STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345254	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Rehabilitation Center	**1212 Sunset Drive East , Monroe, North Carolina, 28112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F0000	INITIAL COMMENTS The survey team entered the facility on 9/9/2025 to conduct a complaint survey and exited on 9/12/2025. Additional information was obtained on 9/24/2025, on 9/29/2025 and on 9/30/2025. Therefore, the exit date was changed to 9/30/2025. Event ID #1D6971-H1. The following intakes were investigated 2583397, 2606223, 2609343, 2615436, 842859 and 842869. 3 of the 7 complaint allegations resulted in deficiency.	F0000		10/15/2025
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation, and resident, resident representative, staff and physician interviews, the facility failed to protect a resident's right to be free from mental abuse and humiliation when Nurse Aide (NA) #1 continued to provide personal care to Resident #1 after Resident #1 was heard saying calmly "leave me alone" in an electronic video that NA #1 recorded with NA #1's personal cellular phone device while providing personal care to a resident (Resident #1). On the electronic video, Resident #1's chest area	F0600	F0600 Free from Abuse and Neglect Interventions for Affected Resident: NA#1 is no longer employed as of 9/16/25. The Assistant Director of Nursing completed a review of resident #1's skin on 9/10/25. No adverse findings were noted. Resident #1 was seen by the attending physician on 9/10/25. No adverse findings were noted. Resident #1 was evaluated by the psychosocial service provider on 9/12/25. No adverse finding noted. Interventions for other residents at risk: Director of Nursing completed an evaluation of resident's skin checks for residents identified with BIMS of 12 or below. No adverse findings were noted. The administrator /designee completed interviews with residents identified with BIMS of 13 or above regarding the use of cell phones by facility staff in resident care areas. The interviews did not reveal reports of	10/01/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0600 SS = G	Continued from page 1 was observed exposed with no clothing or linens covering Resident #1's chest area. Resident #1's behaviors were observed escalating from a calm verbal tone to cursing and physically swinging her left arm at NA #1. This occurred for 1 of 3 residents reviewed for abuse (Resident #1). The reasonable person concept was applied to this deficiency as individuals would feel humiliated by the distribution of demeaning video recordings from personal cellular phone devices that included nudity of oneself. Findings included: Resident #1 was admitted to the facility on 6/30/2021 with diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 8/5/2025 indicated Resident #1 was moderately cognitively impaired and had exhibited verbal behaviors toward others 1 to 3 days for the seven-day look back period. The MDS further indicated Resident #1 required assistance with personal care. There were no physical behaviors toward others coded for Resident #1 on the MDS assessment. Resident #1's care plan last reviewed 6/24/2025 included a focus for activities of daily living, and interventions included one person assisting Resident #1 with bathing. Resident #1 was also care-planned for resisting care due to dementia. Interventions included providing opportunities for choice when providing personal care. An initial allegation report completed by the Administrator and dated 9/10/2025 at 2:59pm reported an allegation of abuse for Resident #1. The initial report documented that the Corporate Compliance Office received an allegation from Caller #1 that NA #1 had posted an electronic video on a social media site from her (NA #1's) personal cellular phone device of Resident #1 nude while NA #1 was providing personal care to Resident #1. The initial report further stated the local law enforcement agency was notified and the initial report was sent to the State Agency. On 9/10/2025 at 5:41pm, the Administrator played an undated electronic video that Caller #1 had emailed the facility on 9/10/2025. There was no audio (sound) on the electronic video, and the electronic video was divided into two parts. In part one of the electronic video, Resident #1 was observed lying supine (on the back) in the bed with a pink baby doll resting on her nude chest area. Resident #1 was observed swinging her left arm toward NA #1 as NA #1 reached toward Resident	F0600	Continued from page 1 staff using their cells phones/cameras in resident care areas. The facility incident and accidents for the period of 14 days (8/28/2025 through 9/10/2025) period were reviewed for bruises and/or injuries by the Director of Clinical Services. No adverse findings were noted. Residents identified with BIMS of 12 or less identified with behaviors of combative or resistance to care were reviewed to ensure that their care plans reflected appropriate interventions to manage their identified behaviors. This audit was completed on 9/10/25 by the Regional Director of Clinical Services. No adverse findings were noted. 9/11/2025 current staff interviews were completed to ensure that no other violations of the social media Policy related to use of cell phones/cameras in resident care areas existed. No other finding was noted during the interviews. The interviews were completed by the Assistant Director of Nursing / designee on 9/11/25. Systemic Change: Facility Staff were provided education regarding Abuse / Neglect and the Social Media Policy that included the use of cell phones/cameras in resident care areas are prohibited. The training was completed by the Staff Development/designee on 9/13/25. Facility staff identified as not receiving the education will receive prior to next scheduled shift. Facility direct care staff (licensed nurses and nursing assistants) were provided education regarding the caring of residents with Dementia with challenging behaviors including combative or resistive during care was completed on 9/13/25 by the SDC/Designee. Facility staff identified as not receiving the education will receive prior to next scheduled shift. Education regarding the center's Abuse and Neglect as well as social media Policy which addresses the use of cell phones/cameras in resident care areas being prohibited has been added to the center's new hire orientation. Ongoing Monitoring:	

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F0600 SS = G	Continued from page 2 #1's left hand that was holding the pink baby doll up off Resident #1's chest area. Resident #1 was observed using her right hand to grab the pink baby doll to the right side of her body and swinging her left lower arm and hand toward NA #1. NA #1 was observed placing her right hand on Resident #1's left shoulder and her (NA #1) left hand on Resident #1's left elbow to turn Resident #1 before the video ended. In part two of the electronic video, NA #1 was observed setting up her personal cellular phone device to video record Resident #1 and returning to Resident #1's bedside. Resident #1 was observed lying supine in the bed dressed in a gown. Resident #1 was not observed moving in bed. The Administrator reported NA #1 had been suspended pending the investigation of the allegation of abuse for Resident #1. On 9/11/2025 at 10:30am, the electronic video emailed to the facility on 9/10/2025 of Resident #1 was observed with audio. In part one of the electronic video, NA #1 was heard telling Resident #1 she was going to get NA #1 in trouble. Resident #1 was heard telling NA #1 "Get your ass out of here" as she held a pink baby doll on her chest area with her left hand. NA #1 was heard saying, "No, I'm trying to help you". Resident #1 was observed picking her left arm up in the air while holding the pink baby doll and NA #1 was observed reaching her left hand toward Resident #1's left hand that was up in the air holding the pink baby doll and NA #1's right hand was touching Resident #1's left elbow. Resident #1 was heard saying "Somebody behind ya" as Resident #1 swung her left arm toward NA #1 and grabbed the pink baby doll with her right hand and positioned on the right side of her body. Resident #1 was observed swinging her left hand toward NA #1 and NA #1 was heard telling Resident #1 "Stop". Resident #1 was observed swinging her left lower arm and hand toward NA #1 two more times. NA #1 was heard telling Resident #1 to stop before NA #1 was observed placing her right hand on Resident #1's left shoulder area and NA #1's left hand was observed touching Resident #1's left elbow to turn Resident #1 toward her right side before the electronic video ended. In part two of the electronic video, Resident #1's head and upper body were visualized in the video and Resident #1 was dressed in a gown. NA#1 was observed positioning her cellular phone device in the direction of Resident #1 in the bed and returning to Resident #1's bedside. NA #1 was heard telling Resident #1 to "Come on" and Resident #1 responded verbally in a soft calm tone, "Leave me alone". An observation and interview were conducted on 9/10/2025 at 6:12pm with Resident #1. Resident #1 was	F0600	Continued from page 2 The Administrator /designee will complete interviews with 3 sample residents identified with BIMs of 13 or greater to ensure that facility staff are not using cell phones /camera / videos in resident care areas. These audits will be conducted by the administrator/Director of Nursing / designee 3 times week for 12 weeks. The administrator will report the findings of the interviews to the QAPI committee monthly times 3 months. The QAPI committee will determine further action is needed.	

