STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Health and Rehabilitation	**625 Ashland Street , Archdale, North Carolina, 27263**

(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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted from 02/15/26 through 02/19/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 1E3FF6-H1.	E0000		03/07/2026
F0000	INITIAL COMMENTS The survey team entered the facility on 2/15/26 to conduct a recertification and complaint investigation survey and exited on 2/18/26. Additional information was obtained on 2/19/26. Therefore, the exit date was changed to 2/19/26. Event ID# 1E3FF6-H1. The following intakes were investigated: 2743637, 798464, 798468, 2743098, 798472, 2604989, 798475, 798469, 798473, 798474, 2704092, 2707362, and 2705358. 6 of the 24 complaint allegations resulted in deficiency.	F0000		03/07/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of	F0550	1. On 02/16/2026, the Human Resource Coordinator/Nursing Assistant immediately ensured Resident #21 received assistance and that care needs were addressed. Staff involved in the incident were identified and counseled regarding expectations for prompt response to resident call lights and maintaining resident dignity. On 02/24/2026, the Director of Nursing reinforced expectations with staff regarding timely response to resident call lights and respectful care practices. 2. On 02/24/2026, the Director of Nursing or designee conducted a review of call light response practices on the affected unit and for residents requiring frequent assistance. Observations were completed to ensure resident call lights were responded to promptly and resident needs were addressed.	03/06/2026

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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F0550 SS = D	Continued from page 1 condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, observations, resident, and staff interviews, the facility failed to treat a resident in a dignified manner when there was a delay in answering a resident ‘s call light for 1 of 4 residents (Resident #21) reviewed for dignity. The findings included: Resident #21 was admitted to the facility on 01/23/26 with diagnosis that included type 2 diabetes mellitus, acute arterial ischemic stroke, multifocal, bipolar I disorder, current manic with psychotic features and Schizophrenia. Resident #21’s admission care plan dated 01/23/26 did not have a focus area for behaviors. An admission Minimum Data Set (MDS) assessment dated 01/29/26 indicated Resident #21’s cognition was intact. Resident #21 required moderate assistance by staff with oral hygiene, ambulating 10 feet, chair/bed to chair transfers, and personal hygiene, maximum assistance by staff with upper body dressing, bed mobility, and toileting transfers, and he was dependent on staff for toileting hygiene, and to shower/bathe self.	F0550	Continued from page 1 No additional concerns were identified. All residents have the potential to be affected by the deficient practice. 3. On 02/24/2026, the Director of Nursing implemented an “All Staff Respond” expectation requiring any available staff member to respond immediately to resident call lights or obtain assistance. The Director of Nursing reinforced expectations with staff during shift huddles and incorporated the expectation into orientation for new employees and contracted staff. On 02/24/2026, education was provided to all staff including contracted staff regarding Resident Rights, resident dignity, and expectations for timely response to resident call lights. All new hires and contracted staff including nursing, therapy, dietary, housekeeping, activities, and administrative staff will receive the same education during orientation. An ADHOC Quality Assurance Performance Improvement Committee meeting was held on 02/24/2026 to review the deficient practice and approve the plan of correction. 4. Beginning 03/04/2026, the Director of Nursing or designee will conduct observational audits related to call light response and resident dignity. Two nursing halls will be audited weekly for four weeks to ensure call lights are answered promptly and resident dignity is maintained. audits will then be conducted on one hall monthly for two additional months. Any failed audit will result in same-day staff re-education and manager follow-up will be brought to the committee by Administrator. Audit results and trends will be reviewed through the facility’s Quality Assurance and Performance Improvement (QAPI) process for 3 months or until substantial compliance is maintained. The Administrator will present the audit findings to the QAPI committee for review. All corrective actions and systemic changes will be fully implemented by the Executive Director by	

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F0550 SS = D	Continued from page 2 A continuous observation was completed on 02/16/26 from 11:10 AM until 11:31 AM of Resident #21's call light being on and he was yelling for assistance. ("Hey, someone help me, hey come here, I need help".) At approximately 11:16 AM This surveyor was at the doorway of Resident #21's room and advised him I would get him some assistance. Nursing Assistant (NA) #3 was in the room next door to him. She stated she would get to him as soon as possible. Resident #21 started yelling out again and continued to do so until approximately 11:30 AM this surveyor went to the nurses' station where 5 staff members (Medication Aide (MA) #2, Human Resource Coordinator/Nursing Assistant (NA), Nurse #2, NA #4, and NA #5) were at. The nursing staff acknowledged the call bell being on, but they did not know how long it had been on. The call light was observed and heard at the beginning of the hall in front of nurses' station. This surveyor asked the staff if they assisted with answering call lights, MA #2 stated "oh he does that," he yells out for assistance", however she did not go to assist Resident #21. Human Resource Coordinator/NA was passing this surveyor approached the nurses' station to assist Resident #21. MA #2 then stated, "I don't know I just got up here". This surveyor asked the staff two more times if they assisted with answering call lights, Nurse #2, NA #4, and NA #5 did not respond to this surveyors' questions. An interview was conducted on 02/16/26 at 11:16 AM with Resident #21. He was yelling out "Hey, someone help me, hey come here, I need help". This surveyor approached Resident #21's room at the door and advised him I would get him some assistance. Resident #21 stated he had been yelling for assistance for approximately 30 minutes, and no one had come to his room. Resident #21 stated he can see the time on his television and that was how he tracked how long it would take staff. He explained this occurred all the time and it did not matter what concern he needed. He indicated this time he needed to be up for therapy. He went on to say he would wait for up to an hour or more waiting for staff to answer his call light but they "just don't care". He then stated it made him upset and frustrated when the staff don't answer his call light. An interview was conducted on 02/18/26 at 4:02 PM with the Director of Nursing (DON). The DON stated she was unaware of the wait times and staff not answering Resident #21's call bell. She was aware that Resident #21 would yell out, scream, and use his call light for assistance. She explained that Resident #21 had mental health conditions that sometimes affected his sense of time. She also stated her expectations were for the call lights to be answered by all staff.	F0550	Continued from page 2 03/6/2026.	

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F0550 SS = D F0577 SS = C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews, the facility failed to post the most recent survey of the facility in the survey results notebook. This occurred for 2 of 4 days of the survey (2/15/26 and 2/17/26). Findings included: According to the iQIES database system, the facility's most recent survey was a complaint investigation survey completed on 11/7/25. During tours of the facility on 2/15/26 at 9:45 AM and	F0550 F0577	1. Upon receipt of the CMS 2567 on 02/27/2026, the facility immediately ensured that survey results, certifications, complaint investigations, and plans of correction for the preceding three years were available for public review in the designated survey notebook located in the facility lobby. The Administrator verified that the survey notebook was present, organized, and accessible to residents, families, and visitors without restriction. The following surveys were verified as present and available for review: Complaint investigation survey dated 01/30/2024 Focused infection control survey dated 04/08/2024 Complaint investigation survey dated 08/22/2024 Recertification survey dated 11/21/2024 Complaint investigation survey dated 12/30/2024 Complaint investigation survey dated 01/15/2025 Complaint investigation survey dated 07/15/2025 Complaint investigation survey dated 11/07/2025. Survey results remained available for review upon request and no residents were negatively impacted by the deficient practice. 2. On 03/04/2026, the Administrator verified that the survey results notebook located in the facility lobby contained survey results, certifications, complaint investigations, and plans of correction for the previous three years. The Administrator confirmed that the survey results notebook was accessible to residents, families, and visitors for review. Residents and families have the ability to review survey results at any time upon request. All residents have the potential to be affected by the deficient practice; however, no residents were identified as impacted. 3.The Vice President of Operations provided re-education to the Administrator on 03/04/2026 regarding regulatory requirements for maintaining the	03/06/2026

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F0577 SS = C	Continued from page 4 2/17/26 at 9:00 AM, the facility's survey results were observed in a notebook placed on a low table in the front lobby. The notebook contained survey results from a recertification survey completed on 8/16/23. The following surveys were not included in the survey results notebook:A compliant investigation survey dated 1/30/24.A focused infection control survey dated 4/8/24.A complaint investigation survey dated 8/22/24.A recertification survey dated 11/21/24.A complaint investigation survey dated 12/30/24.A complaint investigation survey dated 1/15/25.A complaint investigation survey dated 7/15/25.A complaint investigation survey dated 11/7/25. In an interview on 2/17/26 at 9:38 AM, the Administrator indicated he began employment at the facility at the end of July 2025. He stated that technical issues prevented him from printing the survey results when he first arrived at the facility. He indicated that he had the survey results in his office but had not placed them in the binder. The Administrator acknowledged that he should have placed the survey results in the notebook as soon as he was able to print them but was unable to state why this had not been done. The Administrator stated he was aware of the regulation regarding the most recent survey results from any survey should be placed in the notebook.	F0577	Continued from page 4 survey results notebook and ensuring survey results remain available for public review. The Administrator provided education to the BOM on 03/04/2026 regarding regulatory requirements for maintaining the survey results notebook and ensuring survey results remain available for public review. Effective 03/04/2026, the facility implemented a Posting Verification Checklist to ensure the survey results notebook remains present, current, and accessible. The Business Office Manager is responsible for completing the Posting Verification Checklist daily. The Administrator will review and sign the checklist weekly to verify compliance. Upon receipt of any future survey results, the Administrator will verify that required survey documentation is placed in the designated survey notebook within 24 hours. 4. The Business Office Manager will complete verification of the survey results notebook one time a week for four weeks and then monthly for two months. The Administrator will review verification documentation weekly for 90 days to ensure sustained compliance. The Administrator will conduct monthly verification thereafter. Audit results and trends will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) process for 3 months or until substantial compliance is maintained. The Administrator will present the audit findings to the QAPI committee for review. Any missing or outdated survey documentation identified during monitoring will be corrected immediately and re-verified the same day. All corrective actions and systemic changes will be fully implemented by 03/6/2026.	
F0584 SS = A	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to	F0584		03/05/2026

