| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345201 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 03/02/2026 |
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| **Pelican Health at Charlotte** | **2616 East 5th Street , Charlotte, North Carolina, 28204** |

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| E0000 | Initial Comments<br><br>An unannounced onsite recertification and complaint investigation survey was conducted 2/22/2026 through 2/25/2026. Additional information was obtained offsite 2/26/2026 through 3/02/2026. Therefore, the exit date was changed to 3/02/2026. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 1E4AF1-H1. | E0000 | | 03/17/2026 |
| F0000 | INITIAL COMMENTS<br><br>An unannounced onsite recertification and complaint investigation survey was conducted 2/22/2026 through 2/25/2026. Additional information was obtained offsite 2/26/2026 through 3/02/2026. Therefore, the exit date was changed to 3/02/26. Event ID# 1E4AF1-H1.<br><br>The following intakes were investigated 2708726, 2696721, 2690991, 2688995, 2677531, 2661529, 2639233, 2636511, 2618357, 2615904, 2566118, 855767, 855768, 855753, 855765, 855749, 855762, 855748, 855747. 12 of the 58 complaint allegations resulted in deficiency.<br><br>Immediate Jeopardy was identified at:<br><br>CFR 483.25 at tag F684 at a scope and severity (J); the IJ began 1/20/2026 and was removed 2/25/2026.<br><br>CFR 483.25 at tag F689 at a scope and severity (J); the IJ began 1/20/2026 and was removed 2/25/2026.<br><br>The tags F684 and F689 constituted Substandard Quality of Care.<br><br>An extended survey was conducted. | F0000 | | 03/17/2026 |
| F0561<br>SS = D | Self-Determination<br><br>CFR(s): 483.10(f)(1)-(3)(8) | F0561 | On 2/25/26 the Director of Nursing and Unit Manager met with Resident #22 to review her preference to return to bed immediately following dialysis, re educated staff regarding resident self determination and timely | 02/28/2026 |

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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| F0561 SS = D | Continued from page 1<br>§483.10(f) Self-determination.<br><br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, record review and resident and staff interviews, the facility failed to honor a resident's request to return to bed after arrival to the facility from dialysis services. The resident stated to a staff member that waiting for over an hour for assistance to return to bed after dialysis treatment made her feel lightheaded and even more tired. This deficient practice affected 1 of 4 residents reviewed for choices (Resident #22).<br><br>The findings included:<br><br>Resident #22 was readmitted to the facility on 8/6/25. Her diagnoses included chronic kidney disease stage 4 with hemodialysis and type 2 diabetes mellitus.<br><br>Resident #22's physician order dated 8/12/25 revealed Resident #22 received hemodialysis every Tuesday, Thursday, and Saturday. | F0561 | Continued from page 1<br>response to resident requests, ensured Resident #22 was returned to bed without delay, and updated the care plan, CNA Kardex, and assignment sheets to reflect timely post dialysis bed placement.<br><br>On 2/26/26 the Director of Nursing and Unit Managers reviewed all residents receiving dialysis or requiring mechanical lift transfers to ensure preferences were documented, care plans and Kardexes reflected resident choices, and staff assignments supported timely care; all identified gaps were corrected immediately.<br><br>The facility implemented systemic changes to require documentation of post dialysis routines and bed preferences for all dialysis residents, added dialysis return priority notation to CNA assignment sheets, re educated beginning on 2/26/26 for all staff: RN, LPN, All Managers, All House Keepers, all nurse aides on staff including any new hires and agency nurses coming in going forward, nurses including any new hires and agency nurses coming in going forward, therapy (all therapy staff), all incoming new hires, including agency staff on resident choice, call light response, and mechanical lift assistance expectations, and reinforced that call lights may not be turned off without addressing resident needs.<br><br>Compliance will be monitored by DON and ADON through weekly audits for four weeks and monthly audits for two months of call light response times, post dialysis care timeliness, staff communication, direct observations of dialysis returns, and random staff interviews, with findings reviewed through clinical meeting weekly, and QAPI monthly.<br><br>Date of compliance is 2/28/26. | |

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| F0561 SS = D | Continued from page 2<br>Resident #22 had a dialysis care plan in place dated 8/12/25 which revealed she was at risk for complications requiring hemodialysis; dialysis treatment days were scheduled every Tuesday, Thursday, and Saturday.<br><br>Resident #22's significant change Minimum Data Set (MDS) assessment dated 8/15/25 revealed Resident #22 was cognitively intact. Resident #22 was dependent on staff for transfers via mechanical lift. The MDS further indicated that it was very important for Resident #22 to choose her bedtime. Resident #22 was coded as receiving dialysis..<br><br>An interview was conducted on 2/22/26 (a non-dialysis treatment day) at 11:59 AM with Resident #22. Resident #22 stated she would typically return to the facility around 10:50 AM from dialysis services. She stated she would notify staff when she returned from dialysis services as she passed the nurses' station or the dialysis transport driver would inform the staff that she (Resident #22) was back from dialysis services if staff were not at the nurses' station. Resident #22 explained she pressed her call light to notify staff she was ready to return to bed. Resident #22 verbalized she gauged the time while watching The Price is Right (a television program that started at 11:00 AM and ended at 12:00 PM) or by looking at the clock on her personal cell phone. Resident #22 also had a clock on her wall next to the bathroom door that she gauged time with. Resident #22 stated there were times she would wait until after lunch (between 12:30 PM and 1:30 PM) to be placed back into bed after her return from dialysis treatment. Resident #22 voiced that her day began at 2:00 AM in preparation for her dialysis treatment. Resident #22 expressed that after her dialysis treatments, she was extremely tired and ready to return to bed once she arrived back at the facility.<br><br>On 2/24/26 at 10:40 AM, a continuous observation was conducted of Resident #22 returning from dialysis services via external transportation. Once Resident #22 was delivered to her room, the call light was activated by Resident #22 at 10:43 AM. Resident #22's call light was turned off by Nurse Aide (NA) #10 at 10:45 AM. At 10:51 AM, an interview was completed with Resident #22. Resident #22 stated NA #10 entered her room and deactivated her call light, then informed Resident #22 that she was completing rounds and would return. Resident #22 verbalized that she did not have a chance to let NA #10 know what she required or needed. Resident #22's call light remained off. At 11:25 AM, the call light was reactivated by Resident #22. At 11:28 AM, NA #7 answered the call light and deactivated | F0561 | | |

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| F0561 SS = D | Continued from page 3<br>it. At 11:34 AM, NA #7 attempted to assist Resident #22 but needed another nurse aide or staff person to assist her during a mechanical lift transfer. NA #7 verbalized to Resident #22 that she had requested assistance from another staff member. At 11:40 AM, the call light was reactivated by Resident #22. At 11:43 AM, the call light was turned off by the Certified Occupational Therapist Assistant (COTA) #1 and NA #7 as they returned to Resident #22's room. COTA #1 and NA #7 were observed transferring Resident #22 with the mechanical lift with no concerns back to bed.<br><br>On 2/24/26 at 2:55 PM an interview was conducted with Nurse Aide #10. NA #10 stated she was assigned to Resident #22 that day and was responsible for assisting with upper and lower body bathing and dressing. NA #10 stated she answered Resident #22's call light after she returned from dialysis and Resident #22 voiced that she was ready to lay down. NA #10 stated she was in the process of assisting another resident located on a different hall with dressing and transferring to a wheelchair at that time. NA #10 acknowledged that she did not notify or request assistance from other staff members. NA #10 explained that, as an agency nurse aide, she had a designated assignment and stated it was not the responsibility of other staff members to address needs for residents on her assignment. NA #10 stated she completed walking rounds at the beginning of her shift; however, she was not aware of any request or preference that Resident #22 should be placed in bed upon returning from dialysis services. NA #10 revealed she did not receive a full report prior to taking the hall and beginning her assignment and did not recall receiving report regarding Resident #22. NA #10 stated she did not return to Resident #22's room after she assisted another resident on a different hall.<br><br>On 2/24/26 at 2:29 PM an interview was conducted with Nurse Aide #7. NA #7 revealed she answered the call light initially and turned off call light. NA #7 indicated she explained to Resident #22 that she needed to get someone to assist her with the mechanical lift transfer. NA #7 explained that it was normal to have two staff members present with mechanical lift transfers. NA #7 then proceeded to come out of Resident #22's room to get someone to assist her, which was COTA #1. NA #7 stated that Resident #22 expressed that she was tired from dialysis treatment. Resident #22 also stated to NA #7 that she had waited a little minute, but NA #7 could not give a definite time frame. NA #7 stated that the nurse aides were aware that when Resident #22 returned from dialysis treatment she liked to go to bed as soon as possible. NA #7 confirmed that the nurse aides who were usually scheduled on the unit | F0561 | | |