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F0600 SS = G	Continued from page 3 observed lying quietly in bed with the television on. There was a pink baby doll observed positioned on the top of a dresser that faced Resident #1's bed. Resident #1 was able to identify herself by name. Resident #1 explained she bathed and dressed herself. Resident #1 further stated she had not been mean (actions typically directed at individuals or groups with aim of causing emotional or physical pain) to anyone and no one had hurt her. Resident #1 stated she did not know of nursing staff using personal cellular phone devices to make an electronic video while providing her personal care. Resident #1 further stated she didn't know how she would feel if she was exposed nude in an electronic video. On 9/10/2025 at 7:15pm in a phone interview with Caller #1 stated on 9/9/2025 around 10:00pm, she observed Resident #1, who she did not know, in an electronic video on NA #1's social media site. Caller #1 stated Resident #1 did not have a shirt on in the electronic video, and Resident #1's chest area was totally exposed. Caller #1 explained she recognized NA #1 and was concerned because Caller #1 had family members at the facility where NA #1 was employed. On 9/11/2025 at 8:38am, a phone interview was conducted with Resident #1's Representative. Resident #1's Representative explained on the evening of 9/10/2025 he was shown an electronic video without audio of Resident #1 that the facility reported was seen on a social media site. Resident #1's Representative stated watching the recorded video of Resident #1 with NA #1 trying to snatch the pink baby doll, Resident #1 swinging her left arm as to defend herself and knowing that video of Resident #1 was on social media disturbed him. He stated when visiting Resident #1 on the evening of 9/10/2025, Resident #1 was unable to recall anything about NA #1 using personal cellular phone device to record an electronic video and explained Resident #1 was not mentally capable of making decisions. He explained Resident #1 treated the pink baby doll like a little baby and the pink baby doll provided comfort for her when in bed. Resident #1's Representative stated that was his mom in the video and he was feeling angry and mad because Resident #1's right to privacy had been violated. Resident #1's Representative stated he felt NA #1 had taken advantage of Resident #1 by recording a video of Resident #1 while providing personal care to be used for her (NA #1's) own personal reason. Resident #1's Representative also voiced concerns of not knowing the whereabouts of the electronic video NA #1 used to expose nudity of Resident #1 chest area on social media.	F0600		

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F0600 SS = G	Continued from page 4 On 9/11/2025 at 12:58pm a phone interview was conducted with NA #1. NA #1 stated she electronically videoed Resident #1 without Resident #1's permission 2 to 3 months ago using her (NA #1's) personal cellular phone device while providing personal care (bed bath) to Resident #1. NA #1 explained Resident #1 was known to display combative behaviors when nursing staff provided her personal care and stated Resident #1's combative behaviors would make her laugh. NA #1 stated she used her personal cellular phone device to video record Resident #1 while performing person care to capture Resident #1's combative behaviors like fighting. NA #1 explained Resident #1 regarded the pink baby doll as a real baby and holding the baby doll provided comfort to Resident #1. NA #1 stated she was not trying to get the pink baby doll from Resident #1. NA #1 stated the electronic video of Resident #1 was located on her personal cellular phone device and did not know why she had not deleted the video of Resident #1. NA #1 stated she had not posted the video of Resident #1 that was located on her personal cellular phone device on social media or sent the recorded video to anyone to view. NA #1 explained that Caller #1 had received a copy of Resident #1's video recording because when a personal friend searched through her personal cellular phone device earlier that week and found the video recording of Resident #1, the personal friend sent the video of Resident #1 to Caller #1. NA #1 stated the video recording of Resident #1 must have been deleted from her personal cellular phone device because she was unable to located the video on her personal cellular phone device. NA #1 stated she had been trained on abuse and prohibition of recording residents at the facility and use of social media and stated, "it (electronically videoing Resident #1 while providing personal care) was a stupid decision". NA #1 further stated she had been trained by the facility when residents were resisting care or told to leave them alone, resident care was not to be provided at the time and the resident reapproached at a later time. On 9/12/2025 at 11:52 am at the request of Resident #1's Representative, a follow up face to face interview was conducted with Resident #1 Representative. He explained that the facility had reported that the electronic video of Resident #1 exposing her nudity was not posted on social media. He stated he did not understand why Resident #1 was swinging her arm toward NA #1 in the recorded video and did not feel Resident #1 was physically abused in the recorded video. When Resident #1's Representative was explained there were different types of abuse: mental, sexual and misappropriation of property, he admitted not understanding the other types of abuse. He stated he	F0600		

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F0600 SS = G	Continued from page 5 had not observed a change in Resident #1's mental state in the last 2 to 3 months when visiting and continued to question why Resident #1 was striking out at NA #1 in the recorded video. He stated he had not observed that behavior from Resident #1. On 9/12/2025 at 12:38 pm in an interview with NA #2, she explained Resident #1 was dependent on nursing staff for all activities of daily living except feeding. She stated Resident #1 complained of hip discomfort often and required nursing staff to give her time before repositioning. NA #2 explained it was all in one's approach to Resident #1 in how she responded to provision of care. NA #2 stated Resident #1 had never swung her arm toward NA #2, verbally cursed at NA #2 or told NA#2 to leave the room when providing personal care. NA #2 explained Resident #1 was infatuated with the pink baby doll and treated the pink baby doll like a child. On 9/12/2025 at 3:30 pm in an interview with the Director of Nursing (DON), she stated Resident #1 was confused and frequently displayed combative behaviors (cursing at the nursing staff) when nursing staff were providing personal care. She stated she was not aware NA #1 had electronically videoed Resident #1 nude while providing personal care. The DON stated NA #1 had received abuse training and training that stated the use of social media and recording videos of residents was not allowed in the facility. The DON further stated when Resident #1 refused care and was physically swinging her arm toward NA #1, NA #1 should have stopped providing personal care to Resident #1, ensured Resident #1 was safe and exited Resident #1's room. The DON stated nursing staff have been educated to stop resident care and reapproach at a later time or by another staff member when residents exhibit combative behaviors. On 9/12/2025 at 1:25 pm in an interview with the Administrator, he stated use of personal cellular phone devices was not allowed in the resident care areas to ensure privacy of the residents and NA #1 should not have used her personal cellular phone device to video Resident #1 while providing Resident #1 personal care and exposing Resident #1's uncovered chest area. The Administrator stated when Resident #1 refused care, NA #1 should have ensured Resident #1 was in a safe position, exited Resident #1's room and informed the nurse assigned to Resident #1. He stated resident abuse of any type was not tolerated at the facility and based on the history of Resident #1 behaviors; there was no evidence of abuse to Resident #1 in the video recording of Resident #1 on NA #1's personal cellular phone	F0600		