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F0584 SS = A	Continued from page 5 receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff and resident interviews, the facility failed to ensure a resident's wheelchair was maintained in a clean and sanitary manner for 1 of 5 residents reviewed for environmental concerns (Resident #51). The findings included:	F0584		

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F0584 SS = A	Continued from page 6 On 2/15/26 at 10:30AM, Resident #51 was observed seated in his wheelchair at the nurse's desk. Multiple areas of dried, thick brown substance were noted on the seat of the wheelchair. A large area of dried brown dried substance was also observed on the metal frame beneath the seat. During an interview with Resident #51 on 2/15/26 at 11:30AM he revealed therapy gave him a new wheelchair last week because he was sliding down in the one he had. He stated staff had cleaned his wheelchair, but he was unsure when it was last cleaned. On 2/16/26 at 10:48AM Resident #51 was observed ambulating with in the hallway with therapy. The Occupational Therapy Assistant (OTA) was walking beside Resident #51 while pushing the resident's wheelchair which was noted to have dried brown substance on the seat and metal frame. During an interview with OTA on 2/16/26 at 10:48AM, he stated he was taking the chair to be cleaned. The OTA indicated he believed the housekeeping department was responsible for cleaning wheelchairs but was unsure of the cleaning schedule. He further revealed the soiled chair was not the wheelchair that Resident #51 was given by the therapy team. The OTA stated the wheelchairs are not labeled and sometimes residents and staff just grab a wheelchair to use. He was not sure where Resident #51 found the soiled chair, but the chair given to him by therapy was smaller than the soiled chair. On 2/17/26 3:34PM the Occupational Therapist (OT) was interviewed and stated the therapy department issued residents a clean wheelchair after their evaluation. The OT indicated that if a wheelchair was observed to be soiled, she would clean it prior to issuing it to a resident. The OT stated she was unsure of any established cleaning schedule for wheelchairs. She further indicated that when residents were discharged, the housekeeping department cleaned the wheelchair and returned it to the therapy gym. The OT stated she did not know when the last time Resident #51's chair was cleaned. On 2/17/26 at 3:42PM, the Housekeeping Director stated the housekeeping department was not responsible for cleaning wheelchairs. She explained that prior to a change in ownership, housekeeping staff cleaned the wheelchairs; however, since the change in ownership, the housekeeping department no longer performed this task. The Housekeeping Director stated that the nursing	F0584		

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F0584 SS = A	Continued from page 7 assistants (NAs) were responsible for cleaning wheelchairs on night shift. On 2/18/26 at 1:50AM, NA #2 stated that NAs were responsible for cleaning the resident wheelchairs on the residents' shower day and anytime they were visibly soiled. NA #2 indicated wheelchairs were cleaned by NAs with a spray cleaner and a towel. NA #2 stated she had not observed the dried brown substance on Resident #51's wheelchair and his wheelchair was last cleaned on 2/12/25. On 2/18/26 at 11:54AM, the Director of Nursing (DON) stated the NAs clean the wheelchairs with wipes on the residents' shower day. The DON stated that when a resident was discharged from the facility the NA or housekeeping staff cleaned the wheelchair and then placed the clean wheelchair in the therapy gym. She stated the wheelchairs were not labeled with the resident's name and the staff identified the residents' wheelchairs by it being the one stored at the resident's bedside. The DON confirmed it was her expectation for wheelchairs to be clean and sanitary.	F0584		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §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. This REQUIREMENT is NOT MET as evidenced by: Based on record review and resident, friend and staff and local Law Enforcement Officer interviews, the facility failed to protect a resident's right to be free from misappropriation of resident's property. This affected 1 of 1 resident reviewed for misappropriation (Resident #19). The findings included: Resident #19 was admitted to the facility on 08/01/25. The quarterly Minimum Data Set (MDS) dated 8/7/25	F0602	1.On 08/29/2025, the facility initiated an investigation after an allegation of misappropriation involving Resident #19 was reported. The allegation was immediately reported to the appropriate state agencies in accordance with regulatory requirements. Resident #19 was interviewed and assessed by nursing staff. the items in question were returned to the resident. No financial loss occurred. The staff member involved was removed from the resident care area pending completion of the investigation in accordance with the facility's abuse prevention policy. The facility completed the investigation and appropriate disciplinary action was taken in accordance with facility policy. Resident #19 was monitored following the incident and no further concerns were identified. 2. All residents have the potential to be affected by the deficient practice. On 3.4.26 the Administrator and Director of nursing completed the following activities: The facility grievance logs for the last 12 months were reviewed to verify proper reporting and investigation	03/06/2026

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F0602 SS = D	Continued from page 8 assessed Resident #19 to be cognitively intact without behaviors. An initial allegation report was received by the State Agency from the facility's former Director of Nursing (DON) #2 on 8/29/25 at 4:15 PM. The report read that the facility initially became aware of the incident on 8/29/25 at 4:00 PM and alleged notification that Nurse #1 received a truck bed from Resident #19 with a BIMS of 12 (this score of 12 indicates the resident was cognitively intact). Resident's contact person notified staff that Nurse #1 was not supposed to receive the truck bed or any other of the items in her possession. Police were notified, and the facility investigation was initiated. The incident was reported to local law enforcement on 8/29/25 at 4:15 PM. Nurse #1 was interviewed on 2/17/26 at 12:27 PM and reported she was in Resident #19's room speaking with him and his Friend back in August 2025 when the conversation came up that she needed another vehicle. Nurse #1 stated the Friend told her they had a car they were selling at an auction that she could go and look at to see if she was interested in purchasing it. Nurse #1 stated she went to look at the car and realized the vehicle needed a lot of work done on it, so she was not interested in purchasing it. Nurse #1 stated there was also a truck bed they all discussed so she asked her mechanic to go and look at it to see if it could be used and turned into a bed for her home. Nurse #1 stated she did not ask him to pick it up for her but only asked him to look at it to see if she wanted to buy it. Nurse #1 reported her mechanic took it upon himself to pick it up and bring it to her house. She reported she did not ask him to do that, but he did it anyway. Nurse #1 reported Resident #19's Friend wanted it back, so she put a tarp over it, and it sat in her yard for 2 months before the Friend had it picked up. Nurse #1 reported that she did contact the Friend about returning the truck bed and arrangements were made for him to come and pick it up from her residence. Nurse #1 also reported she knew nothing about a trailer with items in it. Nurse #1 reported that she had received training and was aware that she should not accept gifts from residents. On 2/17/26 at 9:18 AM an interview was conducted with Resident #19 who stated he did tell Nurse #1 she could have the truck bed but could not recall the exact date. Resident #19 reported he did not realize at the time the truck bed was scheduled to go to auction and be sold. Resident #19 reported he told Nurse #1 the next	F0602	Continued from page 8 of allegations. Alert and oriented residents with BIMS of 11 and up were interviewed regarding any concerns related to misappropriation of personal property. Responsible Parties of Residents of BIMS 10 or less were interviewed regarding any concerns related to misappropriate of personal property. No additional concerns were identified during resident and responsible party interviews or review of the grievance logs. 3. On 03/04/2026, the Director of Nursing provided re-education to all staff including contract staff regarding the facility's abuse prevention policy including misappropriation of resident property. This education included recognizing and reporting allegations of abuse or misappropriation, protection of resident belongings, staff responsibility to safeguard resident property. Abuse prevention education will be provided in orientation for all newly hired staff to include contract staff by the Executive Director, Director of Nursing, Social Worker, or Designee. An Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting was conducted on 03/05/2026 to review the deficient practice and implement corrective actions. 4. Beginning 03/04/2026, the Administrator or designee will conduct three interviews weekly with alert and oriented residents and two interviews weekly with family members of non-alert residents for four weeks to assess for any concerns related to resident personal property. Monitoring will then occur monthly for two months. Incident reports and grievance reports related to property concerns will be reviewed during the monitoring period to ensure that no misappropriation of resident property has occurred. Results of resident and family interviews, as well as review of incident and grievance reports, will be brought to the committee by Administrator. Audit results will be reviewed during Quality Assurance and Performance Improvement (QAPI) committee meetings for three months and trends will be addressed through additional education or disciplinary action as indicated.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Health and Rehabilitation	**625 Ashland Street , Archdale, North Carolina, 27263**