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| F0561 SS = D | Continued from page 4<br>were aware of Resident #22's request and would put her to bed upon her return to the facility from dialysis treatment. NA #7 added, if the aides were in the middle of something, then it would typically be 10 to 15 minutes (depending on what they were completing) to assist her to bed. NA #7 was not certain why it took so long to assist Resident #22 back to bed after her dialysis treatment and return to the facility.<br><br>On 2/24/26 at 2:22 PM, an interview was completed with the Certified Occupational Therapy Assistant (COTA) #1 who stated she worked at the facility for approximately 6 years. She confirmed that Resident #22 was on Occupational Therapy (OT) caseload and no other therapies at the time. COTA #1 explained she responded to Resident #22's call light around 11:40 AM and went to look for NA #10 to assist with getting Resident #22 back into bed. NA #10 verbalized she needed assistance with another resident, so COTA #1 assisted NA #10 with the resident NA #10 was working with and then returned to Resident #22's room to assist with getting her back to bed. COTA #1 stated NA #7 assisted with putting Resident #22 back to bed via mechanical lift per Resident #22's transfer status. COTA #1 verbalized that Resident #22 informed her she was very tired and lightheaded from her dialysis treatment. Resident #22 also informed COTA #1 that she had been waiting over 45 minutes. COTA #1 stated staff was aware that when Resident #22 returned from dialysis treatment she liked to go to bed. COTA #1 explained that because a different nurse aide was assigned to the hall, Resident #22's routine and preferences must not have been communicated with NA #10.<br><br>On 2/24/26 at 2:42 PM, an interview was conducted with the Unit Manager. The Unit Manager stated that nurse aides were to respond immediately to call lights and notify staff if any additional assistance was required. The Unit Manager further explained that staff were aware that Resident #22 preferred to go to bed upon return to the facility after dialysis treatments. The Unit Manager stated Resident #22 should not have had to wait over an hour to be assisted back to bed and that NA #10 should have anticipated Resident #22's need and made sure she was put to bed immediately upon her return from dialysis treatment. If NA #10 could not assist Resident #22 then NA #10 should have requested assistance from other staff on the unit that were available.<br><br>On 2/25/26 at10:10 AM, an interview was completed with the Director of Nursing (DON). The DON confirmed | F0561 | | |

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| F0561 SS = D | Continued from page 5<br>Resident #22 was alert, oriented and could clearly communicate regarding her preferences and choices. Resident #22 could make the request to return to bed after she arrived back at the facility after dialysis treatment. The DON indicated NA #10 was not aware of Resident #22's preferences as she was agency staff. The DON further stated that if NA #10 was in the middle of care with another resident, then the appropriate process would have been to return to Resident #22 as soon as possible or NA #10 should have followed up and provided an update as to when she would be able to assist her. The DON explained that the facility attempted to accommodate Resident #22's preferences and choices when she returned from dialysis treatment to be placed back to bed.<br><br>On 2/25/26 at 4:33 PM, an interview with the Administrator revealed that staff should have responded to Resident #22's call light immediately or within 5 minutes to 10 minutes at maximum to assist with Resident #22's request. The Administrator stated that waiting 45 minutes to go to bed after dialysis services was not acceptable and staff should have acknowledged Resident #22's request by returning her to bed after dialysis treatment. | F0561 | | |
| F0584 SS = D | Safe/Clean/Comfortable/Homelike Environment<br><br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br><br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br><br>§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.<br><br>(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.<br><br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. | F0584 | F0584<br><br>Safe/Clean/Comfortable/Homelike Environment<br><br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br><br>The facility failed to maintain the footboards on beds in a resident room in good repair (Residents #25 and #27). The deficient practice affected 1 of 21 rooms on 1 of 4 halls observed for a safe and homelike environment. On 2/24/26 maintenance replaced the damaged footboards for Residents #25 and #27, inspected the beds for safety, and the Administrator and Director of Nursing verified repairs were completed.<br><br>On 2/25/26 a facility wide inspection of beds and bedroom furniture was completed by maintenance and nursing leadership, with no additional hazards identified and minor issues corrected immediately.<br><br>The facility re educated on 2/26/26 all Staff to include: All dietary staff, all housekeeping staff, all clinical staff, all management staff and agency staff | 02/27/2026 |

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| F0584 SS = D | Continued from page 6<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§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<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, record review, and staff interviews, the facility failed to maintain the footboards on beds in a resident room in good repair (Residents #25 and #27). The deficient practice affected 1 of 21 rooms on 1 of 4 halls observed for a safe and homelike environment.<br><br>The findings included:<br><br>An observation conducted on 2/23/26 at 1:15 PM in the shared room of Residents #25 and Resident #27 revealed that the footboards on both residents' beds were in disrepair. Resident #25's footboard was missing the banding which left an exposed, rough area of particle board approximately 3 to 4 inches in length. Resident #27's footboard exhibited multiple damaged areas, each approximately 6 inches long, with rough, exposed particle board. The laminate covering was missing from the footboard.<br><br>A review of the facility's online maintenance work order system from March 2025 to February 2026 revealed no documented requests for repair of the bed footboards for Resident #25 or Resident #27.<br><br>An interview and observation were conducted with Nurse | F0584 | Continued from page 6<br>(this is also added to all new hire orientation from 2/26/26 ongoing) on environmental hazard reporting. On 2/26/26 Administrator clarified supervisory expectations, implemented daily visual environmental checks by Unit Managers and Maintenance, reinforced environmental safety as a quality of care measure, and reinforced immediate submission of maintenance work orders.<br><br>Monitoring began 2/26/26 will include weekly environmental safety audits by maintenance for four weeks and monthly audits for two months focusing on beds, headboards, footboards, and furniture, with results reviewed through Quality Assurance Performance Improvement.<br><br>Date of compliance is 2/27/26. | |

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| F0584 SS = D | Continued from page 7<br>Aide (NA) #1 on 2/23/26 at 12:54 PM revealed that the outer coating on Resident #25's bed footboard was missing, which exposed a rough area of particle board. She confirmed that the footboards for both Resident #25 and Resident #27 had exposed particle board. The interview revealed both footboards had been damaged for some time, but she had not notified any staff members.<br><br>An interview with Nurse #4 on 2/24/26 at 11:36 AM revealed she had observed damage to the outer coating of Resident #25's and Resident #27's bed footboard. She reported that, as an agency staff member, she assumed Maintenance was already aware of the issue. Nurse #4 stated she did not know how long the footboard had been in that condition but had observed the damage a couple of weeks earlier.<br><br>An interview with the Maintenance Director on 2/24/26 at 10:02 AM revealed he had been at the facility since April of last year and on 2/23/26, he stated the Administrator called him on 02/24/26 and notified him of an issue with the footboards in a resident room. He stated he noticed the laminate covering had been rubbed off on the bottom of Resident #25 and Resident #27 footboards. He stated Resident #27's bed was replaced and Resident #25's bed, looked like the banding was coming off and the particle board was exposed. The Maintenance Director stated that was not how the beds were supposed to look and it was warranted for the footboards to be changed. He stated when he was notified about the situation, verbally by the Administrator, he immediately went and changed them as he keeps extra footboards and headboards in the maintenance shop. The Maintenance Director stated if staff saw beds in disrepair, he expected them to put in a work order to have it changed out. The interview revealed he was not aware of the damage to the footboards until the Administrator called him.<br><br>A combined telephone interview with the Director of Nursing (DON) and Administrator occurred on 2/26/26 at 10:36 AM. The DON stated she had the expectation that all nursing staff to put in a work order for anything that needs to be repaired by maintenance. The Administrator stated NAs have access in their point of care system to request any maintenance concerns 24 hours a day. The Administrator stated there were many items in the facility which needed attention and some had been marked as urgent requests. The Administrator stated maintenance, checked Resident #25 and Resident #27's beds and did not find anything on them that was rough and he did not see anything urgent in replacing them until after the State Surveyor pointed out the concern. The footboards were replaced by the | F0584 | | |