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F0600 SS = G	Continued from page 6 device. On 9/12/2025 at 2:14 pm a phone interview was conducted with Physician #1. He stated Resident #1 was known not to be cooperative with care and had used inappropriate verbal terms toward the nursing staff and physician in the past. He explained Resident #1 was declining cognitively and in her health due to the disease process of dementia. He stated Resident #1 had not displayed any new behaviors in the last 2 to 3 months. A Psychiatry physician progress note dated 9/12/2025 indicated Resident #1 was evaluated for potential emotional disturbances following a social media post by a nursing team employee. The physician documented Resident #1 was alert to self but exhibited chronic confusion regarding time and place due to Alzheimer's dementia. The Psychiatrist recorded there were no acute behavioral disturbances, impulsivity, restlessness or agitation observed during the visit. There was no recommendation to change Resident #1's medications at the time and recommended to continue monitoring Resident #1 for changes in her condition. The investigation report dated 9/16/2025 for an allegation of abuse was completed by the Administrator and sent to the State Agency. The investigation report recorded the local law enforcement agency and Adult Protective Services (APS) were notified and NA #1 was terminated from employment on 9/16/2025 for not following the facility's social medial policy. Resident #1 was assessed by the nursing staff and the physician with no new behaviors or physical findings. The facility conducted skin assessments on all residents with a Brief Interview for Mental Status (BIMS) score of 12 or less with no findings of abuse. Interviews on the use of phones and social media by staff in resident care areas were conducted with residents with a BIMS score of 13 or greater with no new findings identified. Facility staff were interviewed on phone/social media usage in resident care areas in the facility with no reports of witnessing nursing staff electronically videoing residents. All staff were educated on the facility's social media policy, abuse policy and how to care for residents with dementia and aggressive behaviors. At the completion of the investigation by the facility, the facility reported the allegation of abuse was not substantiated because the recorded video of Resident #1 did not provide evidence that NA #1 willfully intended to hurt, harm, intimidate or punish Resident #1 by any means. The investigation report indicated Resident #1 was safe and had not suffered any injuries or mental anguish.	F0600		

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F0600 SS = G	Continued from page 7 On 9/24/2025 at 12:03 pm in a phone interview with the Administrator, he explained based on the screen displaying the recorded video of Resident #1, the facility determined that the recorded video of Resident #1 shared with the facility on 9/10/2025 was not from a social media site and the recorded video of Resident #1 was from NA #1's camera roll located on NA #1 personal cellular phone device. He explained Caller #1 was told by the facility to delete the video recording of Resident #1 that Caller #1had uploaded onto her personal cellular device and use to report to the facility. The Administrator stated NA #1 had reported during her interview, she had already deleted the recorded video of Resident #1 from her personal cellular phone device. He further stated neither Caller #1 nor NA #1 had been to the facility as requested to verify the recorded video of Resident #1 had been deleted from their personal cellular phone devices. On 9/24/2025 at 12:18 pm in a phone interview with Caller #1, she stated as instructed by the facility, she had deleted the recorded video of Resident #1 that she had uploaded to her personal cellular phone device on 9/9/2025.	F0600		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 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 REQUIREMENT is NOT MET as evidenced by: Based on record review, and resident, staff and physician interviews, the facility failed to perform a physical assessment of a resident when Nurse Aide (NA) #3 reported to Nurse #2 and Nurse #3 on 9/2/2025 on the 3:00 pm to 11:00 pm shift the report of a fall and a change in Resident #2's self-transfer status from the wheelchair to the bed. Resident #2 was sent to the hospital on 9/3/2025 on the 7:00 am to 3:00 pm shift and admitted for a left hip fracture. This occurred for 1 of 1 resident reviewed for injury of unknown origin (Resident #2). Findings included:	F0684	"Past Noncompliance - no plan of correction required"	09/08/2025

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F0684 SS = D	Continued from page 8 Resident #2 was admitted to the facility on 12/24/2024 with diagnoses including dementia, stroke and legal blindness. The quarterly Minimum Data Set (MDS) assessment dated 6/19/2025 indicated Resident #2 was moderately cognitively impaired and required supervision for all mobility tasks including wheelchair to bed. The care plan last reviewed 6/19/2025 for Resident #2 included a focus for falls. Interventions included the following: bed in lowest position, use of non-skid footwear and post fall event skin checks and providing cues for safety awareness. Physician #2's progress notes dated 9/1/2025 recorded a regulatory visit was conducted with Resident #2 on 9/1/2025. Physician #2 recorded Resident #2 voiced no complaints of pain on 9/1/2025 and there was no documentation of Resident #2 having a recent fall. There was no nursing report dated for 9/1/2025 on the 7pm to 7 am shift reporting a fall for Resident #2. There was no nursing documentation in Resident #2's electronic medical record (EMR) for 9/1/2025 or 9/2/2025. A review of Resident #2's September 2025 Medication Administration Record recorded Resident #2's pain level as zero from 9/1/2025 to 9/3/2025. In an interview with NA #4 on 9/10/2025 at 3:13pm, she stated on 9/1/2025 from 11:00 pm to 7:00am, Resident #2 was up in his wheelchair in the hallway with her until 5:00 am when Resident #2 went to bed. She stated Resident #2 did not want to go to bed that night and she assisted him to the bathroom with no change in his mobility observed and Resident #2 voiced no complaints of pain with movement. In an interview with Nurse #4 on 9/10/2025 at 7:15 am, Nurse #4, who was assigned to Resident #2 on 9/1/2025 7:00 pm to 7:00am, stated she did not recall Resident #2 having a fall on 9/1/2025 or recently. In an interview with NA #5 on 9/10/2025 at 2:29 pm, she explained Resident #2 was able to move independently and used furniture arrangement in the room to touch when walking to the bathroom on 9/2/2025 from 7:00 am to 3:00 pm. She stated Resident #2 required supervision when walking to the bathroom and in his room and used the call bell to notify nursing staff for assistance.	F0684		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Rehabilitation Center	**1212 Sunset Drive East , Monroe, North Carolina, 28112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F0684 SS = D	Continued from page 9 She stated on 9/2/2025, she assisted Resident #2 with his personal care and observed Resident #2 walking to the bathroom with no complaints of pain or change in his mobility. In a phone interview with Nurse #5 on 9/10/2025 at 9:41 am, she stated she was assigned to Resident #2 on 9/2/2025 on the 7:00 am to 7:00 pm shift and at the change of shifts at 7:00am, there was no report of Resident #2 experiencing a fall on 9/1/2025. She explained Resident #2 was at his baseline on 9/2/2025 sitting up in the wheelchair in the hallway at the nursing station with no complaints of pain verbalized. She stated Resident #2 was assisted with his personal care, assisted to the bathroom and repositioned in the wheelchair on 9/2/2025 and Resident #2 did not mention he had fell or voice complaints of pain during the shift. In an interview with Occupational Therapist on 9/10/5 at 2:30 pm, he stated Resident #2 could stand and transfer without assistance and the need for supervision was stressed Resident #2 when moving in his room. He stated Resident #2 would call at times for help and was not consistent in calling for help when up in his room. He explained when occupational therapy worked with Resident #2 on 9/2/2025, Resident #2 was observed changing positions per himself without assistance slower than normal from the wheelchair to standing and walking to the bathroom. He stated Resident #2 did not endorse any pain during therapy. He explained at baseline Resident #2's walked with his upper body leaned forward which decreased the speed of his movement and there were no acute concerns observed with Resident #2's left leg/hip area. In an interview with NA #3 on 9/10/2025 at 3:05 pm, she explained Resident #2 always required supervision with self-transfers from wheelchair to bed when preparing to go to bed. She stated on 9/2/2025 around 9:30 pm when Resident #2 stood up from wheelchair to turn to sit on the bed, Resident #2 could not turn and said, "it's my hip" and she had to help Resident #2 to shift his left leg back to sit on the bed. She explained Resident #2 moved his right and left legs onto the bed himself with no facial grimace or complaints of pain and she provided a little assistance in straightening his legs in the bed, which she normally would do for Resident #2. She stated when Resident #2 was in the bed he said, "I believe it's my hip" and asked NA #3 if his left hip was blue. She stated Resident was lying on his right side and there was no blue discoloration observed to Resident #2's left hip. She stated she asked Resident #2 what happened, and Resident #2 stated "I don't know"	F0684		

