspected infection, he/she would have the following info: when symptoms first observed, resident's hydration status, current medication list, and infection type.	F 0757		

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F 0760	Continued From page 110	F 0760		
F 0760 SS=D	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This STANDARD is not met as evidenced by: Based on medical record reviews, staff interviews, and policy review, the facility failed to ensure residents were free from significant medications errors. This affected four (#3, #10, #51 and #53) residents out of five residents reviewed for medication administration. The facility census was 47. Findings include: 1. Review of the medical record for Resident #10 revealed an admission date of 09/04/25 with medical diagnoses of cerebral infarction with left hemiplegia, mood disorder, hypertension (HTN) and epilepsy. Review of a quarterly MDS assessment, dated 12/31/25, which indicated Resident #10 had moderate cognitive impairment and required partial/moderate staff assistance with toilet hygiene, bathing and supervision with bed mobility and transfers.	F 0760	F760 Residents are Free of Significant Med Errors The PoC will what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #51 is no longer in the facility. Resident # 10 received an order from a visit to urgent care, Keflex, that was never taken off and 3/18/26 the wound CNP stated to not take off the Keflex order but continue with Diflucan instead due to the diagnosis of fungal rash on 3/18/26. Resident #10 was assessed by the wound CNP, and the rash is improving per wound CNP on 4-7/26. Resident #3 has blood sugar parameters for insulin coverage the previous order was revised by ADON PA on 3/27/26. Resident assessed by MDS on 4-9-26-26 with blood sugars stable over the last month. Staff have been in-serviced, and audits support the resident is receiving correct doses of insulin. ADON reviewed and revised blood sugar orders 3/27/26 Resident #53 is no longer in the facility How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents in the facility have the potential for the same practice. An audit of all orders on 3-19-26 ensures orders are correct and medication is in place. Parameters for glucose administration reviewed and revised 3/27.26 by ADON. A sweep of antibiotics prescribed was completed 3/25/26 with all having a diagnosis and stop date. This was completed by DON. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. DON/designee in serviced nursing staff to 1.	04/10/2026

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F 0760	Continued From page 111 Review of a nurses note dated 03/02/26 at 7:02 P.M. stated Resident #10's significant other requested to take Resident #10 to Urgent Care due to excoriation under breasts and new rash covering extremities and torso. Review of a nurse's note dated 03/02/26 at 9:53 A.M. stated Resident #10 returned to the facility with new orders for Keflex (antibiotic) and Diflucan for a fungal infection of the skin and candidal intertrigo. Review of an Urgent Care note dated 03/02/26 stated Resident #10 presented with complaints of rash under bilateral breasts, umbilical area, under stomach, arms, and abdomen. The note stated examination of skin revealed rash was macular, papular, and purpuric with areas of erythema and excoriation under bilateral breasts, lower abdomen, and umbilical was sloughing. The note stated an order for Keflex and Diflucan were given. Review of the medical record for Resident #10 revealed no documentation to support the facility administered Keflex as ordered by Urgent care on 03/02/26. Interview on 03/12/26 at 9:13 A.M. with Director of Nursing (DON) confirmed the medical record did not have documentation to support Keflex was administered as ordered by Urgent Care.	F 0760	Retrieve and review any orders from appointments 2. Monitor closely and follow parameters set for insulin coverage. 3. To medicate residents within the accepted standards of practice, applying state local and standard laws. also Nurses were in serviced on what a significant med error is and details of antibiotic stewardship including a diagnosis to support the antibiotic. Completed 4/9/26 How the corrective action will be monitored to ensure the deficient practice will not recur. A daily audit is in place done by DON or designee began on 3/26/25 to review MARs to ensure insulin had not been administered outside parameters. an audit begun 3/31/26 to review orders received from all appointments are written per DON/designee, an audit began 3/31/26 to ensure a diagnosis is in place to support the antibiotic order per unit manager and an audit begun 3/31/26 to verify labs have written orders DON/designee. all audits listed are being done 5xaweek X 4 audits and will ensure diagnosis will support a diagnosis to support insulin administration, labs have orders in place, orders from appointments are taken offand insulin is given within parameters. weeks with oversight submitted to QAPI committee weekly. Concerns identified will be corrected and staff reeducated.	

