STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345166	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stokes County Nursing Home	**1570 NC 8 and 89 Highway , Danbury, North Carolina, 27016**

(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
E0001	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:	E0001	Corrective action to be accomplished for the deficient practice: Policies and procedures have been in place for the CAH Emergency Preparedness, to include the Long Term Care (LTC) but were not identified as specific to the LTC. The staff are knowledgeable of the CAH emergency preparedness plan. A separate Emergency Preparedness Manual is being developed for the LTC to include the required components. The Nursing home conditions of participation will be reviewed to ensure all components are updated and/or added to ensure compliance. Address how the facility will identify other issues with the potential to be affected by the same deficient practice: Policies and procedures have been in place for the CAH Emergency Preparedness, to include the Long Term Care (LTC) but were not identified as specific to the LTC. The staff are knowledgeable of the CAH emergency preparedness plan. A separate Emergency Preparedness Manual is being developed for the LTC to include the required components. The Nursing home conditions of participation will be reviewed to ensure all components are updated and/or added to ensure compliance by the Assistant Administrator/Safety Officer. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The Emergency Program (EP) for CFR(s) 483.73 will be utilized along with all conditions of participation to develop an Emergency Preparedness Manual for the LTC. This manual will be a separate document from the CAH Emergency Preparedness manual to ensure all required LTC components are included and that the plan is integrated with the Facility Assessment. The LTC staff will participate in the development of the unified and integrated EP program. The EP plan will be accessible to staff in hard copy as well as on the shared drive and they will be trained on how to utilize the EP plan in an emergency. This manual will be approved by the Housewide Safety Committee, QAPI, Housewide QI, Medical Staff and	02/03/2026

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 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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E0001	Continued from page 1 This CONDITION is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to maintain annual emergency preparedness updates, the facility assessment and all-hazard approach, including missing residents. The facility failed to provide primary and alternate means for communication with facility staff, residents, responsible parties and Federal, State, regional and local emergency management agencies. The facility failed to develop a minimum subsistence need for staff and residents during an emergency. The facility failed to provide a procedure for the tracking of staff and residents during an emergency. The facility failed to provide a method of sharing information and medical documentation for residents under the Long-Term Care (LTC) facility's care, as necessary, with other health care providers. The facility failed to have a method for sharing the information from the emergency plan. The facility failed to complete staff training on the emergency preparedness plan. The facility failed to demonstrate that the LTC entity participated in the development of the unified Emergency preparedness program. This deficient practice had the potential to affect all residents and staff. The findings included: The facilities Emergency Preparedness (EP) program plan dated for the year 2025 (no day or month identified) was reviewed and revealed: a. The EP plan did not include the facility assessment, and the all-hazard approach did not include missing residents and strategies for addressing emergency events are not identified by the risk assessment. b. The EP plan did not include delegation of authority and succession plans during an activation of the EP program. c. The EP plan did not have evidence that included a process for cooperation and collaboration with local, regional, State, and Federal EP program officials during a disaster or emergency situation. This includes documentation of the Long-Term Care (LTC) facility's efforts to contact such officials. d. The EP plan did not include the development and implementation of a communication plan within the EP policy and procedures. e. The EP plan did not include at a minimum, the provision of subsistence needs for staff and residents	E0001	Continued from page 1 governing board. Key elements that are will be part of the emergency preparedness program include: Integration with the facility assessment and the all-hazard approach for missing residents and strategies for addressing emergency events that are not identified by the risk assessment. Delegation of authority and succession plans during an activation of the EP program. A process for cooperation and collaboration with local, regional, State and Federal EP program officials during a disaster or emergency situation to include documentation of the Long Term Care (LTC) facility's efforts to contact such officials. Development and implementation of a communication plan within the EP policy and procedures. The provision of subsistence needs for staff and residents whether they evacuate or shelter in place including food, water, medical supplies, pharmaceutical supplies, alternate source of energy to maintain temperature, emergency lighting, fire detection, extinguishing, and alarm systems and sewage and waste disposal. A system to track the location of on-duty staff and sheltered patients in the LTC facility's care during an emergency. Policies and procedures that include a system of medical records that preserves the resident's information, protects confidentiality of resident information, and secures and maintains the availability of records. Evidence that a communication plan is developed that maintains and complies with Federal, State and local laws with a process to review at least annually. Names and contact information for other LTC facilities, and all staff and volunteers. Contact information for Federal, State, regional or local emergency preparedness staff, State Licensing and certification Agency, and other sources of assistance. Policies and procedures for primary and alternate means of communication with external sources of assistance.	