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F0684 SS = D	Continued from page 10 and Resident #2 did not mention having a fall. NA #3 stated she informed Nurse #2 that Resident #2 was observed having difficulty in self-transferring from the wheelchair to the bed and Resident #2's roommate had reported Resident #2 fell a couple nights ago. In an interview with Nurse #2 on 9/10/2025 at 3:44 pm, she stated on 9/2/2025 NA #3 reported to her that Resident #2 experienced difficulty in self-transferring from his wheelchair to the bed and it may be his hip. Nurse #2 stated NA #3 reported Resident #2's roommate reported to her that Resident was on the floor in the room on the night of 9/1/2025. Nurse #2 stated she went to Nurse #3, who was assigned to Resident #2. Nurse #2 explained she and Nurse #3 reviewed Resident #2's EMR and there was no documentation of a fall in Resident #2's EMR. Nurse #2 also stated she went to Nurse #4 who was assigned Resident #2 on the night of 9/1/2025 and Nurse #4 reported Resident #2 had not experienced a fall on the night of 9/1/2025. She stated because Resident #2 was not assigned to her, she did not go assess Resident #2. In an interview with Nurse #3 (who was assigned to Resident #2 on 9/2/2025 7:00pm to 11:00pm) on 9/12/2025 at 11:50 am, she stated NA #3 reported to Nurse #2 that Resident #2 self-transferred with difficulty when transferring from wheelchair to bed and Resident #2's roommate had reported Resident #2 fell on 9/1/2025. Nurse #2 reviewed Resident #2's EMR and was unable to locate documentation that Resident #2 had experienced a fall on 9/1/2025 or recently. Nurse #3 stated when she went to Resident #2's room before the end of her shift, Resident #2 was observed sleeping and she did not assess or observe Resident #2's left leg/hip area. She stated due to NA #3 reporting a change in Resident #2's ability to self-transfer, Resident #2's left leg/hip area should have been assessed by a nurse to determine if an injury existed and if notification of physician required immediately rather than reported in the physician communication book. Nurse #3 stated she reported to Nurse #6 on 9/2/2025 at 11:00 pm the change NA #3 reported in Resident #2 condition. In an interview with NA #4 on 9/10/2025 at 3:13pm, she stated on 9/2/2025 from 11:00 pm to 7:00 am, Resident #2 slept, turned self and did not get up to go to bathroom during the shift. She further stated Resident #2 did not complain of pain for the shift. In a phone interview with Nurse #6 on 9/12/2025 at 12:27 pm, she stated she was assigned to Resident #2 on 9/2/2025 from 11:00 pm to 7:00 am. She explained when she checked on Resident #2 during the night of	F0684		

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F0684 SS = D	Continued from page 11 9/2/2025, Resident #2 was resting with his eyes closed and did not complain of pain during the shift. She stated NA #4, who was assigned to Resident #2, reported no concerns or complaints of pain from Resident #2 during the shift. Nurse #6 stated Nurse #3 did not report a fall, a change in Resident #2's ability to self-transfer or concerns with Resident #2's hip area at the change of shift at 11:00 pm. Nurse #6 reported she left (time unable to recall) before the end of the shift (7:00 am) and Nurse #4 assumed the keys to her medication cart/assignment. In an interview with Nurse #4 on 9/10/2025 at 7:15 am, she explained she received report and the medication keys from Nurse #6 at 6:00 am on 9/3/2025. She stated Nurse #6 reported Resident #2 had been in bed all night. She stated Resident #2's roommate reported Resident #2 was in pain. Nurse #4 stated when she went to ask Resident #2 if he was having pain, Resident #2 was resting with his eyes closed. Nurse #4 stated she did not wake Resident #2 to assess Resident #2 and made an entry into the physician communication book for the physician to evaluate. Nursing documentation dated 9/3/2025 at 7:54 am by Nurse #4 stated Resident #2 had complained of hip pain, was having difficulty walking and a message was left for the physician for further evaluation. There was an entry dated 9/2/2025 (7p-7a shift) with no time stamp in the physician communication book for Resident #2. The entry recorded by Nurse #4 stated Resident #2 complained of hip pain, difficulty to walk and need for x-ray. The entry was recorded completed by Physician #2 on 9/3/2025. Physician #2's progress note dated 9/3/2025 recorded the reason for the visit was due to Resident #2 complaining of left hip pain. Physician #2 documented moderating factors of pain included movement of left leg. Physician #2 wrote Resident #2 stated he fell but was not able to recall the fall. Physician #2 recorded nursing reported Resident #2 fell on the night of 9/1/2025. Physician orders dated 9/3/2025 at 9:53 am included a pelvis and left hip x-ray immediately for left hip pain and fall. In a phone interview with Nurse #5 on 9/10/2025 at 9:41 am, she explained when she came in on 9/3/2025 for the 7:00 am to 7:00 pm shift, the Director of Nursing (DON) requested that morning she go with her (DON) to Resident #2's room and stated she had not been to	F0684		