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| F0584 SS = D | Continued from page 8<br>maintenance department on 2/24/26. The Administrator and DON both stated they were not aware of any damage to Resident #25 or Resident #27's footboards until it was brought to their attention during the survey on 02/24/26. | F0584 | | |
| F0641 SS = D | Accuracy of Assessments<br><br>CFR(s): 483.20(g)(h)(i)(j)<br><br>§483.20(g) Accuracy of Assessments.<br><br>The assessment must accurately reflect the resident's status.<br><br>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>§483.20(i) Certification.<br><br>§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.<br><br>§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.<br><br>§483.20(j) Penalty for Falsification.<br><br>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(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<br><br>(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.<br><br>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observations, record reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of range of motion and mobility devices for 1 of 21 | F0641 | On 3/2/26 the MDS Coordinator and Director of Nursing reviewed therapy documentation for Resident #25, confirmed range of motion impairment and wheelchair use, corrected the assessment process going forward, and aligned the care plan with interdisciplinary findings.<br><br>On 3/3/26 and again on 3/17/26 all residents with active or recent therapy services were reviewed to verify accurate MDS coding for range of motion and mobility devices, with no additional inaccuracies identified.<br><br>System changes included mandatory therapy documentation review effective 3/3/2026 prior to MDS completion, documented interdisciplinary verification, Director of Nursing oversight of functional coding, and staff re education of all licensed clinical staff and MDS Director on MDS coding requirements on 3/3/2026.<br><br>Monitoring audits began on 3/3/2026 will include weekly MDS audits by DON for four weeks and monthly audits for two months, with findings reviewed and addressed through QAPI.<br><br>Date of compliance is 3/4/26. | 03/04/2026 |

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| F0641 SS = D | Continued from page 9<br>sampled residents (Resident #25).<br><br>The findings included:<br><br>Resident #25 was admitted to the facility on 08/15/24 with diagnoses of fracture of the right tibia, muscle weakness and physical debility.<br><br>A care plan dated 09/05/25 revealed a focus area related to Activities of Daily Living (ADL) care. Resident #25 required assistance with her ADL. The goal was for the resident to maintain their current level of function through the next review date. Interventions included two staff member assistance using a mechanical lift with transfers.<br><br>A Physical Therapy evaluation dated 11/14/25 signed by Physical Therapist #1 revealed Resident #25 demonstrated decreased bilateral lower extremity range of motion due to contractures and weakness. She demonstrated decreased function with bed mobility and wheelchair mobility. Resident #25 was noted to be limited by contracture and malalignment of the right lower extremity due to a chronic break. The assessment revealed Resident #25 did not tolerate upright positioning for long and was unable to sit in a wheelchair without bilateral lower extremities elevated on pillows and leg rests.<br><br>On 02/25/26 at 5:00 PM, an interview was conducted with Physical Therapist #1. During the interview, she stated she had worked with Resident #25 during sessions in November 2025 and December 2025. She explained Resident #25's range of motion was severely decreased in her bilateral lower extremities and her legs remained elevated on pillows and leg rests with use of a wheelchair as a mobility device.<br><br>A quarterly Minimum Data Set (MDS) assessment dated 11/24/25 revealed Resident #25 was cognitively intact and dependent upon two staff members for personal and toileting hygiene, showering/bathing and upper and lower body dressing. Resident #25 was coded as having no range of motion impairment to the upper or lower extremities and no use of mobility devices during the assessment period.<br><br>An interview with the MDS Coordinator was conducted on 02/25/26 at 4:58 PM. She confirmed she had completed Resident #25's 11/24/25 MDS. She indicated after reviewing the Physical Therapy notes from 11/14/25 Resident #25 did have bilateral lower extremity impairment and did use a wheelchair as a mobility device. The MDS Coordinator explained that the MDS was | F0641 | | |

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| F0641 SS = D | Continued from page 10<br>completed incorrectly and should have been coded for use of a wheelchair and bilateral lower extremity range of motion impairment.<br><br>An interview conducted with the Administrator on 03/02/26 at 10:00 AM revealed Resident #25's MDS should have been coded to accurately reflect her range of motion and mobility devices. | F0641 | | |
| F0684 SS = SQC-J | Quality of Care<br><br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br><br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observations, record review and interviews with the resident, staff, Responsible Party (RP), Wound Nurse Practitioner, and Medical Director, failed to recognize the severity of the injury, the extent of bleeding, and the resident's increased risk for bleeding due to her daily anticoagulant medication (helps prevent blood from forming clots). On 01/20/26 Nurse Aide #1 pulled Resident #25 backwards alongside the bed hitting the Resident's lower left leg against the corner of the footboard. Resident #25's footboard was damaged, and the outer layer of protective laminate was gone, and pressboard was exposed (pressboard is a dense, stiff engineered material). Resident #25 immediately cried out in pain, and her lower left leg was bleeding. Resident #25 reported a pain scale of 10 on a scale of 1 to 10 (0 being no pain and 10 being the worst possible pain. Nurse #1 observed a 1-inch laceration to the residents left lower extremity, applied pressure for 5 minutes to stop the bleeding and applied a pressure dressing. Despite this known risk factor and the presence of active bleeding Emergency Medical Services (EMS) were not initiated by facility staff. The resident's RP arrived at the facility after being called by the resident who reported pain and the RP observed blood on the outside of the pressure dressing and called EMS. Resident #25 was subsequently transported to the hospital emergency department (ED) for evaluation and treatment. The ED physician noted Resident #25 had a large soft tissue hematoma (a | F0684 | Resident #25 was transferred to the hospital on 1/20/26, and upon return on 2/5/26 received physician ordered wound care, pain management, ongoing wound evaluations, and updated care planning.<br><br>On 2/24/26 all residents receiving anticoagulants were identified, skin assessments were completed, recent incident reports were reviewed, and no additional residents were found to require emergency intervention.<br><br>The facility completed a root cause analysis, reinforced change in condition and anticoagulation protocols, required SBAR and e INTERACT use, re educated licensed staff and nurse aides on bleeding risk recognition and emergency response, and reinforced Stop and Watch use.<br><br>Ongoing monitoring includes weekly audits for four weeks and monthly audits for three months focusing on anticoagulant related incidents, nursing assessments, and provider notification, with review through QAPI.<br><br>Immediate Jeopardy was removed on 2/25/26 and validated on 3/2/26; monitoring continues to address remaining lower level noncompliance. | 02/25/2026 |

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| F0684 SS = SQC-J | Continued from page 11<br>localized collection of clotted or partially clotted blood, trapped in tissue caused by a ruptured blood vessel from an injury) measuring 16.2 centimeters (6.3 inches) to her left lower extremity. Laboratory studies demonstrated a decline in hemoglobin from 11.1 to 7.3 (normal range 11.5 to 15) over the first two days of hospitalization, consistent with acute blood loss anemia, necessitating transfusion of packed red blood cells. Subsequently, the skin overlying the hematoma became necrotic (dead or dying tissue), requiring operative evacuation (surgically removing a collection of blood from inside of the body) of the hematoma and surgical debridement of the necrotic tissue, with placement of a wound vacuum-assisted closure (VAC) device. The facility's failure to assess the severity of the injury, consider the impact of anticoagulant therapy, and initiate emergency medical intervention placed Resident #25 at risk for serious complications related to acute blood loss. Resident #25 was discharged back to the nursing facility on 02/05/26 with orders for oxycodone 5 milligrams (mg) one tablet every 6 hours as needed for severe pain and wound care orders. This deficient practice affected 1 of 3 residents reviewed for quality of care (Resident #25).<br><br>Immediate Jeopardy began on 01/20/26 when Nurse #1 failed to recognize the severity of the injury and Resident #25's increase risk of bleeding due to her use of an anticoagulant. Immediate Jeopardy was removed on 02/25/26 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to ensure the monitoring systems put into place are effective and education is completed.<br><br>The findings included:<br><br>Resident #25 was admitted to the facility on 08/15/24 with diagnoses including diabetes mellitus, fracture of the right tibia, hypertension, muscle weakness, osteoporosis, history of a deep vein thrombosis (DVT- a medical condition in which a blood clot (thrombus) forms in one or more of the deep veins of the body), and physical debility.<br><br>A physician's order dated 11/02/25 revealed an order for Eliquis 5 milligrams, one tablet by mouth twice a day, for the prevention of deep vein thrombosis (DVT), a medical condition in which a blood clot (thrombus) forms in one or more of the deep veins of the body. Eliquis is a blood thinning medication that reduces blood clotting. Manufacturer's guidelines for the | F0684 | | |