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F 0760	Continued From page 112 2. Review of the medical record for Resident #51 revealed an admission date of 05/14/24 with DM, Down's Syndrome, Hirschsprung's disease, and morbid obesity. Resident #51 discharged to the hospital on 07/06/25 and did not return to the facility. Review of an annual Minimum Data Set (MDS) assessment, dated 05/18/25, indicated Resident #51 had severe cognitive impairment and was dependent upon staff for activities of daily living. The MDS indicated Resident #51 had an indwelling catheter. Review of Resident #51's nurse's note, dated 04/09/25 at 2:27 P.M., documented the nurse noted purulent drainage from the catheter site when cleaning and a small amount of grey greenish drainage from the catheter. The note stated Resident #51 complained of pain "where he peed". Review of Resident #51's physician orders revealed an order dated 04/11/25 for urinalysis (UA) with reflex culture. Review of the laboratory report for Resident #51 revealed UA culture result dated 04/16/25 was positive for greater than 100,000 pseudomonas and noted on the paper copy of the culture results was a handwritten physician order for Bactrim Double Strength (DS) two times per day for seven days.	F 0760		

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F 0760	Continued From page 113 Review Resident #51's medication administration record for April 2025 revealed no documentation to support the facility administered the Bactrim. Interview on 03/16/26 at 9:01 A.M. with Minimum Data Set (MDS) nurse #201 confirmed Resident #51 was not administered Bactrim as ordered in April for urinary tract infection. Review of the facility policy titled, "Medication Administration," medications would be administered by legally-authorized and trained personas in accordance to application State, Local, and Federal laws and consistent with accepted standards of practice. 3. Review of Resident #53's closed medical revealed and admission date of 09/27/24. Diagnoses listed included breast cancer, hypertension, major depressive disorder, and osteoarthritis. Resident #53 was discharged on 08/19/25. Review of a quarterly Minimum Data Set (MDS) dated 08/08/25 revealed Resident #53 was cognitively intact. Review of outpatient oncology appointment documentation revealed on 06/26/25, Verzenio (breast cancer medication) 150 milligrams (mg) by mouth (PO) twice daily was ordered. A prescription dated 06/26/25 was included.	F 0760		

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F 0760	Continued From page 114 Review of a nurse's note dated 07/02/25 at 2:13 P.M. revealed Resident #53 stated she was supposed to be on a new medication from oncology, but the nurse did not see any orders. The oncology office was called and a message was left. Further review of progress notes revealed no documentation of any follow-up or correspondence with outpatient oncology regarding Verzenio. Review of outpatient oncology appointment documentation dated 07/10/25 revealed Resident #53 had yet to receive Verzenio. Review of physician orders revealed Verzenio 150 mg PO twice daily for cancer treatment was first ordered on 08/15/25. Review of medication administration records (MAR) revealed Verzenio was documented as being administered to Resident #53 the first time on 08/15/25 at 11:00 A.M. During an interview on 03/10/26 at 8:00 A.M. with the Assistant Director of Nursing (ADON) #210 stated Verzenio had to be acquired from an outside pharmacy, and they didn't get a prescription from oncology. ADON #210 confirmed she documented on 07/02/25 that Resident #53 reported that she should be on a new cancer treatment medication. ADON #210	F 0760		

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F 0760	Continued From page 115 stated the Ombudsman had been at the facility to investigate the concern. During an interview on 03/11/26 at 10:14 A.M. MDS Nurse #201 and ADON #210 confirmed a prescription for Verzenio was dated 06/26/25. MDS Nurse #201 stated that she discovered Resident #53 was not receiving Verzenio on 08/07/25 and informed nursing staff. Both confirmed there were no clarifications or follow-ups with oncology documented after the nurse's note dated 07/02/25. Both confirmed Verzenio was not administered to Resident #53 until 08/15/25. 4. Review of the medical record revealed Resident #3 was admitted on 03/24/22. Diagnoses included acute and chronic respiratory failure with hypoxia, type two diabetes mellitus with hyperglycemia, and chronic kidney disease stage 3. Review of the Minimum Data Set (MDS) assessment, dated 02/02/26, revealed the resident was cognitively intact and received insulin. Review of the physician orders, dated 02/28/25, revealed an order for Humalog kwikpen subcutaneous solution 100 unit/milliliters (ml) with instructions to inject 18 units subcutaneously one time a day for diabetes if blood sugar is above 140 milligrams per deciliter (mg/dL) give 18 units. Review of the physician orders, dated	F 0760		

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F 0760	Continued From page 116 10/13/25, revealed an order for Humalog kwikpen subcutaneous solution 100 unit/ml (insulin) with instructions to inject 2 unit subcutaneously at bedtime for resident requests for elevated glucose at night related to type two diabetes mellitus if blood sugar is above 160. Review of the blood sugar values, dated February 2026, revealed the following blood sugar values for Resident #3: 02/02/26 at 4:24 P.M. blood sugar value was 116 mg/dL, 02/03/26 at 9:06 P.M. blood sugar value was 138 mg/dL, 02/08/26 at 11:24 P.M. blood sugar value was 160 mg/dL, and on 02/09/26 at 7:50 P.M. and 10:40 P.M. blood sugar was 153 mg/dL. Review of the Medication Administration Record, dated February 2026, revealed Resident #3 received 18 units of insulin on 02/02/26 at approximately 4:00 P.M. and 2 units of insulin on 02/03/26, 02/08/26, and 02/09/26 at approximately 9:00 P.M. Review of the blood sugar values, dated March 2026, revealed the following blood sugar values for Resident #3: 03/11/26 at 8:11 P.M. blood sugar value was 140 mg/dL. Review of the Medication Administration Record, dated March 2026, revealed Resident #3 received 2 units of insulin on 03/11/26 approximately 9:00 P.M.	F 0760		