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E0001	Continued from page 2 whether they evacuate or shelter in place, including food, water, medical supplies, pharmaceutical supplies, alternate source of energy to maintain temperatures, emergency lighting, fire detection, extinguishing, and alarm systems and sewage and waste disposal. f. The EP plan did not include a system to track the location of on-duty staff and sheltered patients in the Long-Term Care (LTC) facility's care during an emergency. g. The EP plan did not include policies and procedures that include a system of medical records that preserves the resident's information, protects confidentiality of resident information, and secures and maintains the availability of records. h. The EP plan did not have evidence that a communication plan was developed and maintained that complied with Federal, State and local laws and was reviewed at least annually. i. The EP plan did not include the names and contact information for other LTC facilities, and all staff and volunteers. j. The EP plan did not include the contact information for Federal, State, regional or local emergency preparedness staff, State Licensing and certification Agency, or other sources of assistance. policies and procedures for primary and alternate means of communication with external sources of assistance. k. The EP plan did not include primary and alternative means of communication with LTC facility staff and Federal, State, regional, and local emergency management agencies. l. The EP plan did not include a method of sharing information and medical documentation for residents that were under the LTC facility's care with other health providers to maintain continuity of care. m. The EP plan did not include a means of providing information about the LTC facility's occupancy, needs and its ability to provide assistance to the authority having jurisdiction, the incident command center or designee. n. The EP plan did not include a method for sharing information from the EP plan, that the facility has determined is appropriate, with residents and their families or representatives.	E0001	Continued from page 2 Primary and alternative means of communication with LTC facility staff and Federal, State, regional and local emergency management agencies. A method of sharing information and medical documentation for residents that were under the LTC facility's care with other health providers to maintain continuity of care. A means of providing information about the LTC facility's occupancy, needs and the ability to provide assistance to the authority having jurisdiction, the incident command center or designee. A method for sharing information that the facility has determined is appropriate, with residents and their families or representatives. After full implementation, an annual review of policies and procedures for compliance with current conditions of participation will be completed by the Assistant Administrator/Safety Officer. Indicate how the facility will monitor our performance to make sure that solutions are sustained: Full implementation of the separate manual which is integrated with the Facility Assessment will be completed by February 3, 2026 when the annual CAH Emergency Preparedness review and revision is complete. Education of the LTC staff regarding the new manual, policies and procedures and resources will be completed as soon as the manual and updates are finalized. A tabletop drill for second requirement will be completed by January 31, 2026. This work will be completed by the Assistant Administrator/Safety Officer. Monthly updates will be provided to QAPI and Housewide QI regarding revisions and any activation of emergency procedures by the Assistant Administrator/Safety Officer or her designee.	

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E0001	Continued from page 3 o. The EP plan did not include documentation, nor did staff demonstrate their knowledge of the emergency preparedness plan. p. The EP plan did not demonstrate the LTC staff's active participation in the development of the unified and integrated EP program. On 11/20/2025 at 2:30 pm the Assistant Administrator was interviewed and stated the emergency plan ran from February to February each year. She based the EP program on the Hospital requirements and was not aware the LTC EP program had specific requirements that need to be met. The Assistant Administrator stated she was unaware the EP plan needed to always be accessible to the staff and that the staff needed to be trained in how to utilize the EP plan in an emergency. The EP program book was in the Assistant Administrators office. On 11/20/2025 at 3:40 pm the Facility Administrator was interviewed and provided the facility reviews the LTC regulations once per year to update the EP plan, turnover has been complex, but the facility still had the responsibility to complete the EP plan per regulations	E0001		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/18/25 through 11/21/25. Event ID#1DB606-H1. The following intake was investigated #871933. 3 of the 3 complaint allegations did not result in deficiency.	F0000		12/21/2025
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §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 . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with	F0605	Corrective action to be accomplished for the residents found to be affected by the deficient practice: The facility implemented the PointClickCare EMR on May 1, 2025. Prior to this date, the paper packets for all resident MDS reviews were prepared to include AIMS completion on a quarterly basis. During the transition, the AIMS evaluation was included in EMR setup but the schedule was not implemented for this one assessment. Upon identification of this omission, the affected residents had an AIMS evaluation completed. The facility did have an interim DON from May 1, 2025 until the current DON started the role in August, 2025. Resident 30 had the AIMS evaluation completed on 11/26/2025.	11/26/2025

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F0605 SS = D	Continued from page 4 §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 . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §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- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or	F0605	Continued from page 4 Resident 2 had the AIMS evaluation completed on 11/25/2025. Resident 3 had the AIMS evaluation completed on 11/26/2025. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The facility implemented the PointClickCare EMR on May 1, 2025. Prior to this date, the paper packets for all resident MDS reviews were prepared to include AIMS completion on a quarterly basis. During the transition, the AIMS evaluation was included in EMR setup but the schedule was not implemented for this one assessment. Upon identification of this omission, all other residents on antipsychotic medications have had an AIMS evaluation completed by a registered nurse. An audit was completed on 11/26/2025 and 14 additional residents were found to have orders for at least one of the categories of anti-psychotic, anti-depressant, anti-anxiety or sedative/hypnotic. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: Education for the DON and MDS coordinator was completed by the administrator on 11/24/2025 regarding the regulations and expectations that all residents would have AIMS completed by the 11/26/2025 and then quarterly with completion of the MDS. The AIMS evaluation has been scheduled for quarterly completion as part of the MDS assessment. The AIMS evaluation will be completed by the MDS Registered Nurse. The consultant pharmacist will review the AIMS evaluation as part of their monthly review with recommendations to the primary physician as needed. Indicate how the facility will monitor our performance to make sure that solutions are sustained: The DON will review monthly that all residents have an AIMS evaluation completed as part of their MDS assessment. The DON will monitor and report monthly that the AIMS evaluations have been completed quarterly with the MDS. Performance of compliance will be monitored monthly for 1 year and recorded on the Nursing home scorecard and	

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F0605 SS = D	Continued from page 5 (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff, Physician and Consultant Pharmacist interviews, the facility failed to provide ongoing Abnormal Involuntary Movement Scale	F0605	Continued from page 5 reported quarterly to the Nursing Home QAPI meeting as well as the monthly Housewide QAPI meeting by the DON. This reporting will continue quarterly for 1 year to make sure the solution is maintained. Dates when corrective action will be completed: 11/26/2025	