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| F0684 SS = SQC-J | Continued from page 12<br>medication Eliquis 05/2025 indicated the medication can cause serious side effects including bleeding which could be serious and may lead to death. The guidelines further stated to call your healthcare provider with any severe bleeding.<br><br>A quarterly Minimum Data Set assessment dated 11/24/25 revealed Resident #25 was cognitively intact and dependent upon two staff members for toileting hygiene, showering/bathing, upper and lower body dressing, and personal hygiene. Resident #25 was coded for receiving an anticoagulant during the assessment period.<br><br>A care plan revised on 01/19/26 revealed a focus area related to anticoagulant usage. Resident #25 was noted to be at risk for bleeding and bruising related to use of an anticoagulant. The goal was for the resident to have no complications related to anticoagulant usage through the next review date. Interventions included observing for any abnormal bleeding or bruising.<br><br>On 02/23/26 at 12:54 PM, an interview and observation were conducted with Nurse Aide (NA) #1. During the interview, she stated she was responsible for Resident #25 on 01/20/26 during the 7:00 AM to 3:00 PM shift. NA #1 explained she was assisting Resident #25 with a bed bath when the resident requested to get up to her wheelchair. She explained that after placing Resident #25 in her wheelchair, with both feet positioned on pillows on top of the wheelchair leg rests, she turned the wheelchair and pulled it backward along the side of the bed. While NA #1 was pulling Resident #25's wheelchair backward along the side of the bed and the resident's left lower leg hit the corner of the footboard. She stated the bed was in a low position and Resident #25 began to yell out in pain. NA #1 indicated she realized Resident #25's left leg had hit the corner of the footboard and had begun to bleed. NA #1 re-enacted this action to the surveyor by pulling the resident's wheelchair backward along the side of the bed. NA #1 explained obtained paper towels from the sink and placed them on the resident's leg in an attempt to stop the bleeding. She stated, "It was bleeding bad." NA #1 the paper towels were saturated, so she then placed a regular bath towel over the leg and yelled for Nurse #1, who entered the room, applied pressure, and placed a dressing on the wound. She stated after Nurse #1 placed the dressing on the resident's leg the resident remained in her wheelchair with her legs elevated. NA #1 did not go back into the room until EMS arrived and she assisted the resident onto the stretcher. NA #1 stated she did not see blood on the dressing when she assisted with the transfer of Resident #25. | F0684 | | |

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| F0684 SS = SQC-J | Continued from page 13<br><br>A Situation, Background, Assessment, Recommendation assessment dated 01/20/26 at 11:30 AM, written by Nurse #1, revealed Resident #25 had received a skin tear to her left lower leg. A dressing was applied, and the Wound Nurse, Nurse Practitioner, or Medical Director were to evaluate. Recommendations included that Resident #25 be sent to the Emergency Department. New orders documented included: Patient to Emergency Department per her request related to skin tear to left leg. Vital signs included the following: blood pressure 132/77 (normal 120/80), pulse 97 (normal range 60-90), respiration 22 (normal range 12/20), temperature 98.2 (normal range 97-99.0), pulse oximetry 97% (normal range >92%) on room air. A pain scale was not included in the documentation.<br><br>A late entry nursing progress note dated 01/20/26 at 3:00 PM, written by Nurse #1, revealed the note was a late entry for 11:30 AM. Nurse #1 was informed Resident #25's leg was "bumped during transfer." Resident #25 was assessed and noted to have a one-inch slit in the middle of her left leg. The resident's anticoagulant was held at that time. Increased bleeding was noted related to Resident #25's anticoagulant therapy. Pressure was applied to the injury site for a duration of five minutes, and then a pressure dressing was applied.<br><br>A late entry nursing progress note dated 01/20/26 at 3:29 PM, written by Nurse #1, revealed Resident #25's Responsible Party (RP) was present in the facility. Upon the RP's arrival, Resident #25 began to scream and yell, "I'm hurting." Nurse #1 left the resident's room to check physician orders and obtain medication. Upon returning, the RP stated, "I called 911 services for Resident #25." Resident #25 stated, "I want to go to the hospital." Bleeding was noted to have stopped. Emergency Medical Services (EMS) arrived at the facility at 1:35 PM. A mechanical lift was used with two staff members to transfer Resident #25 onto the stretcher for EMS.<br><br>On 02/23/26 at 1:45 PM, an interview was conducted with Nurse #1. She stated she was an agency nurse working in the facility for the first time 01/20/26. She recalled NA #1 calling for assistance on 01/20/26 around 11:30 AM and entering the room to find Resident #25's left leg bleeding with a one-inch laceration located on her left lower leg. Due to the "increased" bleeding that saturated a towel NA #1 applied, she applied pressure for approximately 5 minutes to stop the bleeding, applied a pressure dressing, and notified the Wound Nurse and Nurse Practitioner #1. She stated, "I didn't | F0684 | | |

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| F0684 SS = SQC-J | Continued from page 14<br>think she needed to go to the hospital; I just notified Nurse Practitioner #1." She explained she did not recall if she administered pain medication to Resident #25 but if she put it into her written note from that date then she would have given pain medication. She didn't know why it wasn't on the MAR. Nurse #1 stated because she was an agency nurse it was difficult to remember the situation and all of the specific details and to refer to her notes of what occurred on 01/20/26.<br><br>On 02/23/26 at 1:10 PM, an interview was conducted with Resident #25. She confirmed NA #1's account of events and stated NA #1 was slowly pulling her wheelchair backward when her left leg hit the footboard because she got too close to the footboard of the bed. She stated her legs were elevated on pillows and positioned outward. She stated immediately when her leg hit the footboard she screamed in pain because it hurt and her leg began to bleed. NA #1 tried to assist her by placing towels onto her left lower leg and got the Nurse (Nurse #1) who entered the room and applied a dressing. She stated both staff members left the room, and she called her Responsible Party who came to the facility, and she told him she felt like she needed to go to the hospital. Resident #25 explained her Responsible Party then called 911. She stated it had been several weeks since the injury and she was still experiencing a lot of pain. Resident #25 described the pain as like no other she had experienced stating, "it's on and off, sharp pain". She explained she had received daily wound care and felt like her injury on her lower leg was improving.<br><br>On 02/23/26 at 3:14 PM, an interview was conducted with NA #4. She stated she worked both first and second shift on 01/20/26. NA #4 assisted with transferring Resident #25 onto the EMS stretcher. She reported Resident #25 was yelling in pain and that her legs remained straight and did not bend.<br><br>On 02/23/26 at 2:10 PM, an interview was conducted with Resident #25's Responsible Party. He stated Resident #25 called him on 01/20/26 and reported a Nurse Aide had hit her leg on the footboard while the NA was backing up her wheelchair beside the bed. During the call Resident #25 did not complain of pain but asked him to come. Upon arrival, he observed red blood on a white dressing on her left lower leg and stated, "The facility wasn't sending her, so I called 911." The interview revealed there was no blood noted in the room when he arrived other than on the resident's dressing and Resident #25 was complaining of pain. EMS arrived shortly after he called and transported her to the hospital. | F0684 | | |