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F 0760	Continued From page 117 Interview on 03/09/26 at 11:39 A.M. with Resident #3 revealed concerns related to insulin administration. Interview on 03/16/26 at 8:36 A.M. with Registered Nurse #201 verified insulin was administered to Resident #3 on the identified dates outside the parameters. Review of the facility policy titled, “Pharmacy Services Policy”, dated 06/21/17, revealed a pharmaceutical service is available to provide residents with prescription and non-prescription medications, infusion therapy products and related equipment, supplies and services. This deficiency represents non-compliance investigated under Complaint Number 2621295, 2615090 and 2568764.	F 0760		

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F 0761	Continued From page 118	F 0761		
F 0761 SS=D	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be	F 0761	F761 Label/Store Drugs and Biologicals The PoC will what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Multidose medication for residents 4 and 25 were replaced on 3/25/26 and have been dated by nurse manager. The loose medication found were destroyed in a medication buster by nurse manager also on 3/25/26. Residents #4 and # 25 both were assessed for any negative outcomes from the practice of not dating vials or loose medications and both residents Residents were not affected by medications not dated, assessed by nurse manager on 4/9/26 with no negative effects. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Like residents are residents on 600 hall with multidose vials. A sweep of the 600 hall for all multidose vials has been completed and all are properly dated by 3-25-26. Nurse manager identified residents receiving medications from multi dose vials all assessed on 3/25/26 and there were no negative effects determined. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. DON/Designee in-serviced licensed nurses that all mutli dose vials must be dated and discarded after 28 days. and also inserviced on preventing loose pills in the cart, discarding any loose pills and proper procedure for that. Inservice completed 4-9-26 How the corrective action will be monitored to ensure the deficient practice will not recur. Audit of all multidose vials began 3/26/26 and completed	04/10/2026

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F 0761	Continued From page 119 readily detected. This STANDARD is not met as evidenced by: Based on observation, staff interviews, and review of facility policy, the facility failed to ensure insulin multi-use vials were dated. This affected two residents' (#4 and #25) insulin vials observed in a medication cart. The facility also failed to ensure multi-dose insulin vials were discarded 28 days after the opened date. This affected one resident's (#12) insulin vial observed a medication cart. The facility also failed to ensure medications were stored in their original containers. This affected one medication cart of two observed. The census was 47. Findings include: Observation of the 600 hall medication cart on 03/16/26 at 10:31 A.M. revealed two multi-dose insulin vials were open and not dated. A 10 milliliter (ml) vial of Lantus (long-acting insulin) belonging to Resident #4 was opened and undated. A 10 ml vial of Novolog (rapid-acting insulin) belonging to Resident #25 was opened and undated. A 10 ml vial of Humalog (fast-acting insulin) for Resident #12 was dated as being opened on 02/14/26. Fifteen unidentified small round yellow pills were loose in the compartment containing insulin vials.	F 0761	weekly X4 by DON or designee Loose pills in carts are done at the same time both to ensure multiuse vials are dated when opened and discarded after 28 days of being opened and medications are properly stored. Results submitted to QAPI committee weekly. identified concerns will be corrected and staff reeducated.	

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F 0761	Continued From page 120 Interview with Licensed Practical Nurse (LPN) #202 on 03/16/2026 10:35 A.M. confirmed the insulin vials were opened and undated for Residents (#4 and #25) and the insulin vial for Resident #12 was open past 28 days. LPN #202 confirmed the 15 loose yellow pills in the compartment but was unable to identify them. Review of the facility's policy titled, "Injectable Medications", dated 06/21/17, revealed multi-dose vials after initial use are to be labeled with date opened and initials of healthcare professional. Opened vials are to be discarded within twenty-eight (28) days unless otherwise specified by the manufacturer. Review of the facility's policy titled, "Medication Storage", dated 06/21/17, revealed medications shall be kept and stored in these packages/containers. Transfer of medications from one container to another is not permitted, except by a licensed pharmacist or except as necessary in the event of an unplanned leave of absence (LOA) of 24 hours duration or less (only as permitted by state regulations.)	F 0761		