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F0605 SS = D	Continued from page 6 (AIMS) assessments for potential adverse reactions to antipsychotic medications for 3 of 5 residents reviewed for unnecessary medications (Residents #30, #2, and #3). The findings included: a. Resident #30 was readmitted on 6/13/24 with diagnoses including dementia with behaviors and generalized anxiety disorder. Physician order dated 6/13/24 included Olanzapine (antipsychotic) oral tablet 2.5 milligrams (MG). Give one (1) tablet by mouth at bedtime related to unspecified dementia, unspecified severity with other behavioral disturbances. Resident #30's active care plan dated 6/2/25 indicated a risk for complications related to the use of psychotropic and antipsychotic medications. Interventions included AIMS testing per protocol. Resident #30's medical record documented one AIMS assessment on file dated 3/10/25. There were no other AIMS found in the medical record. b. Resident #2 was admitted on 11/22/22 with diagnoses including unspecified dementia unspecified severity without behavior, psychotic disturbance, mood disturbance, and anxiety. Physician order dated 5/15/25 included Olanzapine (antipsychotic) oral tablet 5 milligrams (MG). Give one (1) tablet by mouth one time a day related to unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Resident #2's active care plan dated 5/15/25 revealed goals and interventions for Resident #2's medication, Olanzapine. The interventions included monitoring/documenting for side effects and effectiveness. There were no interventions for an AIMS to be completed. The quarterly Minimum Data Assessment (MDS) dated 10/8/25 revealed Resident #2 was severely cognitively	F0605		

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F0605 SS = D	Continued from page 7 impaired. The MDS also revealed Resident #2 received antipsychotic medications. Review of Resident #2’s medical record revealed there were no AIMS assessments completed. c. Resident #3 was readmitted to the facility on 6/2/25 with diagnoses including unspecified dementia, unspecified severity, with other behavioral disturbance; anxiety disorder; anxiety with delusional thoughts and behaviors harmful to self and others with psychotic features and lying; major depressive disorder, recurrent, unspecified multiple episodes of paranoia and restlessness; cerebral infarction. Resident #3’s active care plan after re-admission to the facility dated 6/10/25 did not have focus, goals and interventions for antipsychotic medication. Physician order dated 6/30/25 included Quetiapine Fumarate (antipsychotic) oral tablet 50 milligrams (MG). Give one (1) tablet by mouth in the morning related to anxiety disorder; major depressive disorder, recurrent; and give 2 tablets by mouth at bedtime related to anxiety disorder, unspecified; major depressive disorder, recurrent. The quarterly Minimum Data Set (MDS) dated 8/1/25 revealed Resident #3 was cognitively intact and was coded for having verbal behaviors towards others 1-3 days during the look back period. The MDS also documented Resident #3 received antipsychotic and antidepressant medications routinely. The last Gradual Dose Reduction (GDR) documented was 5/19/25. Review of Resident #3’s medical record revealed there were no AIMS assessments completed. An interview with the Director of Nursing (DON) on 11/19/25 at 2:30 PM revealed she was unaware the AIMS assessments were not being completed. She stated prior to her employment, the previous DON did not follow through with obtaining AIMS and she stated the unit went without a DON for “a while” and no one else followed up so the AIMS have not been completed as needed. The DON was unaware how often and when the AIMS assessments needed to be completed. She also stated in	F0605		

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F0605 SS = D	Continued from page 8 the past, the nurses were responsible for completing the AIMS assessments. The DON indicated there was not a process in place to alert staff when the AIMS assessments were due. She stated the AIMS assessments should have been completed as required. An interview was held with the Pharmacy Consultant on 11/19/25 at 3:45 PM. The Pharmacy Consultant stated she did not think the AIMS assessments still needed to be completed for residents prescribed antipsychotic medications. She indicated the AIMS was completed in one of the sections of the MDS. The Pharmacy Consultant stated she had not seen an AIMS assessment form in any of the residents' records. An interview with the Medical Director on 11/20/25 at 9:55 AM indicated he was unaware when and how often the AIMS assessment needed to be completed. He stated he would set up a meeting with the DON regarding completing the AIMS assessments. An interview conducted with the facility Physician on 11/20/25 at 10:22 AM revealed he did not complete the AIMS assessment for residents on antipsychotics. He discussed that since the facility had begun using the electronic medical record, he was unaware if staff were completing them. He stated since he assessed residents monthly, and if not monthly, then every other month, he could potentially add it to his list to do. The facility Physician stated he would meet with the DON to determine who would complete the AIMS going forward. An interview was held with the Administrator on 11/20/25 11:46 AM. The Administrator was made aware the AIMS assessments were missing or were past due. She stated the nursing staff historically were responsible for completing the AIMS assessments. Prior to transitioning to the electronic medical record, the AIMS assessment was included in a paper "MDS packet." The AIMS assessment was supposed to be built into the electronic medical record software, but it was not. The Administrator stated other contributing factors to the missing and past due AIMS assessments were the MDS coordinator left in April 2025, the transition from paper chart to electronic medical record (EMR) at the end of May/beginning of June, and the previous DON left on 5/01/25.	F0605		
F0657 SS = D	Care Plan Timing and Revision	F0657	Corrective action to be accomplished for the residents found to be affected by the deficient practice:	01/16/2026

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F0657 SS = D	Continued from page 9 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and resident and staff interviews, the facility failed to revise the comprehensive care plan to include antipsychotic medication use for 1 of 5 residents reviewed for care plans (Resident #3). The findings included: Resident #3 was readmitted to the facility on 6/2/25 with diagnoses including dementia with behavioral disturbance, anxiety disorder, anxiety with psychotic features and, recurrent unspecified major depressive disorder. A review of Resident #3's active comprehensive care plan dated 6/10/25 did not reveal a care plan had been	F0657	Continued from page 9 The care plan for resident 3 was updated to include a plan for antipsychotic medication on 11/21/2025. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: A query for all residents on antipsychotic medications was run 11/26/2025 to identify other residents having potential to be affected. Five other residents were identified as having antipsychotic medication orders in November but one resident order had been discontinued. The other four residents had care plans in place for taking antipsychotic medication Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: A monthly query will be completed for residents taking antipsychotic medications as well as anti-anxiety, anti-depressant, and sedative-hypnotic medications by the DON. All resident care plans will be reviewed by the DON or her designee to ensure they are care planned for each of these medication types. Education was provided as a memo communication for all nurses regarding alerting the DON or MDS Coordinator of changes to medications and specifically for anti-psychotics, anti-depressants, anti-anxiety and sedative/hypnotic medications. The memo stressed that the alert is essential for the needed care plan timing and revision to be completed as soon as possible. In addition, for proper notification and documentation of patient, family and/or POA regarding the medication implementation or change. The Memo communication was posted on January 16, 2025 by the DON. Indicate how the facility will monitor our performance to make sure that solutions are sustained: The DON will perform the monthly query for all residents with orders for these medication classifications and ensure they are care planned. The DON or her designee will report compliance with care planning. Performance of compliance will be monitored monthly for 1 year and recorded on the nursing home scorecard and reported monthly to the Housewide QAPI committee and quarterly to the Nursing Home QAPI. This reporting will continue quarterly for 1 year to make sure the solution is maintained. Dates when corrective action will be completed:	