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| F0684 SS = SQC-J | Continued from page 15<br><br>Emergency Medical Services (EMS) records dated 01/20/26 revealed EMS was called at 1:27 PM arrived at Resident #25's bedside at 1:42 PM. The nurse reported to EMS that Resident #25 was transferred from her, "wheelchair to her bed" when her leg was hit on a rounded corner, causing a 1 to 2-inch laceration to her left lower leg. Nurse #1 stated to EMS she had controlled the bleeding with gauze and tape and had administered pain medication. The resident's RP arrived approximately 30 minutes after the incident and requested Resident #25 be transported to the hospital for further evaluation. Resident #25 was noted to be in emotional distress due to pain with bilateral lower extremity swelling. Resident #25's left lower leg was noted to have bruising and swelling where she was injured but no obvious deformity. EMS did not remove Resident #25's dressing to her left lower extremity. of Vital signs revealed an elevated blood pressure of 182/110 (normal 120/80) and an elevated heart rate of 123 (normal 60–90). Resident #25 continued to complain of pain to her left lower extremity while en route to the hospital with a pain level of 10, on a 0-10 scale (0 being no pain, 10 being the worst pain). She was administered pain medication (acetaminophen) along with a diuretic (torsemide), and muscle relaxant (methocarbamol).<br><br>Hospital records dated 01/20/26 revealed Resident #25 presented to the Emergency Department (ED) from the nursing facility for evaluation of a hematoma and laceration to the left lower leg. She reported moderate to severe pain. The ED note indicated difficulty controlling bleeding at the nursing facility, and due to swelling, she was referred for further evaluation. Assessment of the left lower extremity revealed a 2 cm skin tear with a small amount of drainage coming from the area. She also had an associated large hematoma measuring approximately 4 x7 inches distally a small distance from the laceration. A picture 01/20/26 was taken while Resident #25 was in the Emergency Department. The picture shows Resident #25 lying in bed with her left leg elevated on a pillow. Blood was observed under her left knee pooled onto the bed and also on the pillow under the residents left leg. Ice was placed to assist with pain and swelling along with 2mg of morphine (a strong opioid pain medication use to treat moderate to severe pain) administered intravenously. Blood is also visualized on the residents left surrounding the laceration. Upon admission on 01/20/26, she was noted to have a large superficial soft tissue hematoma measuring 16.2 cm (6.38 inches). Laboratory studies demonstrated a decline in hemoglobin from 11.1 to 7.3 over the first two days of hospitalization, consistent with acute | F0684 | | |

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| F0684 SS = SQC-J | Continued from page 16<br>blood loss anemia, necessitating transfusion of packed red blood cells. Subsequently, the skin overlying the hematoma became necrotic, requiring operative evacuation of the hematoma, surgical debridement of necrotic tissue, and placement of a wound vacuum-assisted closure (VAC) device. Resident #25 was discharged back to the nursing facility on 02/05/26 with orders for oxycodone 5 milligrams (mg) one tablet every 6 hours as needed for severe pain and acetaminophen 650 mg every 8 hours as needed for pain. Wound care discharge instructions included daily dressing changes to the left lower extremity with petroleum gauze an abdominal pad and gauze wrap.<br><br>A nursing note dated 02/05/26 at 2:17 PM revealed Resident #25 had arrived back at the facility at 1:00 PM. The resident was assessed by the nurse, with a wound noted to her left lower leg. Resident #25 denied any pain or discomfort at that time.<br><br>A physician progress note written by the Medical Director on 02/06/26 revealed Resident #25 was evaluated on this date for a new admission following a recent hospitalization. The note revealed she was admitted into the hospital on 01/20/26 through 02/05/26 for a left leg hematoma and laceration. Resident #25 had sustained the left lower leg injury during a transfer at the nursing facility resulting in a laceration and large hematoma measuring 16.2 cm. Orders included to continue daily dressing changes with petroleum gauze, abdominal pad, and a gauze wrap per discharge wound care instructions.<br><br>A Wound Care NP note dated 02/10/26 revealed wound care was reestablished for Resident #25 due to a new hematoma to the left lateral lower leg. Resident #25 was hospitalized from 01/20/26 through 02/05/26 for a large laceration and hematoma to the left leg. Surgical evacuation of the hematoma was completed on 01/30/26 due to necrosis and a wound VAC was placed. The Wound Vac was removed at discharge from the hospital. During the assessment Resident #25 reported that pain in the left leg was worse with dressing changes and improved with rest and pain medication. The area to Resident #25's left lower leg measured 15.5 cm in length, 8.8 cm in width and 0.5 cm in depth with an overall 136.4 cm surface area. Orders included cleanse area with normal saline, pat dry, apply Santyl to necrotic areas of the wound, followed by ¼ strength Dakin's moistened gauze fluffed and filled into the wound bed. Apply an abdominal pad and kerlix. Change the wound daily and as needed.<br><br>A Wound Care NP note dated 02/17/26 revealed the | F0684 | | |

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| F0684 SS = SQC-J | Continued from page 17<br>hematoma to Resident #25's left lower extremity was improving. She did report pain with dressing changes, but the pain improved with rest. The area to Resident #25's left lower leg measured 15.2 cm in length, 8.5 cm in width and 0.4 cm in depth with an overall 129.2 cm surface area. Orders for the dressing change included to cleanse with wound cleanser, pat dry, apply xeroform, cover with an abdominal pad and kerlix. The dressing was changed daily and as needed.<br><br>Review of the Medication Administration Record dated February 2026 revealed Resident #25 received an order for oxycodone HCL (a strong prescription opioid pain reliever used for moderate to severe pain) oral tablet 5 mg, give one tablet by mouth every 6 hours as needed for pain, initiated on 02/05/26 and discontinued on 02/23/26. An order for oxycodone HCL oral tablet 5 mg, give one tablet by mouth every day shift (give with AM wound care to left lower extremity) was initiated on 02/24/26. An order for acetaminophen 8-hour tablet extended release 650mg by mouth every 8 hours as needed for pain initiated on 02/05/26. A 0-10 pain scale was documented on the MAR with 0 being no pain and 10 being the worst pain experienced. Resident #25 was documented as received acetaminophen 650mg for having a level 4 on 2/7, level 2 on 2/10, level 8 on 2/14, level 8 on 2/16, level 1 on 2/18, level 8 on 2/20, level 8 on 2/21, level 5 on 2/22 and level 8 on 2/23. Resident #25 received oxycodone 5 mg on 13 of the 17 days reviewed. Resident #25 received oxycodone 5mg on 2/6 at 10:57 AM (pain level of a 4) and at 6:59 PM (pain level of a 5). On 2/7 at 8:05 PM for a pain level of 4, on 2/8 at 6:16 PM for a pain level of 7, on 2/10 at 9:48 AM for a pain level of 4 and again at 8:50 PM for a pain level of 10. On 2/12 at 10:24 AM for a pain level of 5, and at 4:32 for a pain level of 6. On 12/13 at 10:45 AM for a pain level of 5, On 2/14 at 12:43 PM for a pain level of 7, on 2/15 at 11:17 PM for a pain level of 10. She received oxycodone 5mg for a pain level of 6 on 2/16 at 3:52 PM, on 2/17 at 5:11 AM for a pain level of 7 and at 11:13 for a pain level of 8, at 4:44 PM for a pain level of 3. Also, on 2/19 at 5:23 AM for a pain level of 0, and at 4:37 PM for a pain level of 5. She received an additional dose on 2/20 at 1:23 AM for a pain level of 6.<br><br>On 02/24/26 at 1:30 PM an interview was conducted with Nurse Practitioner #1. During the interview she stated she was not in the facility on 01/20/26 and by the time she was notified of the situation to give orders to hold the residents anticoagulant Resident #25 was already at the hospital per Family Member #1's request. Nurse Practitioner #1 explained she did not know how the injury to Resident #25's leg had occurred. | F0684 | | |