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F0684 SS = D	Continued from page 12 Resident #2's room prior to that time. Nurse #5 stated Resident #2 was lying in bed quietly with arms across his chest and verbalized no complaints of pain. She explained when touching and attempting to roll Resident #2 over to his side, Resident #2 said, "Oh, oh". She further stated Resident #2's left foot was observed turned inward. She explained the paperwork to transfer Resident #2 to the hospital for an evaluation was started, and Resident #2 was transferred to the hospital. Nursing documentation dated 9/3/2025 at 9:00 am by Nurse #5 recorded she was made aware Resident #2 had experienced a previous fall and reported pain to the left hip. Resident #2 was sent to the hospital's emergency department (ED) for further evaluation and x-rays of the affected area. A transfer form for Resident #2 dated 9/3/2025 at 8:47 am was completed by Nurse #5. The transfer form recorded Resident #2 had suffered a fall and Resident #2's left leg was visibly rotated inward with pain to left hip area when attempting to reposition the left leg. Physician was notified and Resident was sent to local hospital for evaluation. Nursing documentation dated 9/3/2025 at 11:08 am by the Director of Nursing (DON) stated the DON was notified by NA #3 that when Resident #2 attempted a self-transfer to the bed on 9/2/2025, Resident #2 had difficulty with standing during the supervised transfer and complained of pain to his left leg. NA #3 stated she did a stand pivot transfer to help put Resident #2 back to bed. The DON recorded she went to assess Resident #2 for any change in condition and assessed Resident #2's left leg rotated, left leg appeared shorter than the right leg and recorded there was no bruising to the left thigh/hip area. The DON recorded when she attempted to move Resident #2's left hip slightly, Resident #2 complained of pain. DON documented Resident #2's assessment was reported to Resident #2's assigned nurse (Nurse #5) and Nurse #5 was instructed to notify Physician #2, who was in the facility, and orders were received to send Resident #2 to the hospital's emergency department for further evaluation. In an interview with the DON on 9/11/2025 at 4:30 pm with the Regional Clinical Director in attendance, the DON stated on 9/3/2025 there was a note written by NA #3 left under her office door reporting Resident #2's roommate reported a couple nights ago a nurse helped Resident #2 up off the floor and back to the bed. She explained all falls were reviewed by the DON and	F0684		

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F0684 SS = D	Continued from page 13 Administrator and when she reviewed Resident #2's EMR, there was no documentation of a recent fall for Resident #2 recorded in the EMR. Therefore, DON reported she went to Resident #2's room to access Resident #2 and observed Resident #2 resting with eyes closed. She stated Resident #2 was not complaining of pain and there was no facial grimacing of pain observed. She explained upon removing the top linen covers, Resident #2's left leg was observed rotated inward and Resident #2 would respond with an "Ouch" when moving the left leg. She stated Physician #1 assessed Resident #2 and Resident #2 was sent to the hospital for evaluation. She further stated Resident #2's family member reported at the hospital that Resident #2 reported he had fallen and got himself back to bed. Hospital discharge summary dated 9/7/2025 for Resident #2 documented Resident #2 was admitted to the hospital on 9/3/2025 with a closed intertrochanteric fracture of left femur (hip fracture) following an unwitnessed fall resulting in inability to ambulate. A computer tomography scan (CT scan) of the pelvis revealed a displaced, rotated and mildly impacted intertrochanteric fracture of the left proximal femur with associated soft tissue and intramuscular edema/hematoma (collection of blood) and Resident #2 had surgery to repair the left hip fracture on 9/4/2025 and was discharged to return to the facility on 9/7/2025. In an interview with Resident #2 on 9/11/2025 at 5:25 pm, Resident #2 was limited in providing information and was more cooperative in answering yes and no questions. Resident #2 answered "yes" to having a fall and getting himself up. When asked if he told the nursing staff of the fall, he answered, "I don't think I did". He answered "yes" when asked if his left leg/hip hurt after the fall and stated, "no" when asked if the pain made him cry. He answered "yes" when asked if he was able to sleep and answered "no" if he informed the nursing staff of pain in his left leg/hip area or requested pain medicine for the pain. During a subsequent interview with Resident #2 on 9/12/2025 at 11:40 am, Resident #2 was more cooperative in answering questions. Resident #2 continued to report he had a fall (date unknown) and was able to get himself up without calling for help and did not report the fall to the nursing staff. Resident #2 stated his left leg/hip did not hurt at the time of the fall. He stated when performing self-transfer on evening of 9/2/25 he did not tell NA #3 he had pain in the left hip and did not tell nursing staff his left leg was	F0684		

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F0684 SS = D	Continued from page 14 hurting. Resident #2 stated he did not recall nursing staff assessing his left leg/hip on 9/2/2025 and he was able to sleep the night of 9/2/2025. Resident #2 recalled when Nurse #5 and DON assessed his left leg/hip on 9/3/2025, there was pain to the left leg/hip area. In an interview with Physical Therapist on 9/12/2025 at 10:27 am, he explained if Resident #2 had fallen near his bed and the bed was in the lowest position Resident #2 could have gotten himself up off the floor and back to bed. He stated Resident #2 would try to get up without help from the bed and wheelchair and did not ask for help. He sated Resident #2 had been redirected to ask for help and Resident #2 as able to self-transfer from the wheelchair to the bed without help. In an interview with Regional Clinical Director on 9/11/2025 at 4:25 pm with the DON in attendance, the Regional Clinical Director stated Nurse #3 was assigned to Resident #2 from 7:00 pm to 11:00 pm on 9/2/2025 and Resident #2 was not scheduled any medications and nursing care during those hours. The Regional Clinical Director stated NA #3 recognized when supervising Resident #2 self-transfer from wheelchair to bed around 9:30 pm that Resident #2 was having difficulty moving his left leg and stated, “I think it’s my hip” and NA #3 assisted Resident #2 with transferring from the wheelchair to the bed with no complaints of increased pain. The Regional Clinical Director stated when Resident #2 asked NA #3 to look at his left hip area to see if bruises, there was no bruising observed and Resident #2 was observed by NA #3 going to sleep. The Regional Clinical Director stated Resident #2’s roommate informed NA #3 before exiting the room that Resident #2 had fallen “the other night” and Resident #2 did not report a fall to NA #3. She stated NA #3 reported to Nurse #2 the fall reported by Resident #2’s roommate and Resident #2 having difficulty with self-transferring from the wheelchair to the bed. She stated when Nurse #2 questioned Nurse #3, who was assigned to Resident #2, if a fall had been reported for Resident #2, Nurse #3 was not aware of a fall. She explained when Nurse #2 and Nurse #3 reviewed Resident #2’s EMR, there was no documentation of a fall for Resident #2 and went to ask Nurse #4, who was assigned to Resident #2 on 9/1/2025 from 7:00 pm to 7:00 am, if Resident #2 had fallen. Nurse #4 reported she was unaware of Resident #2 having a fall on 9/1/2025. The Regional Clinical Director explained Nurse #2, Nurse #3 and Nurse #4 were unable to determine that Resident #2 had experienced a fall and stated Resident #2 had not complained of pain. She stated Nurse #4 requested in	F0684		