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F0602 SS = D	Continued from page 9 day, she could not have it because it was already promised for auction. Resident #19 reported that Nurse #1 obtained the truck bed after he told her she could no longer have it. Resident #19's Friend was interviewed by phone on 2/17/26 at 11:00 AM and stated he found out Nurse #1 was talking to Resident #19 about a car and a truck bed she could have. The Friend reported when Nurse #1 went to look at the car she also saw a trailer full of stuff she took. The interview further revealed that once the items were noticed missing, the Friend spoke to Resident #19 about missing items and was told that Resident #19 had given Nurse #1 permission to have the truck bed not realizing it was up for auction. The Friend explained he handled all affairs for Resident #19, and it was not okay for her to take those items. The Friend reported he contacted the police but ended up not pressing charges because he got the items back. The Friend reported that Nurse #1 went to Resident #19's house initially alone to look at buying a car. The Friend reported that the Nurse later had someone come and pick up the truck bed for her. The Friend reported he was not present when any of the items were looked at or picked up. Attempt was made to contact Adult Protective Services by phone for interview. Voice mail message left requesting a return call were not returned. Local Law Enforcement was interviewed by phone on 2/23/26 at 8:53 AM. Officer stated local law enforcement was contacted because items were taken from Resident #19's property. The Officer reported it was a 2002 Ford truck bed and other miscellaneous property. The Officer reported allegedly, Resident #19 initially told Nurse #1 she could have the truck bed and other miscellaneous items. The Officer stated later Resident #19 found out from his Friend the items could not be given away because they were up for auction. The Officer indicated it was unclear if Nurse #1 took the items before or after finding out she could not have them. The Officer stated the items were eventually returned and no charges were pressed. DON #2 was interviewed by phone on 2/17/26 at 10:06 AM. She stated Resident #19 did report he gave Nurse #1 permission to have some of his items but reported he was unaware his belongings were involved in probate. DON #2 reported there were other items on a trailer	F0602	Continued from page 9 All corrective actions and systemic changes will be fully implemented by 03/06/2026.	

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F0602 SS = D	Continued from page 10 mentioned but she does not recall the details of what they were. DON #2 reported Resident #19's Friend made the facility aware there was a problem because of the probate situation. DON #2 reported Nurse #1 was suspended while an investigation was conducted, education was also provided, and then Nurse #1 was permitted to return to work once the facility had completed the investigation. DON #2 reported the situation was resolved by having the items returned and the investigation was concluded as unsubstantiated. DON #2 reported no other residents were involved and there were no other concerns regarding Nurse #1 accepting items from other residents. The Administrator was interviewed on 2/17/26 at 11:39 AM and stated allegedly Nurse #1 had received permission to have some of the items Resident #19 offered her. The Administrator reported later, Resident #19's Friend who handles his affairs, came to the facility and reported Nurse #1 could not have those items that were taken because the items were already scheduled to go to auction. The Administrator reported Nurse #1 was made aware the items needed to be returned. The Administrator reported the Friend did not press charges and referred to it as a misunderstanding. The Administrator reported disciplinary corrective action was provided including not accepting gifts from residents per policy. The Administrator reported this education was provided to Nurse #1 initially when she was hired and again after the incident. The Administrator reported Nurse #1 was still employed at the facility.	F0602		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.	F0641	1. Resident #21 received a modification of the Minimum Data Set (MDS) assessment on 2/16/26 by the MDS Coordinator to correct Section N to accurately reflect injections and anticonvulsant medications. Resident #11 received a modification of the Minimum Data Set (MDS) assessment on 2/17/26 by the MDS Coordinator to correct Section J to accurately reflect a fall with minor injury. Resident #49 received a modification of the Minimum Data Set (MDS) assessment on 1/18/26 by the MDS Coordinator to correct Section N to accurately reflect antibiotic medications. On 2/18/26 the facility MDS Consultant re-educated the MDS Coordinator on accuracy of Minimum Data Set (MDS) assessments related to Section N injections, antibiotics and anticonvulsants and Section J falls with minor injury.	03/06/2026

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F0641 SS = D	Continued from page 11 §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of accidents (Resident #11), and medications (Residents #49 and #21). This was for 3 of 24 residents whose MDS assessments were reviewed. The findings included: 1. Resident #11 was originally admitted to the facility on 5/12/25 with diagnoses that included history of a stroke and muscle weakness. A review of Resident #11's medical record revealed he had a fall on 12/13/25 with a minor injury of a skin tear to his right arm. The quarterly MDS assessment dated 12/17/25 indicated Resident #11 had severely impaired cognition. He was coded with one fall with no injury since the previous assessment. On 2/17/26 at 3:03 PM, an interview occurred with the MDS Consultant who had coded the 12/17/25 quarterly MDS assessment. She reviewed the MDS assessment dated 12/17/25 as well as Resident #11's medical record and	F0641	Continued from page 11 2. On 2/16/26 the Regional Clinical Reimbursement Specialist audited all current residents that had the potential to be affected by the alleged deficient practice. The results included: 1 out 19 MDS assessments were affected by antipsychotic injections and anticonvulsant. On 2/17/26 1 out of 37 MDS assessments were affected for falls with minor injuries. On 2/18/26 1 out of 7 assessments were affected for antibiotic. On 2/18/26 the Clinical Reimbursement Specialist completed necessary modifications to ensure all MDS assessments were accurate. 3. On 2/18/26, the Regional Clinical Reimbursement Specialist in-serviced the MDS team on MDS accuracy of assessments. This training included: Antipsychotics (including injections): Check if MAR injectable antipsychotic medication was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days). Anticonvulsants: Check if MAR for any anticonvulsant medication was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days) Antibiotic: Check if an antibiotic medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Falls: Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. Include medical records generated in any health care setting since last assessment. All relevant records received from acute and post-acute facilities where the resident was admitted during the look-back period should be reviewed for evidence of one or more falls. 4. Beginning 3/4/2026 The Regional Clinical Reimbursement Specialist or designee will monitor compliance utilizing the F657 Quality Assurance Tool weekly 2 residents x 4 weeks and 2 residents monthly x 2 months. The tool will monitor facility identified concerns that need to be addressed by the QA committee.	

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F0641 SS = D	Continued from page 12 confirmed Resident #11 had a fall on 12/13/25 that resulted in a skin tear to his right arm. She indicated that the fall section should have been coded as one fall with a minor injury instead of one fall with no injury and felt it was an oversight. An interview was conducted with the Director of Nursing (DON) on 2/18/26 at 2:42 PM, who stated that it was her expectation for the MDS assessments to be coded accurately for accidents. 2. Resident #49 was admitted to the facility on 10/21/22 with diagnoses that included neuromuscular dysfunction of the bladder and age-related cataracts. A review of Resident #49's Medication Administration Record (MAR) from 1/16/26 to 1/22/26 revealed he received the following antibiotics: Macrobid 100 milligrams (mg) by mouth once a day. Moxifloxacin 0.5% solution one drop to the left eye every two hours for post cataract removal. The quarterly MDS assessment dated 1/22/26 revealed Resident #49 was not coded for antibiotic use. On 2/17/26 at 3:03 PM, an interview occurred with the MDS Consultant. She reviewed the January 2026 MAR and confirmed that antibiotic use should have been coded on the quarterly MDS dated 1/22/26. The MDS Consultant stated that someone had been assisting remotely to complete this MDS assessment and felt it was an oversight. During an interview on 2/18/26 at 2:42 PM, the DON indicated it was her expectation for the MDS to be coded correctly for antibiotic use 3. Resident #21 was admitted to the facility on 01/23/26 with diagnosis that included bipolar I disorder, current manic with psychotic features and Schizophrenia. Review of Resident #21's January 2026 active physician orders revealed an order dated 01/24/26 for Fluphenazine Decanoate Injection Solution 25 milligram	F0641	Continued from page 12 Regional Clinical Reimbursement Specialist or designee Reports will be presented to the weekly Quality Assurance committee by the Executive Director to ensure corrective action is initiated as appropriate. Compliance will be monitored, and the ongoing auditing program reviewed at the Quality Assurance meeting, for 3 months until substantial compliance is maintained. All corrective actions and systemic changes will be fully implemented by 03/6/2026.	