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F 0773	Continued From page 121	F 0773		
F 0773 SS=D	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This STANDARD is not met as evidenced by: Based on medical record review, staff interview, and policy review, the facility failed to notify the physician of an abnormal laboratory (lab) results timely. This affected one (#51) resident of one residents reviewed for laboratory test. The facility census was 47. Findings include: Review of the medical record for Resident #51 revealed an admission date of 05/14/24 with diagnoses including	F 0773	F773 Lab Srvcs Physician Order/Notify of Results The PoC will what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #51 is no longer in the facility How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Any of the residents receiving lab draws in the facility could be affected by this practice. A sweep of all residents receiving labs was done by DON/designee back to 3/2/2026 and the physician has been notified of all abnormal labs. Completed 3/25/26 Residents were not negatively affected as noted on the sweep. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. DON/designee in-serviced all nursing staff about notification of abnormal labs timely completed on 4/9/2026. The corrective action will be monitored to ensure the deficient practice will not recur. Daily audit of lab draws over the previous days not audited for MD and resident /family notification and follow through, are audited and DON/ADON are auditing that the physician is being notified next day any of all abnormal labs to ensure labs are not being missed. audits began 3/25/2026. All lab draws are audited daily. This audit is done 5xa week for 4 weeks with results presented to QAPI committee. concerns are corrected and staff reeducated.	04/10/2026

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F 0773	Continued From page 122 diabetes mellitus, Down's Syndrome, Hirschsprung's disease, and morbid obesity. Resident #51 discharged to the hospital on 07/06/25 and did not return to the facility. Review of an annual Minimum Data Set (MDS) assessment, dated 05/18/25,indicated Resident #51 had severe cognitive impairment and was dependent upon staff for activities of daily living. The MDS indicated Resident #51 had an indwelling catheter. Review of the medical record for Resident #51 revealed a physician order dated 06/11/25 for urinalysis (UA). Review of the medical record revealed a UA culture was completed on 06/14/25 and indicated the culture was positive for Methicillin Resistant Staphylococcal Aureus (MRSA). Review of the medical record revealed no documentation to support the physician was notified of the abnormal lab results until 06/27/25 and an order was given for Macrobid 100 milligram (mg) one capsule by mouth two times per day for seven days for a Urinary Tract Infection (UTI). Interview on 03/16/26 at 10:34 A.M, with the Assistant Director of Nursing (ADON) #210 confirmed the medical record for Resident #51 did not have documentation support the facility notified the physician timely of the abnormal lab results on 06/14/25. Review of the facility policy titled, "Lab	F 0773		

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F 0773	Continued From page 123 and Diagnostic Test Results," dated November 2018, stated the physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. The policy stated when test results are reported to the facility, a nurse would first review the results and identify the urgency of communicating with the attending Physician based on the seriousness of any abnormality, and the individual's current condition. The policy stated the physician could be notified by phone, fax, voicemail, e-mail, mail, pager, or a telephone message to another person acting as the physician's agent (office staff). This deficiency represents non-compliance investigated under Complaint Number 2615090.	F 0773		

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F 0791	Continued From page 124	F 0791		
F 0791 SS=D	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;	F 0791	F791 Dental Services The PoC will what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #34 has been scheduled by social worker on3-26-2026 for the closest dental care in an acute care setting as referred by her dentist. Resident refused on 3-26 2026 to go to the setting scheduled and wants to wait until next visit by the dentist in the facility The social Worked placed resident on the list for next dental visit. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Residents residing in the facility have a potential need for dental care. A sweep of the facility residents to determine any residents needing dental care was done by interviews chart review and the dentist list. scheduled revealed that resident have been scheduled to see the dentist. except for those who have refused in the past. Those residents have been offered to schedule a visit. Completed 4-7-26 per SW. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. Administrator conducted an in-service for the social worker on 3-17-26 to include need to timely find dental services as needed for the residents and what is available for the residents needing routine dental care. How the corrective action will be monitored to ensure the deficient practice will not recur. Weekly audit began 4-7-2026 of new admissions and any residents requesting needing dental services or complaining of dental pain to ensure all residents are	04/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365936	(x2) multiple construction a. building b. wing	(X3) DATE SURVEY COMPLETED 03/19/2026

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LIBERTY RETIREMENT COMMUNITY OF LIMA INC	**2440 BATON ROUGE AVENUE LIMA OH, 45805**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0791	Continued From page 125 §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This STANDARD is not met as evidenced by: Based on medical record review, resident interview, staff interview, and facility policy review, the facility failed to ensure residents received dental services. This affected one (#34) of two residents	F 0791	scheduled for dental care per social services X 2 months.Results submitted to QAPI committee.Concerns identified are immediatly resolved and reeducation of staff completed by social worker/administrator.	