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F0657 SS = D	Continued from page 10 initiated for antipsychotic medication use. Resident #3's physician's orders revealed an order dated 6/29/25 to give one tablet of Quetiapine Fumarate (an antipsychotic medication) 50 milligrams (MG) by mouth in the morning and give two tablets by mouth at bedtime related to unspecified anxiety disorder and unspecified recurrent major depressive disorder. Review of Resident #3's Medication Administration Record (MAR) from June 2025 through November 2025 revealed Resident #3 received Quetiapine Fumarate as ordered. The MAR also indicated Resident #3 was observed three times per day for side effects and behaviors. The quarterly Minimum Data Set (MDS) dated 8/1/25 revealed Resident #3 was cognitively intact and was coded for having verbal behaviors towards others 1-3 days during the look back period. The MDS also documented Resident #3 received antipsychotic medications routinely. The quarterly MDS dated 10/21/25 indicated Resident #3 was cognitively intact with no behaviors coded and received antipsychotic medication on a routine basis. An interview with the Director of Nursing (DON) on 11/20/2025 at 3:20 PM revealed she was not aware the care plan for Resident #3 did not include a plan for the antipsychotic medication, but there should be one. She stated the MDS coordinator or Administrator created and updated the care plans. Interview with the MDS Coordinator on 11/20/25 at 4:12 PM revealed that she was in training and was not responsible for creating care plans. She stated the Administrator was responsible for initiating and updating resident care plans. The Administrator was interviewed on 11/20/25 at 4:14 PM. The Administrator was made aware the care plans for Resident #3 did not include a care plan for antipsychotic medication. She stated the previous MDS Coordinator created resident care plans. The Administrator explained she had assisted with creating and updating care plans while the new MDS Coordinator was training. She stated the care plan was missing because Resident #3 was discharged to the hospital and later readmitted (6/2/25). Resident #3 was not prescribed an antipsychotic upon readmission. Resident #3 began to exhibit behaviors, and the antipsychotic medication was restarted on 6/29/25. The Administrator stated the care plan was not updated after the	F0657	Continued from page 10 1/16/2026	

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F0657 SS = D	Continued from page 11 antipsychotic medication was resumed.	F0657		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 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 REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews, the facility failed to post cautionary and safety signage that indicated the use of oxygen for 3 of 4 residents reviewed for respiratory care (Residents #2, #5, and #37). The findings included: a. Resident #2 was admitted to the facility on 11/22/22 with the diagnosis of Streptococcus pyogenes (Contagious bacterial infection that causes swelling and sudden painful sore throat). Resident #2’s physician orders dated 6/19/25 revealed an order for oxygen to be administered continuously via nasal cannula at 2 liters per minute (lpm) to keep oxygen level above 90% (normal range for oxygen level is 95-100%) as needed. Resident #2’s annual Minimum Data Set (MDS) dated 10/8/25 indicated Resident #2 was coded for receiving oxygen. Observations on 11/18/25 at 12:11 PM, 11/19/25 at 9:06 AM, 11/19/25 2:37 PM and 11/20/25 at 9:17 AM revealed Resident #2 was lying in bed in his room wearing a nasal cannula with oxygen administered at 2 lpm. There was no cautionary or safety signage posted at Resident #2's room to indicate oxygen was in use during the observations.	F0695	Corrective action to be accomplished for the residents found to be affected by the deficient practice: The Purchasing Manager ordered magnetic oxygen in use signage on 12/08/2025 and the magnetic signs were received on 12/12/2025. These magnetic signs have been placed on the door frame to the resident rooms for Residents 2, 5, and 37. The policy and procedure for oxygen therapy was updated on November 25, 2025 to include placing the oxygen in use sign on the door of the resident receiving oxygen. Staff have been educated per review of the updated policy and procedure regarding the need for signage and to place signage for any resident who has oxygen therapy implemented. The education was provided by the DON beginning November 25, 2025 through December 12, 2025. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit was completed on 11/26/2025 to determine how many other residents had an order for oxygen therapy. There were 8 additional residents who had oxygen therapy orders and have magnetic signs that have been placed on the door frame to the resident room. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: A monthly review of all residents with oxygen orders will be completed by the DON. The list will be utilized to ensure the magnetic signage is in place. An extra supply of magnetic signs is in stock in the event a new order for another resident is received. Education regarding the policy and procedure for oxygen therapy and signage is part of the nursing orientation checklist. Indicate how the facility will monitor our performance to make sure that solutions are sustained: The DON or her designee will report the percent of compliance with signage monthly. Performance of compliance will be monitored monthly for 1 year and recorded on the nursing home Scorecard and reported	12/12/2025