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F0641 SS = D	Continued from page 13 (MG)/milliliter (ML), inject 50 mg intramuscularly one time a day every 21 day(s) for bipolar disorder (antipsychotic intramuscular injection). There was also an order dated 01/23/26 for Lamotrigine oral tablet 25 MG, give 2 tablets by mouth two times a day for Extrapyramidal Symptoms (EPS) (involuntary movements such as tremors, rigidity, and restlessness) (anticonvulsant medication). Review of the January 2026 medication administration record (MAR) revealed Fluphenazine Decanoate injection was administered on 01/24/26 at 9:00 AM and Lamotrigine oral tablet was administered daily from 01/24/26 through 01/31/26 at 9:00 AM and 5:00 PM. An admission Minimum Data Set (MDS) assessment dated 01/29/26 indicated Resident #21's cognition was intact. The medication section was coded for receiving 0 out of 7 injections of any type during the lookback period. The medication section was not coded for receiving an anticonvulsant medication during the lookback period. An interview was conducted on 02/16/26 at 3:26 PM with the Corporate MDS Consultant. She reviewed the admission MDS assessment dated 01/29/26 along with the January medication administration record (MAR). The Corporate MDS Consultant verified she did not accurately code the admission assessment and stated she overlooked the intramuscular part of the antipsychotic medication order. She explained that she was thinking about antipsychotic medications and not anticonvulsants when she was reviewing the MAR and overlooked the anticonvulsant medication. She indicated she expected the MDS assessments to be coded accurately to reflect Resident #21's medications and needs. An interview was completed on 02/18/26 at 1:32 PM with the Administrator. He stated the MDS should be coded accurately to reflect Resident #21's physical, cognitive, emotional and behavioral conditions, and care needs.	F0641		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F0686	1. The Wound Nurse reviewed Resident #2's medical record on 03/04/2026 related to the sacral wound identified on 12/27/2025. Documentation was reviewed confirming the wound physician evaluated Resident #2 on 02/25/2026 and the sacral wound was resolved. On 2/25/2026 the Wound Nurse and wound physician reviewed the resident's wound condition and confirmed the wound had healed and no further treatment was required. 2. On 03/04/2026, the Director of Nursing and Wound	03/06/2026

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F0686 SS = D	Continued from page 14 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation, Medical Wound Provider and staff interviews, the facility failed to assess a newly identified pressure ulcer that included the pressure ulcer stage, characteristics, and presence of pain and failed to complete pressure ulcer treatments as ordered 3 out of 5 days. This was for 1 of 5 (Resident #2) residents reviewed for pressure ulcer care. The findings included: Resident #2 was admitted to the facility on 12/3/25 with diagnoses that included recent left above the knee amputation and history of a stroke. An admission progress note dated 12/3/25, completed by Nurse #9, indicated Resident #2 had a surgical wound to the left thigh with 35 staples present. Her right foot was dry and cracked. Discoloration and scarring were present to the right leg, bruising was present to the right ankle, and her buttocks were free from any skin breakdown. An admission Minimum Data Set (MDS) assessment dated 12/7/25 indicated Resident #2 had moderately impaired cognition. She required maximum assistance with bed mobility and was dependent on staff for toileting hygiene and transfers. There was no pressure ulcers noted on the MDS but Resident #2 was coded for a surgical wound. A nursing note dated 12/27/25, written by Nurse #7, indicated Resident #2 was noted with a sacral wound, orders were received for wound care and Resident #2 would be seen by wound physician. The nurses' note read that wound care had been completed as ordered. There was no description of the sacral wound.	F0686	Continued from page 14 Nurse conducted a wound roster review of all residents with wounds to ensure complete wound assessments, physician orders, Treatment Administration Record activation, and treatment documentation were present in the medical record. Any identified concerns were corrected immediately. 3. On 03/04/2026, the Director of Nursing re-educated licensed nurses regarding the process for newly identified wounds including completion of a full wound assessment, physician notification, entry of physician orders, and activation of the order to the Treatment Administration Record to ensure treatments are completed as ordered. On 3/4/2026 Licensed Nursing staff were instructed to ensure wound documentation includes stage, characteristics of the wound, and presence of pain when wounds are identified. Beginning 3/4/2026 The Wound Nurse or Director of Nursing will review new wound documentation and verify that treatment orders are activated in the electronic medical record. On 3/4/2026 Certified Nursing Assistants were educated by the director of nursing or designee on identifying and immediately reporting any skin concerns to the licensed nurse for assessment. Any Newly hired licensed nurses and Certified Nursing Assistants will receive the same education during the orientation process by the Wound Nurse or Director of Nursing or designee. An ADHOC Quality Assurance Performance Improvement Committee meeting was held on 03/04/2026 to review the deficient practice and approve the plan of correction. 4. Beginning 03/04/2026, the Director of Nursing and Wound Nurse will conduct Wound/Treatment Administration Record Compliance Audits to ensure wound assessments, physician orders, and treatment documentation are completed and activated appropriately in the electronic medical record. Audits will be conducted weekly for 4 weeks and monthly for three months thereafter. Any identified variance will result in immediate correction, staff re-education, and follow-up monitoring.	

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F0686 SS = D	Continued from page 15 A review of Resident #2's physician orders included an order dated 12/27/25 to cleanse wound to the sacral area with wound cleanser. Apply calcium alginate (a highly absorbent material used to create a moist healing environment) to the wound bed and cover with a dry dressing daily and as needed if soiled or dislodged. This order was discontinued on 12/31/25. A review of the December 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not contain the order for wound care to the sacral area dated 12/27/25. There was no documentation in the medical record that wound care had been provided to Resident #2's sacral wound on 12/28/25, 12/29/25 or 12/30/25. A phone interview was conducted with Nurse #7 on 2/18/26 at 11:37 AM. She stated that she began employment at the facility in the middle part of December 2025 as an as needed nurse (PRN) and recalled Resident #2 being found with skin breakdown to the sacral area. She was unable to recall which side of the sacrum the breakdown was noted on or how the area looked on 12/27/25. Nurse #7 stated that she contacted the Medical Wound Provider for wound orders and provided the care on that day. She stated she entered the wound care order into the Electronic Medical Record (EMR) system and that there was a box to activate the order onto either the MAR or TAR. She couldn't recall if that had been done but if the order didn't show up on the December 2025 MAR or TAR that would be why. Nurse #7 stated that she couldn't recall measuring the wound and felt the Medical Wound Provider would have done that when he assessed Resident #2. She stated that she only documented the new skin breakdown in the nursing note and thought she had reported it to the oncoming nurse, who she could not recall. Nurse #7 added that she didn't think there was a wound nurse at that time and that she had not been assigned to Resident #2 since 12/27/25. An interview occurred with Nurse #3 on 2/17/26 at 9:50 AM who was able to recall Resident #2. She recalled when Resident #2 was admitted to the facility on 12/3/25 she presented with a very thin area of pink and white tissue to her buttocks with the appearance of previously healed wounds. Nurse #3 stated when she completed skin assessments for Resident #2 on 12/6/25 and 12/21/25 the thin pink and white tissue area to her buttocks remained without any openings. Staff were	F0686	Continued from page 15 Audit results will be presented to the committee by the Wound Nurse/Director of Nursing or Designee and will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) process for 3 months or until substantial compliance is maintained. All corrective actions and systemic changes will be fully implemented by 03/6/2026.	

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F0686 SS = D	Continued from page 16 providing protective skin care after each incontinent episode. Nurse #3 explained that when an order was placed in the EMR system it must be activated to show up on the MAR or TAR so staff would follow the order. An observation of wound care for Resident #2 was completed with the Wound Care Nurse on 2/17/26 at 10:13 AM. A very small area of pink and white scar tissue was present to the right buttock, with no open areas. The left buttock contained a very small, irregular shaped open area that had no depth and pink/red wound bed. There was no drainage or odor. Wound care was completed as ordered. On 2/17/26 at 4:07 PM, an interview occurred with the wound care nurse. She stated that she had worked at the facility since October 2025 as a floor nurse and had recently transitioned to the wound care nurse position in January 2026. She recalled being assigned to care for Resident #2 in December 2025 and that Resident #2 had a very thin area of pink and white tissue to the sacral area when she was first admitted to the facility. The wound care nurse had been assigned to Resident #2 on 12/29/25 and 12/30/25. She stated at that time the floor nurses were completing wound care, but she couldn't recall if she had provided any wound care to Resident #2 on 12/29/25 or 12/30/25 or if she was aware Resident #2 had skin breakdown to her sacrum as she was not the wound care nurse during this time. She added that during the end of December 2025 the Medical Wound Provider was responsible for measuring the wounds and assessing them for proper treatment, as there was not a wound care nurse. The wound care nurse reviewed the initial order for sacral wound care that was entered in the physician orders on 12/27/25 and explained that if the initial order was not activated to show up on the MAR or TAR, nursing staff would not have known to complete the wound care. She further explained that in the role of wound care nurse, she was made aware of any new skin concerns by the floor nurses and followed up to ensure the wound care orders had been entered appropriately and the resident was assessed by the Medical Wound Provider. She indicated that she provided wound care to all residents Monday through Friday and that floor nurses were responsible for any wound care that was needed after 5:00 PM and on the weekends. A phone interview was completed with the Medical Wound Provider on 2/18/26 at 10:11 AM. The Medical Wound Provider could not recall any concerns of a dressing	F0686		