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F 0791	Continued From page 126 reviewed for dental service. The facility census was 47. Review of the medical record revealed Resident #34 was admitted on 04/29/25. Diagnoses included chronic obstructive pulmonary disease, heart failure, type two diabetes mellitus without complications, hypothyroidism, and major depressive disorder. Review of the Minimum Data Set (MDS) assessment, dated 12/07/25, revealed the resident was cognitively intact. Review of the care plan, revised on 05/12/25, revealed Resident #34 had potential for oral/dental health problems due to poor oral hygiene. Interventions included to coordinate arrangements for dental care as needed/as ordered and monitor/document/report as needed any signs and symptoms of oral problems needing attention. Interview on 03/09/26 at 10:37 A.M. with Resident #34 revealed a few months after admission she had met with the dentist and was to be notified when they would be back. Resident #34 stated she has never been notified of the dentist returning to the facility or a follow-up appointment. Resident #4 stated she also needs four teeth removed by an oral surgeon but no appointment had been scheduled.	F 0791		

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F 0791	Continued From page 127 Review of dentist documentation, dated July 2025, verified on 07/03/25 Resident #34 met with the dentist for treatment include an initial exam, dental cleaning, full mouth x-ray, and a note for a possible oral surgeon referral. Interview on 03/16/26 at 2:55 P.M. with Social Services #284 verified the dentist returned to the facility in December 2025 and confirmed Resident #34 was not on the list to see the dentist. Social Services #284 was not aware of why Resident #34 was not on the list. Interview on 03/17/26 at 11:14 A.M. with Resident #34 verified having ongoing concerns with her teeth and has requested Tylenol to help alleviate tooth pain. Review of policy, Dental Examination/Assessment, revised December 2013, verified residents shall be offered dental services as needed. Review of policy, Dental Services, revised December 2016, verified routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident assessment and plan of care. Social service representatives will assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan if eligible.	F 0791		

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F 0791	Continued From page 128	F 0791		
F 0806 SS=D	483.60(d)(4)(5) Resident Allergies, Preferences, Substitutes §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This STANDARD is not met as evidenced by: Based on medical record review, resident interview, staff interview, review of meal ticket, and review of facility policy revealed Resident #4 did not receive food items per preference. This affected one (#4) of four residents reviewed for nutrition. The facility census was 47. Findings include:	F 0806	F806 Resident Allergies, Preferences, Substitutes The PoC will what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. As of 3-17-2026 Resident #4 is ensured by the dietary Manager that she is now receiving requested 2 milks and 2 yogurts and cranberry juice with each tray. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Dietary manager has done a sweep of all facility residents and determined likes and ensured these likes are on their meal tickets. Completed 3-17-26 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. DM in serviced dietary staff in reading and following dietary tickets In-service completed 3-17-2026. How the corrective action will be monitored to ensure the deficient practice will not recur. DM/designee auditing all trays for compliance with meal tickets 5 x a week X4 weeks during lunch and dinner. Results submitted to QAPI committee.to ensure all residents receive the requested diet. Identified concerns by audits are immediately corrected and staff reeducated.	04/10/2026

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F 0806	Continued From page 129 Review of the medical record revealed Resident #4 was admitted on 07/01/25. Diagnoses included type two diabetes mellitus without complications, anxiety disorder, major depressive disorder, schizoid personality disorder, paraplegia, and malignant neoplasm of unspecified female breast. Review of the Minimum Data Set (MDS) assessment, dated 01/08/26, revealed the resident was cognitively intact. Review of the meal ticket, dated 03/09/26, breakfast meal, verified Resident #4 was to receive two 2% milks, cranberry juice, and yogurt. Observation on 03/09/26 at approximately 7:45 A.M. revealed Resident #4 refused the meal tray due to not having requested items. Observation of the meal tray revealed no milk or cranberry juice was on the tray. Review of the meal ticket, dated 03/12/26, lunch meal, verified Resident #4 was to receive two 2% milks and yogurt. Observation on 03/12/26 at 12:10 P.M. of Resident #4's lunch tray revealed the resident only received one milk and one yogurt. Subsequent interview with Resident #4 stated her meal ticket shows one yogurt but the dietary department knows she wants two milks and two yogurts at every meal.	F 0806		

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F 0806	Continued From page 130 Interview on 03/10/26 at 12:14 P.M. with Certified Nursing Assistant (CNA) #230 verified Resident #4 did not receive two milks and two yogurts per resident preference. CNA #230 verified Resident #4 always wants two milks and two yogurts at each meal. Review of the meal ticket, dated 03/16/26, lunch meal, verified Resident #4 was to receive two 2% milks and yogurt. Observation on 03/16/26 at 12:24 P.M. revealed Resident #4 did not receive any yogurt on the meal tray. Interview on 03/16/26 at 12:26 P.M. with Licensed Practical Nurse (LPN) #202 verified Resident #4 did not receive any yogurt on the lunch tray. Review of policy titled, "Purpose and Objectives of the Food and Nutrition Services Department", dated 2021, verified the facility will promote optimal nutrition status of each individual through medical nutrition therapy, in accordance with written orders for nutrition care and consistent with each individual’s physical, cultural, and religious needs and personal preferences.	F 0806		