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F0684 SS = D	Continued from page 15 the physician communication book for Resident #2 to be evaluated for left hip pain and stated Nurse #2, Nurse #3 or Nurse #4 did not physically conduct an assessment of Resident #2 when NA #3 reported a change in Resident #2's ability to self-transfer and stated it was his hip. The Regional Clinical Director stated Resident #2 should have been assessed by a nurse after a change in condition was reported to determine physician notification and the nursing staff have received education on conducting an observation and assessment of residents with a change in condition and notification of the physician. The Regional Clinical Director further shared Nurse #6, who was assigned Resident #2 on 9/2/2025 from 11:00 pm to 7:00 am, reported Resident #2 slept with no complaints of pain. In a phone interview with Physician #2 on 9/10/2025 at 9:33 am, he stated he had seen Resident #2 on 9/1/2025 and Resident #2 did not verbalize any pain to the left leg. He explained when Resident #2 started complaining of pain to the left leg on 9/2/2025, there was no report of a fall for Resident #2 and nursing staff communicated in the physician communication book for the physician to evaluate on 9/3/2025. He stated there was no report on 9/2/2025 Resident #2 experiencing increased pain and Resident #2 was able to walk around in his room. Physician #2 stated Resident #2, who was cognitively impaired and not a good historian, self-reported when examined on 9/3/2025 he had fallen two days ago, and he did not report the fall to the nursing staff. He explained Resident #2 was sent to the local hospital for a further evaluation and radiology imaging studies. In an interview with Physician #1 on 9/12/2025 at 10:59 am, he stated it was possible for Resident #2 to have a fracture of the left hip and continue to have movement of the left leg/hip area with minimal to no discomfort. He stated that when there was a change in pain or mobility reported to the nursing staff, nursing staff should have assessed Resident #2, written nurse progress note, and notified the physician of a change in Resident #2. He stated if the nursing staff had assessed Resident #2 and notified the physician on the evening of 9/2/2025 instead of the morning of 9/3/2025, Resident #2 could have been ordered an x-ray earlier but the treatment and outcome for Resident #2 would not have changed. In an interview with the Regional Clinical Director and DON on 9/12/25 at 9:20 am, the DON stated a fall for Resident #2 was reported and the nursing staff communicated with the physician by placing an entry in the physician communication book which was	F0684		

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F0684 SS = D	Continued from page 16 read the next day. The DON stated none of the nursing staff aware of the allegation that Resident #2 had experienced a fall physically assessed Resident #2 due to observing Resident #2 sleeping. The DON stated Resident #2's roommate report of a fall on 9/1/2025 was discounted due to Resident #2's roommate may have confused Resident #2 with another resident with the same first name as Resident #2. The DON stated Resident #2 should have been physically assessed by a nurse when a change in condition was reported. The Regional Clinical Director stated during the investigation of Resident #2's injury of unknown origin investigation, the facility identified nursing staff failed to assess Resident #2 when a change in condition was observed in Resident #2's transfer status and notification of a change to the physician of Resident #2's status and a plan of correction had been completed. The facility provided the following corrective action plan: On 9/3/2025 at 3:00pm, an AD HOC Quality Assurance Performance Improvement meeting was held. Problem: The Quality Assurance Performance Improvement committee identified the nursing staff failed to assess Resident #2 when there was a change in condition in Resident #2's transfer status and failed to notify the physician of change in Resident #2's condition on 9/2/2025. Address how corrective action will be accomplished for the resident found to have been affected by the deficient practice: Resident #2 was evaluated by a registered nurse on 9/3/2025 with pain to left hip area with movement. The physician was notified and Resident #2 was sent to emergency room for x-rays. The Resident #2's Representative was notified of Resident #2's change in condition and transfer to the hospital. An x-ray of Resident #2's left hip reported a fracture left hip and was admitted to the hospital for surgery. The Director of Nursing investigated the change in Resident #2's transfer status with interviews of the nursing staff assigned to Resident #2 on 9/1/2025 and 9/2/2025 and conducted an reenactment of Resident #2's transfer with the assigned nurse aide on the 3:00 pm to 11:00 pm shift on 9/2/2025. The information gathered in the investigation was reviewed by the Quality Assurance Performance Improvement committee and a plan of correction for assessing residents with a change in	F0684		

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F0684 SS = D	Continued from page 17 transfer status and notification of the physician with a change of condition was implemented. Address how the facility will identify other residents having the potential to be affected by the same deficit practice: The following audits were conducted by the facility to identify residents with a change in condition and notification of the physician and resident representative was conducted when there was a change in a resident's condition by 9/5/2025. 1. Residents' electronic medical record were reviewed by the Assistant Director of Nursing on 9/5/2025 for completion of documentation of assessments for residents with changes in condition in the past 2 weeks. 2. Physician orders in residents' electronic medical record for the past 2 weeks were reviewed by the Director of Nursing on 9/5/2025 to identify changes in residents' condition that may have not been assessed. 3. The Director of Nursing reviewed the physician communication book to identify residents that had a change of condition received an assessment for the past 2 weeks on 9/5/202. 4. The Director of Nursing reviewed incident reports for the past 2 weeks on 9/5/2025 to identify residents that had a change of condition received an assessment. 5. The Assistant Director of Nursing and unit managers on 9/6/2025 conducted body audits of the residents to identify changes in mobility and transfer status and notification of the physician and resident representative. 6. The Assistant Director of Nursing and Director of Nursing on 9/5/2025 interviewed residents for changes in mobility and transfer status. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur include: The nursing staff (nurses and nurse aides) were provided in-person educational in-services and via phone education instructions by the Director of Nursing on evaluating and assessing residents with a change of condition and notification of physician with a change in resident's condition from 9/3/2025 to 9/7/2025. After 9/7/2025, the Director of Nursing was responsible	F0684		