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| F0684 SS = SQC-J | Continued from page 18<br><br>On 02/24/26 at 8:45 AM, a telephone interview was conducted with the Medical Director. He stated Resident #25 was prescribed a high dose of an anticoagulant (Eliquis), which contributed to the blood loss following the incident. He explained anticoagulation increased her risk of bleeding. He stated he was not aware a Nurse Aide had struck Resident #25's leg on the footboard and had only been told about the injury, not how it occurred. He stated he would have sent her to the hospital on 01/20/26 due to her increased bleeding risk however, it sounded like she was sent out anyway due to a Responsible Party request for her to be evaluated so the outcome would have been the same.<br><br>On 02/25/26 at 11:50 AM, a follow-up in person interview was conducted with the Medical Director. He stated the facility could perform in-house testing (such as x-rays) and assess whether hospital transfer was necessary. He explained he could have, "put in a stitch" if necessary, due to the laceration and increased bleeding. He stated, "Most patients do not need to be sent out initially unless there is a red flag," and noted decisions vary on a case-by-case basis. A red flag would have been any obvious change in her medical status such as blood pressure, increased bleeding and pain.<br><br>On 02/24/26 at 9:33 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that, from her recollection, NA #1 had transferred Resident #25 to her wheelchair on 01/20/26 and the resident's leg struck either the wheelchair or bed. She was notified of the incident by Nurse #1 after it occurred. The DON stated Nurse #1 had called Nurse Practitioner #1 and obtained orders to hold the anticoagulant. The DON explained it was her understanding Resident #25 did not need to go to the hospital and the DON wanted orders to hold the next dose of anticoagulant for that night. She stated, "everything just happened so quickly". The interview revealed the DON was in the facility on 01/20/26 when the incident occurred however she did not go into the room nor did she look at the wound to Resident #25's left lower extremity. The DON stated, based on what had occurred with Resident #25's leg hitting the footboard, she wouldn't have sent her to the hospital immediately. The DON stated it was her understanding Nurse #1 had the bleeding controlled however, the Responsible Party insisted she be sent out. The DON stated the main focus when she learned of the incident was getting an order to hold the resident's anticoagulant dose for that evening. However, by the time Nurse #1 notified Nurse Practitioner #1 and received orders to hold the | F0684 | | |

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| F0684 SS = SQC-J | Continued from page 19<br>medication and to monitor the residents' left leg she realized Resident #25 was already sent to the hospital per the Responsible Parties request.<br><br>On 02/23/26 at 2:27 PM, an interview was conducted with the Administrator. She stated she was notified after staff had addressed the incident on 01/20/26. She was informed that NA #1 had bumped Resident #25's leg on the footboard. She stated the Nurse Practitioner was notified and a pressure dressing was applied.<br><br>On 02/24/26 at 10:17 AM, an interview was conducted with the Wound Care Nurse Practitioner. She stated she had evaluated Resident #25 weekly after the resident's discharge from the hospital on 02/05/26. She confirmed Resident #25 sustained a hematoma requiring surgical intervention at the hospital. She explained large hematomas can result in pooled blood, which may become necrotic. After reviewing hospital records, she stated the hospital monitored the area for several days before surgically evacuating the hematoma, debriding necrotic tissue, and applying a wound VAC. Once Resident #25 returned to the facility she had received daily wound care with weekly evaluations. The Wound Care Nurse Practitioner stated the wound was improving; however, it would be difficult to fully heal due to the surface area. She stated she was considering an allograft (a type of tissue taken from a donor to replace damaged tissue) to cover the area to the residents left lower leg since it remained an open area and probability of skin healing was low.<br><br>The Administrator was notified of the immediate jeopardy on 02/24/25 at 2:00 PM.<br><br>The facility provided the following credible allegation of immediate jeopardy removal.<br><br>F684 Credible Allegation:• Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; Resident #25 (on anticoagulant therapy) suffered a serious adverse injury following the incident when the resident sustained a significant skin tear resulting in significant bleeding and hematoma to left lower leg on 1/20/26. While Nurse Aide (NA) 1 was maneuvering resident's wheelchair, NA #1 bumped residents' left leg on the foot board of the bed. NA #1 immediately applied pressure to the laceration on left lower leg and notified Nurse #1 of the incident. Nurse #1 assessed wound, applied pressure dressing and notified Nurse Practitioner (NP) #1. NP #1 gave order for anticoagulant to be held and to monitor skin tear. Nurse #1 reported to NP #1 that resident received a | F0684 | | |

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| F0684 SS = SQC-J | Continued from page 20<br>skin tear to left lower leg on 01/20/26. Nurse #1 did not recognize the severity of the injury and the need to transfer Resident #25 to a higher level of care. NP #1 was notified on 1/20/26 by Nurse #1 of the skin tear Resident #25 obtained. Resident #25 notified her own Responsible Party (RP) via phone that she received an injury to her lower leg on 01/20/26. Responsible party arrived at facility and discussed with nurse prior to resident going out via Emergency Medical Services (EMS). Resident #25 was sent to the Emergency Department and admitted on 01/20/2026. Resident #25 was admitted to the hospital from 1/20/26-2/5/26. Resident #25's RP notified EMS of the need for transfer to the hospital. Nurse #1 notified NP #1 that resident was transferred to ED at the request of RP on 01/20/26.<br>Other residents on anticoagulants were at risk of serious adverse outcomes (e.g., uncontrolled bleeding, significant bruising) due to the identified practice gaps. On 2/24/26 the Assistant Director of Nursing (ADON) completed an audit of the electronic health record order listing report to identify all residents receiving anticoagulant therapy. 21 residents were noted to receive anticoagulant therapy. This is an ongoing audit that is updated with each admission. The Director of Nursing (DON) completed an audit of all incident and accident reports for the past 30 days on 2/24/26 to ensure that any incident that resulted in an injury received timely and appropriate treatment. No concerns were identified. A facility wide skin assessment of all residents was completed by Licensed Nurses on 02/24/2026 for all residents receiving anticoagulant therapy to ensure no other residents exhibited excessive bruising or bleeding associated with anticoagulant use. Results of the skin assessments found no additional residents affected by this deficient practice. Skin assessments are maintained in the residents electronic health care record. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: A root cause Analysis was completed on 2/24/26 by the facility Administrator and DON. It was determined that the cause of the deficient practice was the lack of recognition by Nurse #1 to identify the need for Resident #1 to be transferred to ED for a higher level of treatment. Nurse #1 was an agency nurse that did not follow the policy on anticoagulants, or significant change in conditions, which includes monitoring individuals on anticoagulation therapy who show signs of excessive bruising and bleeding to discuss the situation with the physician. An ad hoc QAPI was held on 2/24/26 with facility Administrator, DON, ADON, Medical Director, and Nurse Managers to review the deficient practice plan of correction.On | F0684 | | |

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| F0684 SS = SQC-J | Continued from page 21<br>2/24/2026, the Administrator reviewed the facilities policy and clinical protocol for anticoagulation and change in condition with no changes warranted. On 2/24/26 the Director of Nursing began education for all licensed nurses, including agency nurses, on the recognition and assessment of abnormal bruising and bleeding (including excessive, uncontrolled bleeding) for residents receiving anticoagulant therapy. Education consisted of utilizing the e-interact tools (a specialized clinical workflow tool to assist facilities in identifying, assessing, and managing resident conditions) to identify residents that may need a higher level of treatment, notifying the Medical Director (MD) or Nurse Practitioner (NP) for residents that receive anticoagulant therapy that have sustained an injury, and to seek higher level of treatment for any resident on anticoagulant therapy that has continued bleeding after 15 minutes of applying pressure with a pressure dressing. Education was provided in person and via electronic education system. After 2/24/26 newly hired nursing staff including agency nurses will receive this education during the orientation process by the DON or designee also via electronic education at onboarding. The DON/ADON will be responsible for tracking and maintaining education record to ensure that staff receive this education prior to start of their next shift. The DON was made aware of this responsibility by the Administrator on 2/24/26.Education began with all nurse aids on 2/24/26 by the DON on recognizing changes in resident conditions, including excessive bleeding. Education included utilization of the Stop and Watch Tool, an early warning tool that prompts Nurse Aids to alert nursing staff to a change in a resident's condition. Education included completion of the tool and providing it to the Licensed Nurse immediately. All newly hired nursing staff, including agency, will be educated on this process in orientation by the DON or designee. The DON was made aware by the Administrator of this responsibility on 2/24/26. The Administrator is responsible for the execution of this plan of Credible Allegation. Date of IJ removal: 2/25/26<br><br>The facility's credible allegation of immediate jeopardy removal was validated on 3/02/26. An interview conducted with the Assistant Director of Nursing (ADON) indicated she completed full body skin assessments for all residents receiving anticoagulant medications on 2/24/26 and no concerns were identified. A review of the skin assessments revealed they were completed on 2/24/26 for all residents receiving anticoagulant medications and no abnormal bruising or new skin concerns were identified. Interviews conducted with licensed nurses revealed they received education on the | F0684 | | |