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F0695 SS = D	Continued from page 12 b. Resident #5 was admitted to the facility on 6/12/24 with a diagnosis of chronic obstructive pulmonary disease (COPD). On 11/17/25, the physician ordered oxygen to be administered to Resident #5 at 2 liters per minute via nasal cannula. Observations conducted on 11/18/25 at 12:12 PM, 11/19/25 at 2:52 PM, and 11/20/25 at 9:17 AM revealed there was no cautionary signage at Resident #5's room indicating oxygen was in use. Resident #5 was in her room using oxygen delivered via nasal cannula during the observation times. c. Resident #37 was admitted to the facility on 1/30/20 with the diagnosis of COPD. Resident #37's physician orders dated 6/19/25 revealed an order for oxygen to be administered continuously via nasal cannula at 2 lpm to keep oxygen level above 90% as needed. A review of the annual MDS dated 10/8/25 indicated Resident #2 was coded for receiving oxygen. Observations on 11/18/25 at 12:11 PM, 11/19/25 at 9:06 AM, 11/19/25 2:37 PM and 11/20/25 at 9:17 AM revealed Resident #37 was lying in bed in her room wearing a nasal cannula with oxygen administered at 2 lpm. There was no cautionary or safety signage posted at Resident #37's room to indicate oxygen was in use during the observations. An interview with Nurse Aide (NA) #5 was conducted on 11/19/25 at 2:34 PM. She stated she does not recall ever seeing cautionary signs at the residents' doors for oxygen in use. The NA stated she was made aware of which residents were on oxygen during her shift report. She was unaware of why there were no signs. An interview was conducted with Nurse #6 on 11/19/25 at 2:52 PM. The Nurse stated she had not seen any oxygen in use signs posted in the facility. On 11/20/25 at 9:21 AM an interview was conducted with	F0695	Continued from page 12 monthly to the Housewide QAPI committee and quarterly to the Nursing Home QAPI committee. This reporting will continue quarterly for 1 year to make sure the solution is maintained. Dates when corrective action will be completed: 12-12-2025	

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F0695 SS = D	Continued from page 13 the Director of Nursing (DON). The DON stated the facility did not need precaution signs for oxygen in use since they were a smoke free facility. An interview with the Administrator was conducted on 11/20/25 at 3:26 PM. The Administrator stated no smoking signs were posted throughout the campus. She stated with being a smoke free facility, there was no need for cautionary oxygen in use signs on the residents' doors.	F0695		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors.	F0732	Corrective action to be accomplished for the deficient practice: The Nurse Staffing Information sheet was revised on 11-22-25 to include all required elements. A Policy and Procedure for "Completion of the Daily Nurse Staffing Report" was developed on 12-3-2025. Training was completed for all charge nurses regarding the required fields and updates needed if staffing or census changes after the posting has been completed. Each shift will update the sheet for current census and staffing per policy. Address how the facility will identify other issues with potential to be affected by the same deficient practice: The Nurse Staffing Information sheet was revised on 11-22-25 to include all required elements. A Policy and Procedure for "Completion of the Daily Nurse Staffing Report" was developed on 12-3-2025. Training was completed for all charge nurses regarding the required fields and updates needed if staffing or census changes after the posting has been completed. Each shift will update the sheet for current census and staffing per policy. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The Nurse Staffing Information sheet was revised on 11-22-25 to include all required elements. A Policy and Procedure for "Completion of the Daily Nurse Staffing Report" was developed on 12-3-2025. Training was completed for all charge nurses regarding the required fields and updates needed if staffing or census changes after the posting has been completed. Each shift will update the sheet for current census and staffing per policy. Shift reviews of form completion with each charge nurse	12/05/2025

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F0732 SS = C	Continued from page 14 §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff interviews, the facility failed to post accurate daily nurse staffing information for 30 of 30 days reviewed (10/20/25, 10/21/25, 10/22/25, 10/23/25, 10/24/25, 10/25/25, 10/26/25, 10/27/25, 10/28/25, 10/29/25, 10/30/25, 10/31/25, 11/1/25, 11/2/25, 11/3/25, 11/4/25, 11/5/25, 11/6/25, 11/7/25, 11/8/25, 11/9/25, 11/10/25, 11/11/25, 11/12/25, 11/13/25, 11/14/25, 11/15/25, 11/16/25, 11/17/25, and 11/18/25). The findings included: A review of the daily nurse staffing sheets dated 10/20/25 to 11/18/25 revealed: - The Registered Nurse (RN)/Licensed Practical Nurse (LPN) designation was not indicated for the assigned nurses. -The census was not listed and left blank for the morning (7:00 AM- 3:00 PM) and evening shifts (3:00 PM- 11:00 PM) for 10/21/25, 10/26/25, 10/27/25, 10/30/25, 11/5/25, 11/13/25, 11/16/25, and 11/18/25. -The census was also not listed and left blank for the evening shifts (3:00 PM- 11:00 PM) for 10/20/25, 10/23/25, 10/24/25, 10/25/25, 10/28/25, 10/29/25, 11/3/25, 11/4/25, 11/6/25, 11/10/25, 11/11/25, 11/12/25, 11/14/25, 11/15/25, and 11/17/25. An interview conducted with Nurse #1 on 11/21/25 at 9:11 AM revealed she was trained on how to complete the daily staffing report during her orientation with an LPN preceptor. Her employment started in April 2025. She was aware that all areas on the form needed to be completed. However, she only documented the census for	F0732	Continued from page 14 have been informally completed to allow them to ask questions and provide clarification. Indicate how the facility will monitor our performance to make sure that solutions are sustained: Performance of compliance will be monitored monthly for 1 year and recorded on the nursing home Scorecard and reported quarterly to the Nursing Home QAPI meeting as well as the monthly Housewide QAPI meeting. This reporting will continue quarterly for 1 year to make sure the solution is maintained.	