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F 0810	Continued From page 131	F 0810		
F 0810 SS=D	483.60(g) Assistive Devices - Eating Equipment/Utensils §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This STANDARD is not met as evidenced by: Based on review of the medical record, observation, staff interview, and review of facility policy, the facility failed to provide adaptive eating utensils. This affected one (#4) of one resident reviewed for adaptative equipment. The facility census was 47. Findings include: Review of the medical record revealed Resident #4 was admitted on 07/01/25. Diagnoses included type two diabetes mellitus without complications, anxiety disorder, major depressive disorder, schizoid personality disorder, paraplegia, and malignant neoplasm of unspecified female breast. Review of the Minimum Data Set (MDS)	F 0810	F810 Assistive Devices - Eating Equipment/Utensils The PoC will what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 4 now has a dietary recommendation, care plan and an MD order obtained by hospice for adaptive equipment she is receiving the requested adaptive equipment with meal trays. The dietary manager verified resident # 4 has adaptive equipment as of 3-24-2026. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. DM audited on 3-19-2026 all residents' records and meal tickets for requested adaptive equipment; no additional adaptive equipment was needed. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. DM in-serviced staff to provide any adaptive equipment noted on the meal tickets to the residents. Inservice completed 3-17-26 by the dietary manager. How the corrective action will be monitored to ensure the deficient practice will not recur. DM is auditing all meal tickets daily 4Xaweek X2 months audits began 3-19-1026 that the meal trays are being audited to ensure the adaptive equipment on the meal trays matches the meal ticket in regards to adaptive equipment being provided. The audit will include all trays including all trays with adaptive equipment. Results of audits submitted to QAPI committee weekly.Any concerns identified will result in immediate correction and re education.	04/10/2026

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F 0810	Continued From page 132 assessment, dated 01/08/26, revealed the resident was cognitively intact and required set-up/clean up with eating. Review of the meal ticket, dated 03/09/26 breakfast meal, verified Resident #4 was to receive built-up utensils (1 each). Observation on 03/09/26 at approximately 7:45 A.M. revealed Resident #4 built-up utensils were not on the meal tray. Review of the meal ticket, dated 03/10/26 lunch meal, verified Resident #4 was to receive built-up utensils (1 each). Observation on 03/10/26 at 12:17 P.M revealed Resident #4 eating lunch in the resident room. Resident #4 did not receive built up utensils on the lunch tray. Interview on 03/10/26 at 12:19 P.M. with Social Services #284 verified Resident #4 did not receive built up utensils on the lunch tray. Review of the meal ticket, dated 03/10/26 lunch meal, verified Resident #4 was to receive built-up utensils (1 each). Observation on 03/12/26 at 12:10 P.M. revealed the resident eating lunch in the resident room. Resident #4 lunch tray revealed the resident did not receive the built up utensils on the lunch tray. Interview on 03/10/26 at 12:14 P.M. with Certified Nursing Assistant (CNA) #230	F 0810		

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F 0810	Continued From page 133 verified Resident #4 did not receive built up utensils on the lunch tray. Review of policy titled, "Adaptive (Assistive) Eating Devices", dated 2021, verified the facility will provide special eating equipment, utensils, and assistance as appropriate to assure that each individual can use the adaptive (assistive) device when consuming meals and snacks. Adaptive devices should be noted on each individual's meal identification ticket.	F 0810		
F 0838 SS=F	483.71(a)(1)(3)(b)(1)(c)(1)-(5) Facility Assessment §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following:	F 0838	F838 Facility assessment The building administrator has completed a facility-wide assessment as of 4-9-2026 and determined the resources necessary to care for its residents completely during day-to-day operations, including nights weekends and emergencies. Also including staffing numbers and staff with appropriate competencies and skill. The administrator was in serviced the expectations of what is included in the Facility 3-17-26 by corporate nurse. This could affect 47 out of 47 residents. Sweep of the residents completed 3-28-2026 by management team didn't reveal any negative outcomes as a result of this practice. The administrator will audit for the changes needed in the facility assessment monthly, to begin 4-9-2026. The facility assessment will be submitted to the monthly QAPI for approval. and monitored in quarterly QAPI	04/10/2026

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F 0838	Continued From page 134 §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following:	F 0838		

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F 0838	Continued From page 135 (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non-medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1).	F 0838		

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F 0838	Continued From page 136 § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3).	F 0838		

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F 0838	Continued From page 137 §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This STANDARD is not met as evidenced by: Based on review of the facility's assessment and staff interview, the facility failed to assess the staffing needed to ensure resident receive the necessary care and treatment in the annual facility assessment. This has the potential to	F 0838		