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F0684 SS = D	Continued from page 18 for ensuring that no nurses or nurse aide worked without receiving the required education prior to their next scheduled shift. Starting 9/7/2025, all new hires will be educated by the staff development coordinator and/or the Director of Nursing regarding resident's change in condition and notification of the physician during clinical orientation. Staff sign-in sheets and nursing staff rosters kept by the Director of Nursing were used as acknowledgement education in-services was received and understood. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing or designee will review daily incident reports, 24-hour progress notes and change of condition forms for all residents to identified residents with a change in condition with mobility and/or transfers for four weeks and then monthly for two months. When a change in condition is identified, the audit will include that the resident was evaluated by a nurse, and the physician and resident representative was notified of the resident's change in condition. The results of the audits will be tracked/trended by the Director of Nursing and presented to the Quality Assurance Performance Improvement committee monthly. Based on the audit results, the Quality Assurance Performance Improvement committee will determine the need of further monitoring for residents with a change in condition for mobility/transfers. Compliance Date: 9/8/2025 On 9/12/2025, the facility's corrective action plan was validated by the following documentation: Residents' EMR for change in condition the past 2 weeks were reviewed by Assistant Director of Nursing on 9/5/2025 with no concerns identified. Physician orders in residents' EMR were reviewed for the past 2 weeks by the DON on 9/5/2025 with no concerns identified. The physician communication book was reviewed for the past 2 weeks by the DON 9/5/2025 with no concerns identified. Incident reports for the past 2 weeks were reviewed by the DON 9/5/2025 with no concerns identified. Body audits for residents with a BIMS less than a 12 were assessed to identify changes in mobility and transfer status and notification of physician and resident representative by the Assistant Director of Nursing and unit managers on 9/6/2025 with no change or injury identified. Residents with a BIMS greater than 13 were interviewed for changes in mobility and transfer status by the Assistant Director of Nursing	F0684		

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F0684 SS = D	Continued from page 19 and DON on 9/5/2025 with no falls identified and not reported to the nursing staff. Educational sign in sheets starting 9/3/2025 recorded nursing staff (nurses and nurse aides) received education in-services on change of condition, recognizing and assessing a change in resident and notifying the nurse and notification of the physician of a change in resident's condition. Interviews with the nursing staff verified education in-services were conducted for the nursing staff as indicated in the POC. The facility's compliance date was validated as 9/8/2025.	F0684		
F0925 SS = E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff, Contracted Pest Control Company Technician, and Wildlife Department Technician interviews, the facility failed to implement an effective pest control program to maintain a pest free living environment after the first sighting of a snake in the building on 8/15/2025 for 110 of 110 residents residing in the building. Findings included: On 9/9/2025 at 1:05 pm, the front entrance of the building was observed with two glass swinging doors. When the two glass swinging doors where closed, there was a half inch opened space area observed between the doors on the lower part of the doors that extended approximately six inches from the bottom of the doors. This opening between the two doors provided an entrance for a snake to enter the building. Upon entering the building, there was a receptionist office observed on the right side and the admission's office was observed across the hall on the left. There was a one-inch open space between the admission's office doors and the floor. A review of the maintenance logs from July 2025 to September 2025 that were located at each nurse's station for the three resident halls recorded no sightings of snakes in the building.	F0925	Interventions for Affected Resident: On 8/15/2025, a snake was observed in the admissions office located next to the facility's front entrance door, 8/22/2025 a snake was observed in the storage room located on the 100-Hall, and 8/25/2025 a snake was observed outside the Dining Room located on the entrance Hall leading to the 200-unit. 8/15/2025, the snake was removed by the Maintenance Director, 8/22/2025, the snake was removed by the Housekeeping Supervisor, and 8/25/2025 the snake was removed by a Certified Nursing Assistant (CNA). No residents were identified as being affected by the deficient practice during any of the sightings. Interventions for other residents at risk: On 8/15 2025, a house wide facility sweep was completed by the Maintenance Director and Administrator to identify any other findings of pests in the facility. No pests were identified. On 8/22/2025, a house wide facility sweep was completed by the Administrator and Maintenace Director to identify findings of pests. No pests were identified. On 8/22/2025, the Administrator contacted EcoLab (facilities contracted exterminator) for a service visit due to the snake sightings. EcoLab came to service the center on 8/25/2025 during business hours. No findings of pests were noted in the service report. On 8/26/2025, the Maintenance Director and the	10/01/2025

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F0925 SS = E	Continued from page 20 In an interview with Nurse #1 on 9/10/2025 at 11:40 am, she stated a small six inch baby snake with diamond shapes on the skin was observed entering the building through the front entrance doors and entering the admissions office one night shift (8/15/2025) in August 2025. Nurse #1 explained the admission's office door was locked and she did not have a code to enter the admission's office. She stated she sent a group text to the Administrator and the Director of Nursing (DON) informing them of the snake in the admissions office. Nurse #1 stated she did not text or notify the Maintenance Director. She stated she did not observe any other sightings of the snake that night. Nurse #1 explained she was unable to provide exact date of the sighting of the snake because her text messages automatically deleted. The distance from the admission's office to the closest room with a resident residing in the room was measured at 192 feet. In an interview with the Director of Nursing (DON) on 9/10/2025 at 4:39 pm, the DON stated Nurse #1, who was working a 7:00 pm to 7:00am night shift on 8/15/2025, had reported in a group text message to the Administrator and DON on 8/16/2025 at 12:00am there was a snake in the admission's office and Nurse #1 was going on break. The DON stated she did not see the group text until 8/16/2025 at 4:44 am and replied to Nurse #1 asking if it was a big snake. The DON stated on 8/16/2025 at 6:42 am, Nurse #1 replied to her text describing the snake as a small tan and black snake and it was in the office (admission's office) across the hall from the receptionist office. The DON stated on 8/16/2025 at 6:48 am she texted Nurse #1 asking if the Maintenance Director was aware because she was going in there (the building) and she was not a snake fan. The DON stated she informed the Maintenance Director and the Administrator of the snake in the admission' office and they conducted an exterior and internal sweep of all areas for other snakes. The DON further stated since beginning employment at the facility in April 2025, she had not observed mice in the building. In an interview with Housekeeper #1 on 9/10/2025 at 11:51 am, she explained she usually reported to work at 7:00 am and cleaned the front entrance area first. She stated one morning in August 2025 (exact date unknown) while cleaning the admission's office, she observed a 6 inch grayish colored snake behind the couch. She stated she called the Maintenance Director, who removed the	F0925	Continued from page 20 Administrator performed a house wide facility sweep to identify any snakes and or other pests. No pests were observed. On 8/29/2025, the facility was treated for snakes by the Department of Wildlife. The Department of Wildlife reported there were no snakes or signs of snake activities noted in or around the building. As a result of faciity wide center rounds by the Administrator and Maintenance Director and inspections and services performed by EcoLab and the Department of Wildlife, no other residents were noted to be at risk. Systemic Change On 9/11/2025 the maintenance director and administrator completed an audit of the entire facility's exterior doors. The 100-hallway front entrance was identified as the only door with inadequate weather stripping. The door was fixed and properly sealed on 9/12/2025. On 9/12/2025 the Administrator and maintenance team was educated by the Vice President of Operations (VPO) regarding the importance of immediately notifying the pest control company at the first sighting of any pest. The administrator and maintenance team were also educated on the importance of inspecting all exit doors to ensure they are properly secured by weatherstripping to not allow any pests in the facility. Monitoring: Weekly x 12 weeks and then ongoing, the Administrator/designee will audit all exit doors leading to the outside to ensure that they are properly secured by weatherstripping to decrease the risk of snakes and other pests from entering the center. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A/QAPI) Committee by the Administrator monthly x 3 months. At the completion of the 3months, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued monitoring is necessary.	