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F0732 SS = C	Continued from page 15 the 11:00 PM to 7:00 AM shift because the number could change with the other shifts. Nurse #1 stated she was not aware the designation of RN and LPN needed to be listed beside each nurse's name. An Interview held with the Director of Nursing (DON) on 11/21/25 at 11:41 AM revealed she was unsure how training was completed for the nurses completing the daily staffing report. She stated it was always completed before she arrived at work in the mornings. The DON also stated she was not aware that the census needed to be fully completed. She thought it was per day, not per shift. However, this facility's report was always completed by the night shift nurse. She was not sure if the designation between RN/LPN was a "state thing" or a facility process. An interview with the Administrator on 11/21/25 at 11:04 AM indicated the nurses received training on completing the daily staffing report during orientation with their preceptor. The Administrator stated all areas of the report should be completed including the census. She also stated each nurse should have their designation listed next to their name determining whether they were an RN or LPN. The Administrator stated education would be provided to staff on how to correctly complete the daily staffing report and was not sure why the daily staffing report was being completed incorrectly.	F0732		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §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)	F0756	Corrective action to be accomplished for the residents found to be affected by the deficient practice: The AIMS assessment was completed for Resident 3 on 11-26-25 and the consultant pharmacist report was completed on 12-6-25 to include review of behaviors, labs, weight, vital signs, pain and blood glucose levels as well as GDR recommendation to the physician. The AIMS assessment was completed for Resident 30 on 11-26-25 and the consultant pharmacist report was completed on 12-5-25 to include review of behaviors, labs, weight, vital signs, pain as well as GDR recommendation to the physician. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: A query/audit of all residents was completed on 11-26-2025 to identify any residents who were receiving anti-psychotic, anti-depressant, anti-anxiety or	01/13/2026

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F0756 SS = D	Continued from page 16 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 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 REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with staff, Pharmacy Consultant, Facility Physician, and the Medical Director, the Pharmacy Consultant failed to identify and report irregularities when conducting monthly drug regimen reviews for 2 of 5 residents reviewed for unnecessary medications (Resident #3, and Resident #30). The findings included: a. Resident #3 was readmitted to the facility on 6/2/25 with diagnoses including unspecified dementia with unspecified severity and other behavioral disturbance, anxiety disorder, anxiety with delusional thoughts and behaviors harmful to self and others with psychotic features and lying, recurrent unspecified major depressive disorder, multiple episodes of paranoia and restlessness, and cerebral infarction. Review of Resident #3’s medical record revealed Resident #3 did not have an Abnormal Involuntary Movement Scale (AIMS) assessment on file. The AIMS is an assessment that determines the severity of uncontrollable and involuntary movements in people prescribed antipsychotic medications.	F0756	Continued from page 16 sedative hypnotic medications. There were 15 additional residents who were receiving a medication with one of these classifications. AIMS assessments were completed for all residents on any antipsychotic or psychoactive medications by 11-26-25. The consultant pharmacist monthly reviews were all completed by 12-15-25 to include documentation of reviews of labs, vital signs, weights, behaviors, pain and recommendations to the physician. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The MDS nurse will complete a monthly query/audit to identify all residents on antipsychotic medications, anti-depressants, anti-anxiety or sedative-hypnotics and ensure AIMS assessments are completed quarterly to identify side effects. In addition, AIMS assessments will be completed on all residents by the MDS nurse at the time of their MDS assessment. The monthly report to medical staff by the consultant pharmacist will be reviewed for any irregularities or recommendations based on monthly resident reviews. A new consultant pharmacist began reviews on 1-8-2026 and completed the January reviews on 1-13-26. An educational meeting was completed by the consultant pharmacist with the hospital/nursing home pharmacist, administrator, DON and MDS coordinator on 1-13-26. Her process will be to provide monthly nursing recommendations as well as the provider recommendations and summary review. Her monthly report and all reviews and recommendations was provided to the administrator, DON, and MDS RN on 1-13-2026 and was comprehensive and complete. Indicate how the facility will monitor our performance to make sure that solutions are sustained: The DON will run the monthly query/audit and report compliance with AIMS assessment completion as well as reporting receipt and review of the consultant pharmacist report. Performance of compliance will be monitored monthly for 1 year and recorded on the nursing home Scorecard and reported monthly to the Housewide QAPI committee and quarterly to the Nursing Home QAPI committee. This reporting will continue quarterly for 1 year to make sure the solution is maintained. Dates when corrective action will be completed: 1-13-2026	

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F0756 SS = D	Continued from page 17 Resident #3's physician's orders revealed an order dated 6/29/25 to give one tablet of Quetiapine Fumarate (an antipsychotic medication) 50 milligrams (MG) by mouth in the morning related to unspecified anxiety disorder and unspecified recurrent major depressive disorder; and give two tablets by mouth at bedtime related to unspecified anxiety disorder and unspecified recurrent major depressive disorder. Review of the facility Pharmacy Consultant monthly drug regimen reviews for Resident #3 dated 7/20/25, 8/15/25, 8/18/25, 9/21/25, and 10/21/25, revealed no documentation of the need for the facility to complete AIMS assessments. b. Resident #30 was readmitted on 6/13/24 with diagnoses including dementia with behaviors and generalized anxiety disorder. Review of the physician order initiated on 6/13/24 documented an order to give one Olanzapine (antipsychotic) 2.5 milligrams (MG) tablet by mouth at bedtime related to unspecified dementia, unspecified severity with other behavioral disturbances. Resident #30's medical record documented one AIMS assessment on file dated 3/10/25 since the last recertification survey completed on 9/19/24. Review of the facility Pharmacy Consultant monthly drug regimen reviews for Resident #5 dated 8/19/25, 9/23/25, and 10/29/25 revealed no documentation of the need for the facility to complete AIMS assessments. During an interview on 11/19/25 at 3:45 PM, the Pharmacy Consultant stated she did not think the AIMS assessments still needed to be completed for residents prescribed antipsychotic medications. The Pharmacy Consultant communicated she rarely looked at the AIMS assessment unless one of the staff members informed her that a resident could be having side effects. The Pharmacy Consultant expressed she had not seen an AIMS assessment form in any of the residents' records. An interview with the Director of Nursing (DON) on 11/19/25 at 2:30 PM revealed she was unaware if the Pharmacy Consultant reviewed the residents' medical records for AIMS assessments during her monthly medication review. The DON indicated the Administrator reviewed the Pharmacy Consultant's report every month. On 11/20/25 at 9:55 AM an interview occurred with the Medical Director. He stated he was not aware if the Pharmacy Consultant performed complete medical record	F0756		