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F 0838	Continued From page 138 affect all 47 residents residing in the facility. The current census is 47. Findings include: Review of the facility assessment updated March 2026 revealed no staffing levels were included in the assessment. The facility assessment did not contain any documented information on staffing levels to ensure that there are a sufficient number of staff with appropriate competencies and skill sets necessary to care for residents' required care. The facility assessment lacked any documentation regarding specific staffing needs for each resident unit in the facility and adjustments necessary based on changes to its resident population. The facility assessment had no documentation of considerations on specific staffing needs for each shift based on any changes to its resident population. Interview on 03/17/26 at 2:00 P.M. with the Administrator verified the facility assessment did not contain the required information regarding specific staffing required for the resident population in the facility.	F 0838		

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F 0880	Continued From page 139	F 0880		
F 0880 SS=F	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies,	F 0880	F880 Infection Prevention and Control The PoC will what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 3 no longer has linen on the floor employee #239 removed the linen on 3-11-2026.The linen is removed with each change by STNA's as all nursing was in-service by Ip by 3-31-26 STNA audits were started 3-31-26 and are ongoing. Enhanced barrier precautions for residents #39 and 40 are posted and PPE are placed on their doors, on 3-31-2026 the signs were verified as posted by the infection preventionist nurse. Education to all nurses by 4-9-26 and audits per IP ongoing. Currently EBP are being used for these residents. The TB Risk Assessment was completed day of survey by the infection preventionist. IP in-serviced by corporate nurse on day of survey to complete annually. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All 47 residents have the potential to be affected by this deficient practice. The sweep completed byIP of these residents didn't yield any further deficiencies. completed 3-25-26. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. All staff including cna#245,#230,#282 and LPN #202. have been in-serviced by DON/designee for a time ending 4-9-2026 to properly handle linen, and education of enhanced barrier precautions. The TB risk assessment was in-serviced to the infection preventionist and DON by corporate nurse on 3-13-26. How the	04/10/2026

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F 0880	Continued From page 140 and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be	F 0880	corrective action will be monitored to ensure the deficient practice will not recur, Audits began 3-19-2026 by infection preventionist nurse observing that observations of staff providing care for three residents with EBP are being conducted five times a week to ensure staff are using PPE, 5 x a week for 4 weeks and rounds are in place to ensure soiled linen is not on the residents floor, 5xa week for 4 weeks both done per nursing management. Annual audit of TB risk assessment is in place every march by QAPI team. Results of all the above submitted weekly to QAPI committee until substantial compliance is achieved. If concerns are identified during the audits staff will be rein serviced.	

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F 0880	Continued From page 141 followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This STANDARD is not met as evidenced by: Based on medical record reviews, observations, resident interview, staff interview, review of Tuberculosis (TB) Risk Assessment, and review of policy, the facility failed to properly handle soiled linen for Resident #3. In addition, the facility failed follow enhanced barrier precautions for Residents #39 and #40. The facility failed to complete the TB risk	F 0880		

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F 0880	Continued From page 142 assessment annually. This had the potential to affect all 47 residents. The facility census was 47. Findings include: 1. Review of the medical record revealed Resident #3 was admitted on 03/24/22. Diagnoses included acute and chronic respiratory failure with hypoxia, type two diabetes mellitus with hyperglycemia, and chronic kidney disease stage 3. Review of the Minimum Data Set (MDS), dated 02/02/26, revealed the resident was cognitively intact and required set-up/clean up assistance with toileting, showering, and personal hygiene. Review of the care plan, revised on 10/01/25, revealed Resident #3 has mixed bladder incontinence. Interview on 03/11/26 at 12:19 P.M. with Resident #3 revealed the odor is coming from the pile of soiled laundry in the corner of the resident room. Resident #3 stated every day she places soiled laundry on the floor in the corner for the aides to get. Resident #3 stated today housekeeping staff also picked up soiled laundry on the floor and added to the piled in the corner. Interview on 03/11/26 at 12:28 P.M. with Certified Nursing Assistant (CNA) #256	F 0880		

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F 0880	Continued From page 143 stated she did not know the soiled linen was on the floor and would collect it. After the laundry was collected, a follow-up interview at 12:55 P.M. with CNA #256 verified the laundry was saturated. Interview on 03/12/26 at 11:57 A.M, with Housekeeping #239 verified collected Resident #3's wet soiled laundry on 03/11/26 and placing it directly on the floor in the corner of the room for the aide to gather. 2. Review of the medical record for Resident #40 revealed an admission date of 09/29/2020 with medical diagnoses of cerebral palsy, profound intellectual disabilities, seizures, hypertension, and dysphagia. Review of an annual Minimum Data Set (MDS) assessment, dated 02/11/26, indicated Resident #40 had severe cognitive impairment and was dependent upon staff for all activities of daily living. Review of the physician orders for Resident #40 revealed an order dated 12/11/25 for Enhanced Barrier Precautions (EBP) and an order dated 12/11/25 Isosource 1.5 milliliter (ml) to administer 300 ml bolus five times per day. Observation on 03/16/26 at 1:18 P.M. revealed Certified Nursing Aide (CNA) #245 prepared Resident #40 for	F 0880		