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F0686 SS = D	Continued from page 17 not being present to Resident #2's pressure area on the initial visit of 12/31/25 and stated he would have noted any concerns he had on the progress note. The initial order provided on 12/27/25 was reviewed with the Medical Wound Provider and stated that he recalled providing that order until he could see Resident #2 in the next few days. He couldn't comment if not having the wound care affected the outcome of the wound but replied there were no concerns for infection. The Medical Wound Provider added that it was evident there was scar tissue in the area of her pressure injuries when he assessed her on 12/31/25 and that due to Resident #2's co-morbidities and overall change from the recent amputation, it was possible the wounds erupted very quickly. The Director of Nursing (DON) was interviewed on 2/18/26 at 2:42 PM and stated that she had recently taken over the role earlier in February 2026 and was unaware that the wound care orders dated 12/27/25, had not been populated to the December 2025 MAR or TAR for Resident #2. The DON stated that in the first part of January 2026, the facility designated a nurse for wound care. The process since January 2026 was when a skin problem was identified, the nurse was made aware. They called the provider for wound care orders, entered them into the EMR system so that it populated to the TAR and sent a communication to the wound care nurse. The wound care nurse ensured that the wound care orders had been transcribed and activated properly in the EMR. The DON added that she would expect wound care to be completed as ordered, as well as expecting Nurse #7 to have documented a description of the wound in the nursing progress note. She was unsure if the prior DON #3 had been made aware. Multiple attempts were made to contact Nurse #5, who was scheduled to care for Resident #2 on 12/27/25 from 7:00 PM to 7:00 AM. These attempts were made on 2/17/26 at 5:45 PM and 2/18/26 at 11:19 AM. Multiple attempts were made to contact the prior DON #3 on 2/17/26 at 5:00 PM and 2/18/26 at 11:17 AM regarding the process for newly identified wounds in December 2025.	F0686		
F0698 SS = B	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	F0698	1.Resident #65 was discharged from the facility on 12/19/2025 and was not residing in the facility at the time of the survey. Upon identification of the concern, the Director of	03/06/2026

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F0698 SS = B	Continued from page 18 The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to maintain evidence of ongoing communication with the dialysis treatment center in the medical record for 1 of 2 residents reviewed for dialysis (Resident #65). The findings included: Resident #65 was admitted to the facility on 11/11/25 with diagnoses which included end stage renal disease (ESRD) and dependence on dialysis (treatment to filter waste and water from the blood). Resident # 65 was discharged on 12/19/25. Resident #65 had a physician order dated 12/4/25 for hemodialysis on Tuesday, Thursday, and Saturday. A review of Resident #65's significant change Minimum Data Set (MDS) assessment dated 12/11/25 revealed Resident #65 was cognitively intact. Resident #65 was not coded as receiving dialysis (not coded in error). A Review of Resident #65's electronic medical record revealed no completed dialysis communication forms. The facility was unable to locate any dialysis communication forms for Resident #65. A review of Resident #65 progress notes revealed there was no documentation of communication between the facility staff and dialysis center. There was no documentation that pre-dialysis or post-dialysis assessments were completed and communicated between the facility and the dialysis center. An interview completed with Nurse #4 on 2/17/26 at 12:16 PM revealed she was Resident #65's nurse regularly on her scheduled dialysis days. Nurse #4 stated she completed the dialysis communication form prior to Resident #65's leaving the facility on her scheduled dialysis days. Nurse #4 stated the information documented on the form prior to dialysis was vital signs, weight, access site condition, and any changes in condition. Nurse #4 stated the dialysis nurse documented on the form their assessment of Resident #65's condition after dialysis was completed.	F0698	Continued from page 18 Nursing reviewed Resident #65's medical record to determine whether dialysis communication documentation had been maintained in the record. The Medical Records Coordinator contacted the dialysis center and attempted to obtain dialysis communication documentation for Resident #65. 2.On 02/24/2026, the Director of Nursing and Nurse Supervisors completed a review of all residents receiving dialysis services to ensure dialysis communication documentation and pre- and post-dialysis assessments were present in the electronic medical record. No additional deficiencies were identified. All residents receiving dialysis services have the potential to be affected by the deficient practice. 3.On 02/24/2026, the Director of Nursing implemented a standardized dialysis communication workflow to ensure documentation is consistently completed and maintained in the resident medical record. Nursing staff are responsible for completing the pre-dialysis portion of the dialysis communication form prior to the resident leaving the facility for dialysis. Upon the resident's return from dialysis, nursing staff will review the completed dialysis communication form and document post-dialysis assessments. Dialysis communication forms will be forwarded to Medical Records and scanned into the electronic medical record within 24 hours of the resident's return from dialysis. On 02/24/2026, the Director of Nursing provided education to nursing staff and Medical Records staff regarding dialysis communication procedures and documentation expectations. Newly hired nurses will receive the same education during orientation. 4.Beginning 03/04/2026, the Director of Nursing or designee will conduct dialysis documentation audits to verify dialysis communication forms and pre- and post-dialysis assessments are maintained in the resident medical record. Audits will be conducted weekly for four weeks and	

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F0698 SS = B	Continued from page 19 Nurse #4 explained that when the resident returned from dialysis she reviewed the form for information provided by the dialysis nurse. During an interview on 2/17/26 at 3:08 PM, Nurse #3 stated the facility communicated with the dialysis center using a dialysis communication form. She explained that each resident receiving dialysis had a notebook that accompanied them to each dialysis treatment. Prior to the resident leaving the facility, the nurse completed the top portion of the dialysis communication form and placed it in the notebook. The form included pre-dialysis information such as vital signs, dialysis access assessment, and any changes in the resident's condition. After dialysis treatment, the dialysis nurse completed a post-dialysis section of the form and returned it to the resident's notebook for the facility nurse to review. Nurse #3 stated she was unsure how long the completed communication forms remained in the notebook before being removed by medical records staff. During an interview on 2/18/26 at 12:50 PM, the Medical Records Manager stated she was unable to locate any dialysis communication forms for Resident #65. She stated there was no scheduled timeframe for removing completed communication forms from the dialysis notebook and uploading them into the resident's electronic medical record. She stated she believed the communication forms completed since Resident #65's admission remained in the notebook that accompanied the resident to dialysis. She further stated it was possible that upon discharge, the resident's family took the notebook home by mistake. She had attempted to contact the family, but they had not returned her call yet. During an interview on 2/18/26 at 12:55 PM, the Director of Nursing (DON) stated the facility was responsible for completing the dialysis communication form prior to the resident leaving for dialysis and for ensuring the dialysis center completed the post-dialysis section. The DON stated the completed forms should be removed from the notebook and placed in the resident's medical record after review by the facility nurse. The DON was unable to explain why the communication forms were not in Resident #65's medical record.	F0698	Continued from page 19 monthly for three months thereafter. Any deficiencies identified will be corrected immediately and addressed through staff re-education as necessary. Audit results and trends will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) process for 3 months or until substantial compliance is maintained. The DON will present the audit findings to the QAPI committee for review. All corrective actions and systemic changes will be fully implemented by 03/6/2026	
F0732 SS = C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information.	F0732	1.On 02/24/2026, the Administrator and Director of Nursing reviewed the nurse staffing posting process and verified that the daily staffing posting board accurately reflects the facility name, current date, resident census, and the total number and hours worked	03/06/2026

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F0732 SS = C	Continued from page 20 §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. §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 staffing information as compared to the daily staff scheduled for licensed	F0732	Continued from page 20 by Registered Nurses, Licensed Practical Nurses, Medication Aides, and Certified Nursing Assistants for each shift. Any discrepancies identified between the staffing schedule and the posted staffing sheet were corrected. 2.On 02/24/2026, the Administrator and Director of Nursing reviewed recent daily nurse staffing postings and compared them to the staffing schedules to verify accuracy. Any discrepancies identified were corrected immediately. All residents have the potential to be affected by the deficient practice. 3.On 02/24/2026, the Staff Scheduler was re-educated by the Administrator regarding the requirement to ensure that daily nurse staffing postings accurately reflect the number and category of staff working each shift. The Staff Scheduler will verify the daily staffing schedule against staff who actually worked each shift prior to completing the daily nurse staffing posting. The Director of Nursing or designee will review the daily nurse staffing posting for accuracy. 4.Beginning 02/24/2026, the Administrator or Director of Nursing will review the nurse staffing posting three times weekly for four weeks and monthly for two months thereafter to ensure the posting reflects the actual staffing schedule. Any discrepancies identified will be corrected immediately and staff will be re-educated as needed. Audit results and trends will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) process for 3 months or until substantial compliance is maintained. The Administrator will present the audit findings to the QAPI committee for review. All corrective actions will be completed by: 3/6/2026	

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F0732 SS = C	Continued from page 21 and unlicensed nursing staff for 22 out of 46 days (1/6/26, 1/7/26, 1/10/26, 1/13/26, 1/14/26, 1/15/26, 1/16/26, 1/17/26, 1/18/26, 1/19/26, 1/20/26, 1/21/26, 1/22/26, 1/23/26, 1/24/26, 1/25/26, 1/28/26, 1/30/26, 1/31/26, 2/1/26, 2/2/26, and 2/3/26). The findings included: A review of the facility's daily posting for nursing staff for 1/1/26-2/15/26 as compared to the daily staffing schedule revealed an inaccurate total of nursing staff worked, which included the following: a. The nursing schedule for 1/6/26 indicated that 6 Nurse Aides (NAs) worked 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 1/6/26 documented that 5 NAs worked 7:00 AM to 3:00 PM. b. The nursing schedule for 1/7/26 indicated that 6 NAs worked 3:00 PM to 11:00 PM. The daily posted nurse staffing sheet for 1/7/26 documented that 7 NAs worked from 3:00 PM to 11:00 PM. c. The nursing schedule for 1/10/26 indicated that 2 Medication Aides (MAs) worked from 7:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/10/26 documented that 1 MA worked 7:00 PM to 7:00 AM. d. The nursing schedule for 1/13/26 indicated that 6 NAs worked from 7:00 AM to 3:00 PM and 6 NAs worked from 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/13/26 documented that 7 NAs worked 7:00 AM to 3:00 PM and 5 NAs worked 11:00 PM to 7:00 AM. e. The nursing schedule for 1/14/26 indicated that 1 MA worked from 7:00 AM to 7:00 PM and 5 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/14/26 documented that 2 MAs worked 7:00 AM to 7:00 PM and 7 NAs worked 11:00 PM to 7:00 AM. f. The nursing schedule for 1/15/26 indicated that 5 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/15/26 documented that 7 NAs worked 11:00 PM to 7:00 AM.	F0732		