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F0756 SS = D	Continued from page 18 reviews that would include reviewing for the completion of AIMS assessments. An interview occurred with the Facility Physician on 11/20/25 at 10:22 AM. The Facility Physician was made aware that the Consultant Pharmacist was not reviewing resident medical records for AIMS assessments. He stated he was unaware the Pharmacy Consultant was not performing complete medical record reviews. The Facility Physician stated he would expect the Pharmacy Consultant to review the entire medical record during each monthly medical record review. An interview was held with the Administrator on 11/20/25 at 11:46 AM. The Administrator discussed being unaware that the Pharmacy Consultant was not reviewing the residents' medical records for an AIMS assessment. She stated she expected the Pharmacy Consultant would identify and report irregularities including the need for AIMS assessments during the monthly drug regimen reviews. The Administrator stated she did review the monthly Pharmacy Consultant reports but did not realize the Pharmacy Consultant was not reviewing for the AIMS assessments.	F0756		
F0838 SS = F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §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: §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	F0838	Corrective action to be accomplished for the deficient practice: The required elements have been added to the Facility Assessment. A contingency plan has been added to the Facility Assessment to include a plan for resident care when care is affected, but there is no need to activate the facility's emergency plan. Address how the facility will identify other issues with the potential to be affected by the same deficient practice: The required elements have been added to the Facility Assessment. A contingency plan has been added to the Facility Assessment to include a plan for resident care when care is affected, but there is no need to activate the facility's emergency plan. Initial training was completed starting December 10, 2025 through December 30, 2025. The training was conducted by the Assistant Administrator. A review of the regulations and conditions of participation is being completed by the Assistant Administrator/Safety Officer. The review began on December 10, 2025. This review includes emergency preparedness planning with Facility Assessment integration and is being completed to determine deficiencies in other areas and with other policies and	02/03/2026

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F0838 SS = F	Continued from page 19 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: (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).	F0838	Continued from page 19 procedures. This will be completed by February 3, 2026 with the Emergency Plan completion for the LTC which will be separate from the CAH. All staff will be trained when the updates are complete and the Facility Assessment has been reviewed and approved in the safety and QI/QAPI meetings. The training will be completed by the Assistant Administrator. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The required elements have been added to the Facility Assessment. A contingency plan has been added to the Facility Assessment to include a plan for resident care when care is affected, but there is no need to activate the facility's emergency plan. Initial training was completed starting December 10, 2025 through December 30, 2025 during the Annual Mandatory Training Classes. The training was conducted by the Assistant Administrator. A review of the regulations and conditions of participation is being completed by the Assistant Administrator/Safety Officer. The review began on December 10, 2025. This review includes emergency preparedness planning with Facility Assessment integration and is being completed to determine deficiencies in other areas and with other policies and procedures. This will be completed by February 3, 2026 with the Emergency Plan completion for the LTC which will be separate from the CAH. All staff will be trained when the updates are complete and the Facility Assessment has been reviewed and approved in the safety and QI/QAPI meetings. The training will be completed by the Assistant Administrator. The Facility Assessment will then be updated and approved annually and as needed changes occur. Staff will be trained on changes by the Assistant Administrator. Indicate how the facility will monitor our performance to make sure that solutions are sustained: Changes to the Facility Assessment and Emergency Plan will be completed and reported to Safety, QAPI and Housewide QI in February, 2026 by the Assistant Administrator/Safety Officer. Performance of compliance will be monitored monthly for 1 year and recorded on the Nursing Home Scorecard and reported quarterly to the Nursing Home QAPI meeting as well as the monthly Housewide QAPI meeting by the Assistant Administrator/Safety Officer or her designee. This	

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F0838 SS = F	Continued from page 20 § 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). §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.	F0838	Continued from page 20 reporting will continue quarterly for 1 year to make sure the solution is maintained. Dates when corrective action will be completed: 02/03/2026	

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F0838 SS = F	Continued from page 21 This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to ensure the facility assessment included a contingency plan that was informed by the facility assessment to address the availability of staff and other resources for events that did not require activation of the facility's emergency plan but had the potential to affect resident care. This had the potential to affect 38 of 38 facility residents. The findings included: The review of the facility assessment dated 2025 did not identify a written contingency plan that was informed by the facility assessment to address the availability of nursing staff and other resources for events that did not require activation of the facility's emergency plan but had the potential to affect resident care. An interview occurred with the Assistant Administrator on 11/20/2025 at 2:30 pm. She stated she was unaware that a contingency plan for staffing/resources for events that did not require activation of the facility's emergency plan needed to be addressed in the facility assessment. She was uncertain why this was not completed. An interview with the Director of Nursing (DON) on 11/20/2025 at 9:15 am, revealed there was no plan in writing that specified what to do when the facility had an event that had the potential to affect resident care. The DON did not know why there was not a written plan in place for staffing/resources during an event that could interrupt resident care needs. An interview with the Administrator on 11/20/2025 at 3:40 pm revealed the Facility Assessment was reviewed and revised annually, however the written contingency plan informed by the facility assessment was not included in the facility assessment. She stated that turnover had been complex related to increased management changes that started in 2025, but the facility still had a responsibility to complete the requirements of the facility assessment.	F0838		
F0919 SS = D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow	F0919	Corrective action to be accomplished for the residents found to be affected by the deficient practice: The call cord was replaced in the bathroom for Resident 28 on 11-20-2025 prior to survey completion. Address how the facility will identify other residents	01/13/2026