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F 0880	Continued From page 144 incontinence care by explaining the procedure, washing her hands, and applying gloves. The observation revealed an EBP sign posted on Resident #40's door and personal protective equipment (PPE), including gown, gloves, and googles, located in the room. CNA #245 proceeded to complete incontinence care for Resident #40. Observation on 03/16/26 at 1:34 P.M. revealed Licensed Practical Nurse (LPN) #202 observed to use hand sanitizer and apply gloves and then proceeded to administer the tube feeding and water flushes as ordered to Resident #40. Interview on 03/16/26 at 1:41 P.M. with CNA #245 and LPN #202 confirmed Resident #40 was on EBP, there was a sign posted on her bedroom door, and PPE was available in her room. CNA #245 and LPN #202 both confirmed they did not donn a gown when they provided incontinence care or administered the tube feedings. 3. Review of Resident #39's medical record revealed an admission date of 09/06/22. Diagnoses listed included hemiplegia, type two diabetes mellitus, bladder dysfunction, and hypertension. Review of a quarterly Minimum Data Set (MDS) dated 01/02/26 revealed Resident #39 was cognitively intact, had an indwelling urinary catheter, and had received an antibiotic.	F 0880		

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F 0880	Continued From page 145 Review of physician orders revealed an order dated 05/24/25 for EBP for extended-spectrum beta-lactamases (ESBL) and indwelling catheter. Follow EBP protocols when providing care. Observation of Certified Nurse Aide (CNA) #230 and CNA #282 providing care to Resident #39 on 03/12/26 revealed they did not follow EBP protocols. CNA #230 and CNA #282 entered Resident #39 on 03/12/26 at 7:28 A.M. and donned gloves but did not don any gowns. CNA #230 and CNA #282 then assisted Resident #39 with dressing and transfer to a wheelchair using a “sit to stand” lift (hydraulic lift device). CNA #282 moved Resident #39’s urinary catheter collection bag from bedside, hung it on her pants leg pocket, attached it to the lift, then attached it to a wheelchair after transfer. CNA #282 then handed a washcloth to Resident #39 to have him wash his face. During an interview on 03/12/26 at 7:37 A.M. CNA #230 confirmed Resident #39 was on EBP and gowns should be used during care. CNA #230 confirmed a sign alerting staff of EBP and personal protective equipment (PPE) were on Resident #39’s entrance door. During an interview on 03/12/26 at 7:39 A.M. CNA #282 confirmed Resident #39 was on EBP and gowns should be used during care. CNA #230 confirmed a sign alerting staff of EBP and PPE were on	F 0880		

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F 0880	Continued From page 146 Resident #39’s entrance door. Interview with Infection Preventionist (IP) #246 on 03/12/26 at 7:55 A.M. confirmed Resident #39’s was ordered to be in EBP and CNA #230 and CNA #282 should have donned gowns when providing care. Review of the facility’s policy titled “Enhanced Barrier Precautions” dated revised 09/08/25 revealed EBP is indicated for residents with the following conditions when contact precautions (contact, droplet, airborne, etc.) would not otherwise apply. Wounds, this generally includes residents with chronic wounds, and not those with only shorter-lasting wounds, such as skin breaks or skin tears covered with a Band-aid or similar dressing. Indwelling medical devices such as catheters, drains, etc., all intravenous (IV) access points regardless of use (except for peripheral intravenous lines, gastronomy tube (G-tube) or jejunostomy tube (J-tube), tracheostomies or ventilators, and infection or colonization with a multidrug resistant organism (MDRO). PPE includes the use of gloves and gown for high contact care activities. High contact care activities include dressing, bathing/shower/hygiene, transferring in the patient's room, changing linens, toileting/changing briefs, indwelling device care, wound care, and therapy sessions. Use face/eye protection if splash/spray possible.	F 0880		

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F 0880	Continued From page 147 4. Review of the facility Tuberculosis (TB) Risk Assessment revealed it was completed on 03/12/26. The facility did not have documentation to of TB Risk Assessment completed in 2025. Interview on 03/12/26 at 8:13 A.M. with Infection Preventionist (IP) #246 confirmed the facility did not have documentation to support a TB Risk assessment had been completed in 2025. Review of the facility policy titled, “Tuberculosis Risk Assessment,” revised October 2010 stated the purpose of the TB risk assessment is to help evaluate the risk of transmission of TB within the facility, and to help establish appropriate administrative, environmental and respiratory protection controls for the recognition and/or prevention of TB transmission. The policy stated the TB risk assessment shall be conducted annually to determine appropriate administrative, environmental, and respiratory protection controls needed for the facility based on the current TB risk classification. This deficiency represents non-compliance under Complaint Numbers 2568764, 2615090, and 2698450.	F 0880		