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F0732 SS = C	Continued from page 22 g. The nursing schedule for 1/16/26 indicated that 1 Registered Nurse (RN) and 1 Licensed Practical Nurse (LPN) worked 7:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/16/26 documented that no RN worked 7:00 PM to 7:00 AM and 2 LPNs worked 7:00 PM to 7:00 AM. h. The nursing schedule for 1/17/26 indicated that 1 RN, 1 MA and 1 LPN worked 7:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/17/26 documented that no RN or MA worked from 7:00 PM to 7:00 AM and that 2 LPNs worked 7:00 PM to 7:00 AM. i. The nursing schedule for 1/18/26 indicated that 6 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 1/18/26 documented that 7 NAs worked 7:00 AM to 3:00 PM. j. The nursing schedule for 1/19/26 indicated that 5 NAs worked from 7:00 AM to 3:00 PM and 4 NAs worked from 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/19/26 documented that 6 NAs worked 7:00 AM to 3:00 PM and 5 NAs worked 11:00 PM to 7:00 AM. k. The nursing schedule for 1/20/26 indicated that 4 NAs worked from 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/20/26 documented that 3 NAs worked from 11:00 PM to 7:00 AM. l. The nursing schedule for 1/21/26 indicated that 1 RN and 2 LPNs worked from 7:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/21/26 documented that no RN worked 7:00 PM to 7:00 AM and 3 LPNs worked 7:00 PM to 7:00 AM. m. The nursing schedule for 1/22/26 indicated that 1 RN and 2 LPNs worked 7:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/22/26 documented that 3 LPNs worked 7:00 PM to 7:00 AM. n. The nursing schedule for 1/23/26 indicated that 2 LPNs worked 7:00 AM to 7:00 PM. The daily posted nurse staffing sheet for 1/23/26 documented that 1 LPN worked 7:00 AM to 7:00 PM.	F0732		

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F0732 SS = C	Continued from page 23 o. The nursing schedule for 1/24/26 indicated that 1 MA worked from 7:00 AM to 7:00 PM. The daily posted nurse staffing sheet for 1/24/26 documented that no MA worked 7:00 AM to 7:00 PM. p. The nursing schedule for 1/25/26 indicated that 6 NAs worked from 7:00 AM to 3:00 PM and 3 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/25/26 documented that 4 NAs worked 7:00 AM to 3:00 PM and 4 NAs worked 11:00 PM to 7:00 AM. q. The nursing schedule for 1/28/26 indicated that no MA worked 7:00 AM to 7:00 PM. The daily posted nurse staffing sheet for 1/28/26 documented that 1 MA worked from 7:00 AM to 7:00 PM. r. The nursing schedule for 1/30/26 indicated that 2 MAs worked from 7:00 AM to 7:00 PM, 1 RN worked 7:00 PM to 7:00 AM and 1 LPN worked 7:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/30/26 documented that no MAs worked 7:00 AM to 7:00 PM, no RN worked 7:00 PM to 7:00 AM and 2 LPNs worked 7:00 PM to 7:00 AM. s. The nursing schedule for 1/31/26 indicated that 1 MA worked from 7:00 AM to 7:00 PM, 1 RN worked 7:00 PM to 7:00 AM and 1 LPN worked 7:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 1/31/26 documented that no MA worked 7:00 AM to 7:00 PM, no RN worked 7:00 PM to 7:00 AM and 2 LPNs worked 7:00 PM to 7:00 AM. t. The nursing schedule for 2/1/26 indicated that 1 RN and 1 LPN worked 7:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 2/1/26 documented that no RN worked from 7:00 PM to 7:00 AM and 2 LPNs worked 7:00 PM to 7:00 AM. u. The nursing schedule for 2/2/26 indicated that 1 RN and 1 LPN worked 7:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 2/2/26 documented that no RN worked 7:00 PM to 7:00 AM and that 2 LPNs worked 7:00 PM to 7:00 AM. v. The nursing schedule for 2/3/26 indicated that 6 NAs worked 7:00 AM to 3:00 PM, 1 LPN worked 7:00 PM to 7:00 AM and 1 RN worked 7:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 2/3/26 documented that 8 NAs	F0732		

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F0732 SS = C	Continued from page 24 worked 7:00 AM to 3:00 PM, no RN worked 7:00 PM to 7:00 AM and 2 LPNs worked 7:00 PM to 7:00 AM. On 2/18/26 at 9:17 AM, an interview occurred with the Staff Scheduler. She reviewed the staffing schedule and daily postings and verified the number of staff who worked from 1/1/26 to 2/15/26 did not match. She explained that she had not counted Nurse #8 as an RN on the nursing schedule or daily posted nurse staffing sheet on 1/16/26, 1/17/26, 1/21/26, 1/22/26, 1/30/26, 1/31/26, 2/1/26, 2/2/26 and 2/3/26 because when Nurse #8 was first hired at the facility, he was an LPN waiting to take the test for his RN license. She stated she couldn't recall when he became an RN. In addition, the Staff Scheduler stated that she failed to ensure the daily posted nurse staffing sheet had been updated when a staff member didn't come to work or if a staff member came in to cover a need The Human Resources Coordinator was interviewed on 2/18/26 at 9:55 AM. She verified that Nurse #8's date of hire was 12/30/25 and that he became an RN effective 1/13/26. An interview occurred with the Administrator and Director of Nursing (DON) on 2/18/26 at 2:42 PM. The staffing schedules and daily postings were reviewed, which did not match the actual staff that worked on a certain day. The Administrator stated he recalled letting the Staffing Scheduler know of Nurse #8's transition from LPN to RN after he passed the RN boards in January 2026. In addition, the Administrator and DON stated that the daily staff schedule posting, and the staffing schedule should match the number of staff worked on any given shift.	F0732		
F0742 SS = D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;	F0742	1.On 02/24/2026, the Social Worker obtained and submitted consent for psychiatric services for Resident #21 to ensure behavioral health services could be initiated. The Director of Nursing verified the referral for psychiatric services and ensured Resident #21 was placed on the psychiatric provider list for evaluation and medication management. Resident #21 was evaluated by the psychiatric provider on 02/27/2026. The resident's care plan was reviewed and updated to include behavioral monitoring and interventions to	03/06/2026

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F0742 SS = D	Continued from page 25 This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation, and interviews with staff and Medical Director, the facility failed to provide behavioral healthcare services to a resident with diagnosed mental health disorders and behavioral symptoms for 1 of 1 resident (Resident #21) reviewed for behavioral and emotional needs. The findings included: A review of Resident #21's hospital discharge summary dated 01/23/26 revealed he was admitted on 12/19/25 and discharged on 01/23/26 with discharge diagnosis that included bipolar I disorder-manic. His hospital course included psychiatry was consulted for Extrapyramidal Symptoms (EPS) (involuntary movements such as tremors, rigidity, and restlessness) agitation, and acute mania. Resident #21's discharge summary also included the following: Follow up appointments: Please make sure to follow up with Psychiatric appointments and medication management. Resident #21 was admitted to the facility on 01/23/26 with diagnosis that included bipolar I disorder, current manic with psychotic features and Schizophrenia. Resident #21's admission care plan dated 01/23/26 did not have a focus area for behaviors. Resident #21's active physician's orders included the following psychotropic medications: - 01/23/26: olanzapine (Zyprexa) Oral Tablet 10 milligram (MG), give 1 tablet by mouth at bedtime for bipolar disorder (atypical antipsychotic medication used to treat schizophrenia and bipolar I disorder). - 01/23/26: Lamotrigine Oral Tablet 25 MG, give 2 tablet by mouth two times a day for Extrapyramidal Symptoms (EPS) (involuntary movements such as tremors, rigidity, and restlessness) (anticonvulsant medication), used to treat bipolar disorder by stabilizing mood. - 01/24/26: Fluphenazine Decanoate Injection Solution 25 milligram (MG)/milliliter (ML), inject 50 mg intramuscularly one time a day every 21 day(s) for bipolar disorder (antipsychotic intramuscular injection used for the long-term management of schizophrenia).	F0742	Continued from page 25 address the resident's mental health needs on 2/16/2026 by MDS coordinator. 2.On 02/24/2026, the MDS coordinator and Social Services Director conducted a review of all residents receiving psychotropic medications and residents with mental health diagnoses to ensure psychiatric services, consents, and care plan interventions were in place. No additional deficiencies were identified. All residents have the potential to be affected by the deficient practice. 3.On 02/24/2026, the Director of Nursing updated the admission process to ensure residents admitted with psychotropic medications, psychiatric diagnoses, or psychiatric referral recommendations are referred to Social Services for psychiatric services and consent verification. Social Services will maintain a psychiatric services roster to track residents requiring psychiatric services and ensure appropriate follow-up is completed. On 3/4/2026 The Director of Nursing provided education to licensed nursing staff regarding the process for identifying residents requiring psychiatric services and initiating referrals to Social Services. Beginning 3/4/2026 any Newly hired licensed nurses will receive the same education during orientation and education will be provided by Director of Nursing or designee. An ADHOC Quality Assurance Performance Improvement Committee meeting was held on 02/24/2026 to review the deficient practice and approve the plan of correction. 4.Beginning 03/04/2026, the Director of Nursing and Social Services will conduct audits on 5 new admissions/readmissions to ensure psychiatric referrals, consents, and follow-up services are completed as indicated. Audits will be conducted monthly for three months. Any identified variance will result in immediate corrective action and staff re-education as indicated. Audit results will be presented to the committee by the DON/SSD and reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) process for 3 months or until substantial compliance is maintained and brought to the committee by the	