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F0919 SS = D	Continued from page 22 residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to ensure a resident call light system was accessible for 1 of 3 residents (Resident # 28) observed for call light system. The findings included: Resident # 28 was admitted to the facility on 12/17/2021 with multiple diagnoses that included absence of left leg above the knee. Review of the quarterly Minimum Data Set (MDS) assessment dated10/3/2025 revealed Resident # 28 was assessed as cognitively intact. Resident #28 was independent for transfers, bed mobility, and toileting. An observation of Resident # 28's bathroom was conducted on 11/18/2025 at 12:05 pm. The call light in the bathroom did not have an attached pull cord. Resident # 28 was interviewed on 11/18/2025 at 12:42 pm. The resident stated he was independent with Activities of Daily Living (ADL) which included getting out of bed, transferring, and using the toilet. Resident # 28 confirmed there was no pull cord for the call light in the bathroom and stated he could not remember the last time the call light had a pull cord. He also stated if he was lying on the floor, he would be unable to use the call light for assistance. Another observation of Resident #28's bathroom occurred on 11/19/2025 at 1:35 pm. The call light in the bathroom did not have an attached pull cord. An observation of Resident # 28's bathroom was conducted on 11/20/2025 at 8:45 am. The call light in the bathroom did not have an attached pull cord. During an interview on 11/19/2025 at 2:30 PM with Nursing Assistant (NA) #6, the NA stated Resident # 28 was able to complete all ADL independently but needed	F0919	Continued from page 22 having the potential to be affected by the same deficient practice: The Administrator did a walk through of all bathrooms on the unit to include all resident rooms and all bathrooms used by residents at the ends of the hall and outside of the dayroom on 11-20-2025. No other bathrooms were without a call cord. One call cord was replaced due to excessive wear on 11-20-2025. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The administrator educated the Housekeeping/Maintenance manager and Infection Prevention nurse on 11-20-2025 of the need for the addition of checking for the bathroom cords for compliance on their weekly rounds. A bathroom section was added to the weekly housekeeping and maintenance checklist that addresses the availability and accessibility of the call cord for all resident room bathrooms and common area bathrooms. The infection prevention nurse joins the Housekeeping/Maintenance manager on her weekly Wednesday rounds and they review them together. An additional RN was asked to complete rounds monthly round and she was educated by the administrator on 12-5-2025 regarding the resident call cords as well as general inspection of cleanliness, repairs or any other concerns. A written report for inspection of each hall has been completed and is being addressed with the Housekeeping/Maintenance manager. Documentation of these reviews will be collected and included on the Maintenance scorecard and reported monthly to Quality and quarterly to QAPI by the Housekeeping/Maintenance manager. A policy and procedure regarding "Resident Call System" was developed to guide expectations for the resident call system to include the resident restrooms as well as the need for immediate corrective action if a bedside call bell or resident bathroom cord is not present or operational. This policy has been placed on the unit for review by staff as education for their role to ensure proper resident call system function. This education began for nursing and ancillary staff on 1-13-2026. Indicate how the facility will monitor our performance to make sure that solutions are sustained: The Housekeeping/Maintenance manager will collect and report compliance monthly. Performance of compliance will be monitored monthly for 1 year and recorded on	

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F0919 SS = D	Continued from page 23 assistance with showers. An interview occurred on 11/19/2025 at 4:15pm with NA #1. She stated Resident # 28 did not ask for assistance with grooming, toileting and transferring because he was able to complete the tasks on his own. An interview occurred on 11/20/2025 8:45AM with Occupational Therapist (OT) #1. She stated Resident # 28 was independent in daily care items such as, transferring from wheelchair to bed / toilet. An interview with the Facility Maintenance Director on 11/20/2025 at 8:50 am revealed the facility had a preventative maintenance program but they had been unable to complete the preventative maintenance. He stated he was unaware of the lack of the call light pull cord in Resident # 28's bathroom. The Facility Maintenance Director stated if staff did not call him or placed the repair needed in the engineering book at the nurse's station he would not know of the concern. Observation of the engineering book on 11/20/2025 at 9:10 am revealed that from 10/1/2025 through 11/20/2025 no service request was placed in the book for a replacement of the pull cord on the call light in Resident # 28's bathroom. An interview with the facility Environmental Service Manager on 11/20/2025 at 10:10 am revealed she utilized weekly checklist to review all rooms. She stated the checklist did not address the call lights and pull cords. She observed Resident # 28's bathroom on her weekly rounds on 11/19/2025 but did not notice the pull cord was missing from the call light. The Environmental Service Manager stated if she had noticed the pull cord was missing, she would have called maintenance to fix it. An interview with the Director of Nursing (DON) on 11/20/2025 at 9:15 am revealed that she was unaware the call light did not have a pull cord and that if a resident was on the floor they would have to yell out as the call light would be unavailable. The DON stated if she was aware of the missing pull cord she would have contacted maintenance to have it replaced. During an interview with the Administrator on 11/20/2025 at 9:40 am, the Administrator stated staff communicated with the maintenance department by writing in the engineering book at the nurse's station or if the area needed an immediate response staff would call maintenance directly. She stated staff would have been expected to call maintenance with a missing pull cord	F0919	Continued from page 23 the Maintenance Scorecard and reported monthly to the Housewide QAPI committee and quarterly to the Nursing Home QAPI committee. This reporting will continue quarterly for 1 year to make sure the solution is maintained. Dates when corrective action will be completed: 01/13/2026	

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F0919 SS = D	Continued from page 24 for the call light system.	F0919		