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| F0684 SS = SQC-J | Continued from page 22<br>importance of completing a thorough assessment for residents receiving anticoagulant medication that sustained an injury, identifying the need for a higher level of treatment when there was uncontrolled bleeding, notifying the Medical Director or NP of changes in condition and reporting the full extent of any resident injury.<br><br>The facility's immediate jeopardy removal date of 2/25/26 was validated on 3/02/26. | F0684 | | |
| F0689 SS = SQC-J | Free of Accident Hazards/Supervision/Devices<br><br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br><br>The facility must ensure that -<br><br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observations, record review, and interviews with the resident, staff, Responsible Party, Wound Nurse Practitioner, and Medical Director, the facility failed to provide care in a safe manner and ensure a resident's environment remained free of an accident hazard for a dependent resident on Eliquis (an anticoagulant medication that prevents blood from clotting). On 01/20/26 Nurse Aide (NA) #1 transferred Resident #25 using a mechanical lift from the bed to the Resident's wheelchair. Nurse Aide #1 proceeded to pull Resident #25 backwards alongside the bed hitting the Resident's lower left leg against the corner of the footboard. Resident #25's footboard was damaged, and the outer layer of protective laminate was gone, and pressboard was exposed (pressboard is a dense, stiff engineered material). Resident #25 immediately cried out in pain, and her lower left leg was bleeding. Resident #25 complained of a pain, on a scale of 10 with 10 being the worst possible pain. She sustained a 1-inch laceration to the leg. Resident #25 was transported to the hospital on 01/20/26. Upon evaluation, she was noted to have a large superficial soft tissue hematoma (a localized collection of clotted or partially clotted blood, trapped in tissue caused by a ruptured blood vessel from an injury) measuring 16.2 | F0689 | Immediate corrective actions included replacement of damaged footboards, repair of shower grab bars, removal of smoking materials from resident rooms, hospital transfer and follow up care for affected residents, and updated care plans and Kardexes.<br><br>On 2/24/26 audits were completed by DON and ADON for anticoagulant residents, mechanical lift residents, environmental hazards, smoking practices, and incident reports, with no additional unresolved hazards identified.<br><br>System changes by DON and ADON included reinforcement of two person mechanical lift use, competency return demonstrations, routine environmental rounds, TELS maintenance reporting education for all staff , smoking policy enforcement with lockbox installation (for all residents who smoke), and daily supervisory oversight.<br><br>Monitoring by DON ADON along with Maintenance includes weekly audits for four weeks and monthly audits for three months covering transfers, environment, and smoking compliance, with direct observation daily and QAPI review monthly.<br><br>Immediate Jeopardy was removed on 2/25/26 and validated on 3/2/26; continued monitoring addresses lower level findings. | 02/25/2026 |