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F0742 SS = D	Continued from page 26 An admission Minimum Data Set (MDS) assessment dated 01/29/26 indicated Resident #21's cognition was intact and there were no behaviors coded during the lookback period. Resident #21 was coded for receiving antipsychotic medications. The identification information section was coded as Resident #21 having a level II Pre-Admission Screening and Resident Review (PASRR). A review of Resident #21's behavioral documentation located on the medication administration (MAR) from 01/23/26 through 02/13/26 revealed the following: - calling out: 01/28/26, 01/29/26, 01/30/26, and 02/03/26, -screaming and calling out: 01/23/26, 01/26/26, 01/31/26, 02/01/26, 02/04/26, 02/05/26, 02/09/26, 02/10/26, and 02/13/26. A review of Resident #21's medical record from 01/23/26 through 02/16/26 revealed no psychiatric services or other behavioral health care services were provided to the resident. A continuous observation was completed on 02/16/26 from approximately 11:10 AM until 11:31 AM of Resident #21's call light being on and he was yelling for assistance. ("Hey, someone help me, hey come here, I need help"). An interview was conducted on 02/16/26 at 11:31 AM with Med Aide (MA) #2. Resident #21 was yelling and screaming for assistance and MA #2 stated "oh he does that," he yells out for assistance". She further stated she did not know how long Resident #21 had been yelling "this time". An interview was conducted on 02/17/26 at 10:00 AM with Nurse #3. She stated that Resident #21 does yell out for assistance, but he didn't utilize his call bell. She verified she was the admitting nurse for Resident #21 however she did not recall seeing the referral for psychiatry services. She explained that when a resident was admitted to the facility the admitting nurse reviewed the hospital discharge summary for several things including follow-up appointments. If there was a referral or follow-up appointment related to psychiatric services or if the resident was on any psychotropic medications a copy of the referral was put in the social workers box for further follow through. She went on to explain that the psychiatry providers came into the building 2-3 times a week. Nurse #3 then stated she did not know how or why Resident #21 had not	F0742	Continued from page 26 administrator. All corrective actions and systemic changes will be fully implemented by 03/6/2026.	

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F0742 SS = D	Continued from page 27 been seen by psychiatry yet due to his behaviors. Nurse #3 went on to say she documented his behaviors on the medication administration record. An interview was conducted on 02/17/26 at 10:25 AM with the Social Services Director. She verified she had not received a referral order for a psychological consultation for Resident #21. She explained that each month she received a list from the psychiatric provider of all residents who were "active" indicating they were receiving services, Resident #21 was not on that list. She indicated the psych consent had not been completed as of right now for Resident #21. She explained that if a resident was admitted to the facility with psychotropic medications, a mental health diagnosis, or a referral from the hospital that the admitting nurse would put the information in her mailbox and she would arrange for a consultation. Psych comes in every 2 weeks, and psych talk comes in weekly. Psych would pick them up on the next visit after the referral had been sent to them An interview was conducted on 02/18/26 at 12:01 PM with the Medical Director. She indicated that it was her expectation for facility residents to receive the care and services necessary to meet their behavioral healthcare needs. An interview was conducted on 02/18/26 at 4:02 PM with the Director of Nursing (DON). She indicated she expected residents to receive the care and services necessary to meet their behavioral healthcare needs. The DON revealed she was unaware Resident #21 had not been referred to or was not being seen by the psychiatric provider.	F0742		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F0757	1.On 02/18/2026, during the survey process, the Director of Nursing reviewed the Medication Administration Record and blood pressure documentation for Resident #49 related to administration of blood pressure medication when the systolic blood pressure was below the ordered parameter of 110. The medication aide and nurse identified as administering medication outside of the ordered parameters were identified. Both staff members were re-educated by the Director of Nursing regarding adherence to physician ordered hold parameters and verification of vital signs prior to medication administration. No adverse outcomes were identified for the resident.	03/06/2026

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F0757 SS = D	Continued from page 28 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on record review, Medical Director and staff interviews, the facility failed to hold a blood pressure medication as ordered by the physician for 1 of 6 residents whose medications were reviewed (Resident #49) for unnecessary medication. The findings included: Resident #49 was admitted to the facility on 10/21/22 with diagnoses that included hypertension and heart failure. Review of Resident #49's physician orders included an order dated 9/6/24 for Metoprolol Tartrate (a medication for high blood pressure) 25 milligrams (mg). Give 12.5 mg by mouth every 12 hours. Hold if systolic blood pressure (SBP-the top number in the blood pressure reading) is less than 110. The January 2026 Medication Administration Record (MAR) was reviewed and revealed Resident #49 had received Metoprolol Tartrate, despite the SBP being below 110 on the following dates:1/3/26 for 9:00 PM dose, SBP was 109 administered by Nurse #5.1/9/26 for 9:00 PM dose, SBP was 109 administered by Medication Aide (MA) #1.1/10/26 for 9:00 PM dose, SBP was 99 administered by MA #1.1/12/26 for 9:00 PM dose, SBP was 106 administered by MA #1. A quarterly Minimum Data Set (MDS) assessment dated 1/22/26 indicated Resident #49 was cognitively intact. On 2/18/26 at 3:30 PM, an interview was conducted with	F0757	Continued from page 28 2.On 02/23/2026, the Director of Nursing and Nurse Supervisors completed a review of Medication Administration Records for residents receiving medications with physician ordered hold parameters. The review included verification that medications were administered within ordered parameters. Any concerns identified during the review were addressed immediately. All residents receiving medications with physician ordered hold parameters have the potential to be affected by the deficient practice. 3.On 2/18/2026, the Director of Nursing provided education to licensed nurses and medication aides regarding verification of vital signs and adherence to physician ordered medication parameters prior to medication administration. Licensed nurses and certified medication aides were instructed by the Director of Nursing to hold medications when ordered parameters are not met and to notify the nurse or provider as appropriate. Staff not present on 2/18/2026 will receive the same education by the Director of Nursing or designee prior to working their next scheduled shift. This education will be incorporated into new hire orientation for licensed nurses and medication aides. 4.Beginning 03/04/2026, the Director of Nursing or designee will conduct MAR Parameter Compliance Audits weekly for eight weeks and monthly for three months thereafter for five residents receiving medications with physician ordered hold parameters. Any variances identified during monitoring will result in immediate counseling and re-education of staff. Audit results and trends will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) process for three months or until substantial compliance is maintained. All corrective actions and systemic changes will be fully implemented by 03/06/2026.	