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F0925 SS = E	Continued from page 21 snake out of the admission's office. In an interview with the Maintenance Director on 9/11/2025 at 12:32 pm, he stated upon reporting to work on the morning of 8/16/2025, he removed a 3-to-4-inch black snake that the housekeeping staff observed out of the admission's office. He explained it was not a copperhead snake because the snake did not have a yellow tail (copperheads have a distinct bright yellow or green tail which they keep for roughly a year). The Maintenance Director reported there had been no issues with mice in the building prior to the sighting of the snake. He explained he conducted an external rounding of the building with no further snakes observed. In a follow up interview on 9/11/2025 at 3:10 pm, the Maintenance Director stated since snake repellent material were obtainable from the local hardware store, the facility did not maintain snake repellent materials at the facility. The Maintenance Director stated that he went to obtain snake repellent material at the local hardware store on 8/16/2025 and the hardware store did not have any snake repellent material. In an interview with the Administrator on 9/10/2025 at 3:17 pm, he stated he did not see the group text message Nurse #1 sent on 8/16/2025 at 12:00 am until waking up that morning. He stated the Maintenance Director had captured and removed the snake from the admission's office upon his arrival to the building. In a follow up interview on 9/11/2025 at 12:35 pm, the Administrator explained he conducted an interior observation of all resident rooms, offices, departments and resident care areas with no further sightings of a snake identified. The Administrator stated he didn't know why he did not email the facility's contracted pest control company on 8/15/2025 about the snake sighting in the admission's office except he felt there was no risk of harm to the residents since there had not been any other sightings of a snake in the building. In an interview with the Housekeeping Director on 9/10/2025 at 11:55 am, he stated in the early morning of 8/22/2025, he observed a small 6-inch brown and black striped snake midway the left side of the 100-hall when facing the front entrance in a hall resident bathroom. He explained the 100-hall was closed for renovations. He stated he removed the snake from the building and informed the Administrator.	F0925	Continued from page 21 Date of alleged compliance:9/13/25	

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F0925 SS = E	Continued from page 22 The distance measured from the 100-hall resident bathroom to the closest room that a resident was residing was 253 feet. There was an email dated 8/22/2025 from the Administrator to the contracted pest control company stating the facility had identified two snakes in the building and requested someone come to the building and assess. In an interview with the Administrator on 9/11/2025 at 11:35 am, he stated the contracted pest control company for the building was notified via email by him on 8/22/2025 of the two snake sightings (8/15/2025 and 8/22/2025). He further stated the Maintenance Director conducted an observation of the exterior parts of the building and he conducted an observation of all the interior rooms and departments of the building with no other snake finding. In an interview with the Maintenance Director on 9/11/2025 at 3:10 pm, he stated the facility did not have snake repellent materials to applied exteriorly to the building. The monthly contracted pest control company invoice dated 8/25/2025 was reviewed. The contracted pest control company reported no pest activity was observed during the visit. There were structural concerns (exterior area with vegetation touching the building structure) reported that could cause pest problems. The invoice recorded an exterior rodent service was performed and accessible bait stations were checked and bait was replaced as needed. The invoice also reported that the Administrator nor the Maintenance Director were onsite on 8/25/2025 at 6:10 pm resulting in the contracted pest control technician service to close improperly. In a phone interview with the Contracted Pest Control Company Technician on 9/11/2025 at 12:14 pm, he stated the contracted pest control company had only received one email on 8/22/2025 from the Administrator reporting snakes in the building. He explained as the contracted pest control technician he was only able to conduct a visual observation for snakes, and he could not remove snakes or treat for snakes per the contract. Therefore, the Wildlife Department was notified of the facility	F0925		

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F0925 SS = E	Continued from page 23 reporting two snakes in the building on 8/22/2025. The Contracted Pest Control Company Technician stated he was out at the facility on 8/25/2025 to conduct the monthly inspection and treatments for the building. He stated on 8/25/2025 he did not see any snakes in the building. He stated the building was proactively treated as part of the monthly program for rodents/mice and rodents/mice had not been an issue in the building. In a phone interview with Nurse #1 on 9/10/2025 at 11:40 am, she stated a diamond head shaped approximately 6-inch small snake was observed on 8/25/2025 around 9:00 pm in the hallway at the dining room door nearest to the residents' rooms. Nurse #1 stated she was from the country and new the snake was a copperhead. She explained another unknown named staff member gathered the snake in a box and removed the snake from the facility. Nurse #1 stated there were no residents around the snake and she notified the Administrator and the DON via text of the snake sighting. The distance from the closest resident room to the closest door of the dining room measured 63 feet. In an interview with the DON on 9/10/2025 at 4:39 pm, she stated Nurse #1 notified her via a group text that included the Administrator on 8/25/2025 at 9:00 pm of a snake at the door of the dining room. The DON stated when the Administrator requested Nurse #1 to send him a photo of the snake, Nurse #1 stated the snake had already been removed by a staff member and the Administrator reported the contracted pest control technician had been to the facility and treated the building on 8/25/2025. In an interview with the Administrator on 9/11/2025 at 12:35 pm, he stated on 8/25/2025 the Contracted Pest Control Company Technician had informed the receptionist that the wildlife department had been notified to treat for snakes in the building. He stated on 8/26/20205 the building was inspected exteriorly by the Maintenance Director, and an interior inspection was conducted by the Administrator with no further snake findings reported. In an interview with the Maintenance Director on 9/11/2025 at 3:10 pm, he stated the facility did not have snake repellent materials to applied exteriorly to	F0925		

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F0925 SS = E	Continued from page 24 the building. A Wildlife Department report dated 8/29/2025 recorded the building was surveyed interiorly and exteriorly and there were no snakes removed from the building. The wildlife department technician recorded snake deterrent was applied around every door of the building to prevent future entry of snakes. In a phone interview with the Wildlife Department Technician on 9/12/2024 at 12:22pm, he stated on 8/29/2025 there were no snakes or mice observed in the building and snake deterrent material was applied around the doors exteriorly. He explained snake deterrent materials were not applied in the interior of the building and encouraged the facility to keep the exterior grounds and interior rooms and offices clean to deter pest that may attract snakes. He explained snake deterrent treatment should last for 4-6 months and the facility should consider retreating with a snake deterrent in the springtime. In an interview with the Administrator on 9/11/2025 at 12:35 pm, he explained there was not a resident safety concern because when the snakes were observed in the building, the snakes were not close to a resident and were disposed of immediately. He stated there had been no further sighting of snakes in the building since the wildlife department technician applied deterrent outside the building around the doors. In an interview with the Regional Vice President of Operations on 9/11/2025 at 12:40 pm, he stated there was a repairman scheduled to come to the facility on 9/11/2025 to close the half inch opened space area between the two front entrance doors where pests could enter the building. On 9/12/2025 at 2:30pm, the front entrance doors were observed with the half inch open space at the bottom when the two front doors were closed. There was enough space for a snake to enter the building.	F0925		