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F0757 SS = D	Continued from page 29 MA #1, who reviewed the January 2026 MAR and verified the Metoprolol Tartrate was administered despite the SBP being below 110 when it should have been held for the 9:00 PM dose on 1/9/26, 1/10/26 and 1/12/26. She stated it was an oversight. Attempts to contact Nurse #5 were made without success on 2/17/26 at 5:45 PM and 2/18/26 at 11:19 AM. The Medical Director was interviewed on 2/18/26 at 12:01 PM and didn't feel Resident #49 would have suffered any serious harm by receiving Metoprolol Tartrate outside the parameter, however, she would expect the nursing staff to follow the orders for the Metoprolol Tartrate blood pressure parameter as written. An interview occurred with the Director of Nursing (DON) on 2/18/26 at 2:42 PM and stated she expected the nursing staff to follow physician orders including blood pressure medications with parameters to hold. The DON explained that she had recently taken over the role earlier in February 2026 and was unaware that the staff had administered the medication outside of the prescribed parameters.	F0757		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of	F0761	1.On 02/24/2026, the Director of Nursing removed and discarded all expired medications identified during the survey. 2.All residents have the potential to be affected by the deficient practice. On 02/24/2026, the Director of Nursing and Nurse Supervisors conducted a facility-wide audit of all medication carts, medication rooms, and medication refrigerators to identify expired or undated medications. Any expired or undated medications identified during the audit were removed immediately. 3.On 02/24/2026, the Director of Nursing re-educated licensed nurses and medication aides regarding medication labeling, expiration requirements, and proper dating protocols for multi-dose medications including insulin pens and refrigerated medications such as Tuberculin solution. Nursing staff were instructed that medications requiring dating must be labeled immediately upon	03/06/2026

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F0761 SS = E	Continued from page 30 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation and staff interviews, the facility failed to discard expired medications and date open multiple-dose medications in 2 of 3 medication carts (A and D medication carts) and 1 of 1 medication storage room observed. Findings included: a. On 2/15/26 at 12:35PM, the medication room was observed with the Director of Nursing (DON) and Nurse #2. There was one open undated vial of Apilsol Tuberculin Purified Protein Derivative (PPD) solution stored in the refrigerator (The manufacturer's storage instruction indicated once opened the solution should be discarded within 30 days). b. On 2/15/26 at 2:38 PM, the medication cart for hall A was observed with Nurse #4. The following expired and undated medications were observed in the cart: - One bottle of Nitroglycerin 0.4 milligram (mg) tablet - expiration date 1/2026, - Two Humalog Insulin KwikPens opened and undated (The manufacturer's Insulin storage instruction indicated once opened, Humalog should be stored at room temperature and used within 28 days), - One Insulin Glargine Injection Pen opened and undated (The manufacturer's Insulin storage instruction indicated once opened, Insulin Glargine should be stored at room temperature and used within 28 days), - One Humalog Insulin KwikPen opened with date opened 1/7/26 (The manufacturer's Insulin storage instruction indicated once opened, Insulin should be stored at room temperature and used within 28 days), - One Basagler Insulin KwikPen opened and undated (The manufacturer's Insulin storage instruction indicated once opened, Basagler should be stored at room temperature and used within 28 days), - One Insulin Glargine Injection Pen opened with dated opened 1/7/26 (The manufacturer's Insulin storage	F0761	Continued from page 30 opening according to manufacturer guidelines. Beginning 3/4/2026 Night shift nurses were assigned responsibility for completing routine medication cart and medication room checks to identify expired or improperly labeled medications daily. A medication cart inspection log was implemented to document completion of routine cart checks. Beginning 3/4/2026 Newly hired licensed nurses and medication aides will receive the same education during orientation by the director of nursing or designee. An ADHOC Quality Assurance Performance Improvement Committee meeting was held on 02/24/2026 to review the deficient practice and approve the plan of correction. 4.Beginning 03/04/2026, the Director of Nursing and Nurse Managers will conduct Medication Storage and Expiration Audits to ensure medications are properly labeled, dated, and stored according to facility protocol. Audits will be conducted weekly for 4 weeks and monthly for 3 months thereafter. Any deficiencies identified will be corrected immediately and addressed through staff re-education as necessary. Audit results and trends will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) process for 3 months or until substantial compliance is maintained. The DON will present the audit findings to the QAPI committee for review. All corrective actions and systemic changes will be fully implemented by 03/6/2026.	

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F0761 SS = E	Continued from page 31 instruction indicated once opened, Insulin Glargine should be stored at room temperature and used within 28 days). On 2/15/26 at 3:32 PM, Nurse #4 stated the nurse who opened a medication was responsible for writing the date opened on medications that required dating. She stated night nurses were expected to routinely check medication carts and the medication room and remove expired medications found; however, she indicated overall monitoring of medications was a “group effort.” Nurse #4 stated she usually looked through the medications on her medication cart but had not had a chance yet today. c. On 2/15/26 at 2: 58PM, the medication cart for hall D was observed with Nurse #6. The following expired and undated medications were observed in the cart: - One Novolin R FlexPen used and undated (The manufacturer's Insulin storage instruction indicated once opened, Novolin R should be stored at room temperature and used within 28 days), - One bottle of 200mg Ibuprofen tablets – expiration date 12/2025. On 2/15/26 at 3:36 PM, Nurse #6 stated monitoring medication carts and medication storage rooms for unlabeled and expired medications was a “team effort.” She indicated she attempted to check her cart daily but had not checked it yet. She confirmed that the nurse who opened a medication was responsible for dating it and removing any expired medications. An interview was conducted on 2/18/22 at 4:13 PM with the DON revealed night shift nurses were responsible for checking medication carts and the medication storage room nightly for expired medications. The DON further stated the Nurse who opened a medication was responsible for dating it if the medication required dating. She indicated it was her expectation that nurses date medications upon opening and discard expired medications as needed.	F0761		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F0812	1.On 2/15/26, The Dietary Manager immediately discarded all unlabeled and undated orange juice, the sausage biscuits, pimento cheese and rice that were not properly sealed, labeled, and dated. 2.On 2/15/2026 the Dietary Manager conducted an audit of all kitchen food storage areas including refrigerators, freezers, and dry storage areas to ensure all food items were properly sealed, labeled,	03/06/2026

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F0812 SS = E	Continued from page 32 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to label and date food items and maintain food in sealed containers in the kitchen. Specifically, the facility did not label and date cups of orange juice in 1 of 1 walk-in cooler; did not seal and label a box of frozen biscuits with the date opened in 1 of 1 walk-in freezer; did not keep a small container of pimento cheese sealed in 1 of 1 reach-in refrigerator; and seal and label a box of rice with the date opened in the dry storage area. These practices had the potential to affect the safety and quality of food served to residents. The findings included: 1. An observation on 2/15/26 at 10:05 AM revealed the following in the reach-in refrigerator: • One small metal container of pimento cheese was loosely covered with plastic wrap, leaving it exposed to air. The date written on the wrap was obscured. The Cook was interviewed during the initial observation on 2/15/26 at 10:05 AM. She stated the pimento cheese was made the morning of 2/15/26. The cook did not respond when asked about the pimento cheese not being sealed. She was observed removing the pimento cheese from the reach-in refrigerator. She replaced the plastic wrap, wrote a date in permanent marker on the plastic wrap, and attempted to place the container back in the reach-in refrigerator. She was made aware the	F0812	Continued from page 32 and dated in accordance with facility policy. Any items not properly sealed, labeled, or dated were discarded immediately. This review confirmed that food items available for resident consumption were stored safely. All residents have the potential to be affected by the deficient practice. 3.The Dietary Manager (or designee) re educated all dietary staff on 2/16/26 the proper food storage procedures, including labeling all opened or prepared food items with name and date, properly sealing all opened food items, following manufacturer and facility guidelines for food storage and expiration. The Dietary Manager implemented a standardized food labeling system and labels are readily available in all food storage areas, Beginning 2/16/26 food safety expectations will be reviewed during new hire orientation and annual competency training for dietary staff by the dietary manager. 4.The Dietary Manager or designee will conduct daily refrigerator, dry storage area and cooler audits to ensure all food items are sealed, labeled, and dated appropriately 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly x 4 weeks. Findings will be documented on a Food Storage Monitoring Log. Any noncompliance identified will be corrected immediately and staff re educated as necessary. Results will be brought to the committee by Dietary Manager and reviewed in Quality Assurance Committee meetings for 3 months, and trends will be addressed with additional education or disciplinary action as indicated. Audit results and corrective actions will be documented and maintained. The facility alleges compliance 03/6/2026.	

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F0812 SS = E	Continued from page 33 pimento cheese was not safe to serve because it was unknown how long it had been unsealed. 2. An observation on 2/15/26 at 10:15 AM revealed the following in the dry storage area: • One 25-pound box of white rice was stored in an unsealed bag open to air and not marked with the date opened. The Cook was interviewed during the initial observation on 2/15/26 at 10:15 AM. The Cook stated she did not know why the box was open to air and not marked with the date opened. 3. An observation on 2/15/26 at 10:25 AM revealed the following in the walk-in cooler: • Seven 4-ounce cups of orange juice covered with plastic wrap but unlabeled and undated. The Cook was interviewed during the initial observation on 2/15/26 at 10:25 AM. She stated night shift staff prepared orange juice each night and were responsible for labeling and dating it. 4. An observation on 2/15/26 at 10:40 AM revealed the following in the walk-in freezer: • One box of frozen biscuits was stored in an unsealed bag open to air and not marked with the date opened. The Cook was interviewed during the initial observation on 2/15/26 at 10:40 AM. The Cook stated she did not know why the box was open to air and not marked with the date opened. On 2/15/26, the Dietary Manager and District Dietary Manager confirmed that all food items should be labeled and dated when prepared, opened, or stored after opening. They stated staff were aware of this requirement and did not understand why it was not followed. They confirmed night shift staff should have labeled and dated the orange juice. A follow-up walkthrough revealed all unlabeled, undated, and unsealed food items had been discarded. On 2/18/26 at 4:27 PM, the Director of Nursing (DON) and Administrator stated they were unaware of the failure to label and date food items. Both acknowledged the requirement and discussed that staff could have used a permanent marker when tape was unavailable. The Administrator stated a better system for labeling and dating food items needed to be implemented. Both	F0812		

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F0812 SS = E	Continued from page 34 reiterated their expectation that kitchen staff follow established protocols.	F0812		