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| F0689 SS = SQC-J | Continued from page 23<br>centimeters (6.3 inches) to the left lower extremity. Hospital laboratory studies demonstrated a decline in hemoglobin from 11.1 to 7.3 (normal range 11.5 to 15.1) over the first two days of hospitalization, consistent with acute blood loss anemia, necessitating transfusion of packed red blood cells. Subsequently, the skin overlying the hematoma became necrotic (dead or dying tissue), requiring operative evacuation (surgically removing a collection of blood from inside of the body) of the hematoma and surgical debridement of the necrotic tissue, with placement of a wound vacuum-assisted closure (VAC) device. Resident #25 was discharged back to the facility on 02/05/26. The facility staff also allowed a resident to use a grab bar that was not secure resulting in a fall in the shower room (Resident #20), the facility failed to follow their smoking policy and allowed residents to keep their smoking materials on their person and in their rooms rather than locked up at the nurses' station (Resident #8, Resident #18 and Resident #65). The deficient practice affected 5 of 8 residents reviewed for supervision to prevent accidents (Resident #25).<br><br>Immediate Jeopardy began on 01/20/26 when Nurse Aide #1 hit Resident #25's outer lower left leg against a damaged footboard. Immediate Jeopardy was removed on 02/25/26 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the monitoring systems put into place are effective and education is completed.<br><br>Example 2, 3, 4, 5 are being cited a lower scope and severity of an E.<br><br>The findings included:<br><br>Resident #25 was admitted to the facility on 08/15/24 with diagnoses including diabetes mellitus, fracture of the right tibia, hypertension, muscle weakness, osteoporosis, history of a deep vein thrombosis (DVT- a medical condition in which a blood clot (thrombus) forms in one or more of the deep veins of the body), and physical debility.<br><br>A care plan dated 09/05/25 revealed a focus area related to Activities of Daily Living (ADL) care. Resident #25 required assistance with her ADLs. The | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 24<br>goal was for the resident to maintain their current level of function through the next review date. Interventions included two staff member assistance with transfers.<br><br>A physician's order dated 11/02/25 revealed an order for Eliquis 5 milligrams (mg), one tablet by mouth twice a day, for the prevention of deep vein thrombosis (DVT), Manufacturer's guidelines for the medication Eliquis 05/2025 indicated the medication can cause serious side effects including bleeding which could be serious and may lead to death. The guidelines further stated to call your healthcare provider with any severe bleeding.<br><br>A Physical Therapy evaluation dated 11/14/25 signed by Physical Therapist #1 revealed Resident #25 demonstrated decreased bilateral lower extremity range of motion due to contractures and weakness. She demonstrated decreased functional with bed mobility and wheelchair mobility. Resident #25 was noted to be limited by contracture and malalignment of the right lower extremity due to a chronic break. The assessment revealed Resident #25 did not tolerate upright positioning for long and was unable to sit in a wheelchair without bilateral lower extremities elevated on pillows and leg rests.<br><br>On 02/25/26 at 5:00 PM, an interview was conducted with Physical Therapist #1. During the interview, she stated she had worked with Resident #25 during sessions in November 2025 and December 2025. She explained Resident #25's range of motion was severely decreased in bilateral lower extremities and her legs remained elevated on pillows and leg rest.<br><br>A quarterly Minimum Data Set (MDS) assessment dated 11/24/25 revealed Resident #25 was cognitively intact and dependent upon two staff members for toileting hygiene, showering/bathing, upper and lower body dressing, and personal hygiene. Resident #25 was coded as having no impairment to the upper or lower extremities and no use of mobility devices during the assessment period. Resident #25 was coded as receiving anticoagulants during the assessment period.<br><br>On 02/23/26 at 12:54 PM, an interview and observation were conducted with Nurse Aide (NA) #1. During the interview, she stated she was responsible for Resident #25 on 01/20/26 during the 7:00 AM to 3:00 PM shift. NA #1 explained she was assisting Resident #25 with a bed bath when the resident requested to get up to her wheelchair. She explained that after placing Resident #25 in her wheelchair, with both feet positioned on | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 25<br>pillows on top of the wheelchair leg rests, she turned the wheelchair and pulled it backward along the side of the bed. While NA #1 was pulling Resident #25's wheelchair backward along the side of the bed the resident's left lower leg hit the corner of the damaged footboard. She stated the bed was in a low position and Resident #25 began to yell out in pain. NA #1 indicated she realized Resident #25's left leg had hit the corner of the footboard and had begun to bleed. NA #1 re-enacted this action to the surveyor by pulling the resident's wheelchair backward along the side of the bed. NA #1 explained obtained paper towels from the sink and placed them on the resident's leg in an attempt to stop the bleeding. She stated, "It was bleeding bad." NA #1 stated the paper towels were saturated, so she then placed a regular bath towel over the leg and yelled for Nurse #1, who entered the room, applied pressure, and placed a dressing on the wound. She stated after Nurse #1 placed the dressing on the resident's leg the resident remained in her wheelchair with her legs elevated. NA #1 did not go back into the room until Emergency Medical Services (EMS) arrived and she assisted the resident onto the stretcher. NA #1 stated she did not see blood on the dressing when she assisted with the transfer of Resident #25.<br><br>A Situation, Background, Assessment, Recommendation assessment dated 01/20/26 at 11:30 AM, written by Nurse #1, revealed Resident #25 had received a skin tear to her left lower leg. A dressing was applied, and the Wound Nurse, Nurse Practitioner, or Medical Director were to evaluate. Recommendations included that Resident #25 be sent to the Emergency Department. New orders documented included: Patient to Emergency Department per her request related to skin tear to left leg. Vital signs included the following: blood pressure 132/77 (normal 120/80), pulse 97 (normal range 60-90), respiration 22 (normal range 12/20), temperature 98.2 (normal range 97-99.0), pulse oximetry 97% (normal range >92%) on room air. A pain scale was not included in the documentation.<br><br>A late entry nursing progress note dated 01/20/26 at 3:00 PM, written by Nurse #1, revealed the note was a late entry for 11:30 AM. Nurse #1 was informed Resident #25's leg was "bumped during transfer." Resident #25 was assessed and noted to have a one-inch slit in the middle of her left leg. The resident's anticoagulant was held at that time. Increased bleeding was noted related to Resident #25's anticoagulant therapy. Pressure was applied to the injury site for a duration of five minutes, and then a pressure dressing was applied. The Wound Nurse was informed and aware of the situation. | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 26<br><br>A late entry nursing progress note dated 01/20/26 at 3:29 PM, written by Nurse #1, revealed Resident #25's Responsible Party (RP) was present in the facility. Upon the RP's arrival, Resident #25 began to scream and yell, "I'm hurting." Nurse #1 left the resident's room to check physician orders and obtain medication. Upon returning, the RP stated, "I called 911 services for Resident #25." Resident #25 stated, "I want to go to the hospital." Bleeding was noted to have stopped. Emergency Medical Services (EMS) arrived at the facility at 1:35 PM. A mechanical lift was used with two staff members to transfer Resident #25 onto the stretcher for EMS.<br><br>On 02/23/26 at 1:45 PM, an interview was conducted with Nurse #1. She stated she was an agency nurse working in the facility for the first time 01/20/26. She recalled NA #1 calling for assistance on 01/20/26 around 11:30 AM and entering the room to find Resident #25's left leg bleeding with a one-inch laceration located on her left lower leg. Due to the "increased" bleeding that saturated a towel NA #1 applied, she applied pressure for approximately 5 minutes to stop the bleeding and notified the Wound Nurse and Nurse Practitioner #1. She stated, "I didn't think she needed to go to the hospital; I just notified Nurse Practitioner #1." She explained she did not recall if she administered pain medication to Resident #25 but if she put it into her written note from that date then she would have given pain medication. She didn't know why it wasn't on the Medication Administration Record (MAR). Nurse #1 stated because she was an agency nurse it was difficult to remember the situation and all of the specific details and to refer to her notes of what occurred on 01/20/26.<br><br>On 02/23/26 at 2:10 PM, an interview was conducted with Resident #25's Responsible Party. He stated Resident #25 called him on 01/20/26 and reported a Nurse Aide had hit her leg on the footboard while the NA was backing her wheelchair beside the bed. During the call Resident #25 did not complain of pain but asked him to come. Upon arrival, he observed red blood on a white dressing on her left lower leg and stated, "The facility wasn't sending her, so I called 911." The interview revealed there was no blood noted in the room when he arrived other than on the resident's dressing and Resident #25 was complaining of pain. EMS arrived shortly after he called and transported her to the hospital.<br><br>On 02/23/26 at 3:14 PM, an interview was conducted with NA #4. She stated she worked both first and second shift on 01/20/26. NA #4 assisted with transferring | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 27<br>Resident #25 onto the EMS stretcher. She reported Resident #25 was yelling in pain and that her legs remained straight and did not bend. The interview revealed assisting with the transfer onto the EMS stretcher was the first time NA #4 had been in Resident #25's room during the shift.<br><br>Emergency Medical Services (EMS) records dated 01/20/26 revealed EMS was called at 1:27 PM and arrived at Resident #25's bedside at 1:42 PM. The nurse reported to EMS that Resident #25 was transferred from her, "wheelchair to her bed" when her leg was hit on a rounded corner, causing a 1 to 2-inch laceration to her left lower leg. Nurse #1 stated to EMS she had controlled the bleeding with gauze and tape and had administered pain medication. The resident's RP arrived approximately 30 minutes after the incident and requested Resident #25 be transported to the hospital for further evaluation. Resident #25 was noted to be in emotional distress due to pain with bilateral lower extremity swelling. Resident #25's left lower leg was noted to have bruising and swelling where she was injured but no obvious deformity. EMS did not remove Resident #25's dressing to her left lower extremity. Vital signs revealed an elevated blood pressure of 182/110 (normal 120/80) and an elevated heart rate of 123 (normal 60–90). Resident #25 continued to complain of pain to her left lower extremity while en route to the hospital with a pain level of 10, on a 0-10 scale (0 being no pain, 10 being the worst pain). She was administered pain medication (acetaminophen) along with a diuretic (torsemide), and muscle relaxant (methocarbamol).<br><br>Hospital records dated 01/20/26 revealed Resident #25 presented to the Emergency Department (ED) from the nursing facility for evaluation of a hematoma and laceration to the left lower leg. She reported moderate to severe pain. The ED note indicated difficulty controlling bleeding at the nursing facility, and due to swelling, she was referred for further evaluation. Assessment of the left lower extremity revealed a 2 cm skin tear with a small amount of drainage coming from the area. She also had an associated large hematoma measuring approximately 4 x7 inches distally a small distance from the laceration. A picture 01/20/26 was taken while Resident #25 was in the Emergency Department. The picture shows Resident #25 lying in bed with her left leg elevated on a pillow. Blood was observed under her left knee pooled onto the bed and also on the pillow under the residents left leg. Ice was placed to assist with pain and swelling along with 2mg of morphine (a strong opioid pain medication use to treat moderate to severe pain) administered | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 28<br>intravenously. Blood is also visualized on the residents left surrounding the laceration. Upon admission on 01/20/26, she was noted to have a large superficial soft tissue hematoma measuring 16.2 cm (6.38 inches). Laboratory studies demonstrated a decline in hemoglobin from 11.1 to 7.3 over the first two days of hospitalization, consistent with acute blood loss anemia, necessitating transfusion of packed red blood cells. Subsequently, the skin overlying the hematoma became necrotic, requiring operative evacuation of the hematoma, surgical debridement of necrotic tissue, and placement of a wound vacuum-assisted closure (VAC) device. Resident #25 was discharged back to the nursing facility on 02/05/26 with orders for oxycodone 5 milligrams (mg) one tablet every 6 hours as needed for severe pain and acetaminophen 650 mg every 8 hours as needed for pain. Wound care discharge instructions included daily dressing changes to the left lower extremity with petroleum gauze an abdominal pad and gauze wrap.<br><br>On 02/25/26 at 10:02 AM an interview was conducted with the Maintenance Director. During the interview he stated he had been working in the facility since April 2025. He explained he was notified by the Administrator on 02/23/26 of an issue with Resident #25's footboard. Once in the room he observed the outer layer of laminate was gone exposing the press board. He stated that was not how the beds were supposed to be and immediately changed the footboard. The interview revealed the facility kept extra footboards in stock and he had received no work orders or mention of the damaged footboard from staff.<br><br>On 02/24/26 at 8:45 AM, a telephone interview was conducted with the Medical Director. He stated Resident #25 was prescribed a high dose of an anticoagulant (Eliquis), which contributed to the blood loss following the incident. He explained anticoagulation increased her risk of bleeding. He stated he was not aware a Nurse Aide had struck Resident #25's leg on the footboard and had only been told about the injury, not how it occurred. He stated he would have sent her to the hospital on 01/20/26 due to her increased bleeding risk however, it sounded like she was sent out anyway due to a Responsible Party request for her to be evaluated so the outcome would have been the same.<br><br>On 02/24/26 at 9:33 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that, from her recollection, NA #1 had transferred Resident #25 to her wheelchair on 01/20/26 and the resident's leg struck either the wheelchair or bed. She was | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 29<br>notified of the incident by Nurse #1 after it occurred. The DON stated Nurse #1 had called Nurse Practitioner #1 and obtained orders to hold the anticoagulant; however, Resident #25 was already at the hospital per the Responsible Parties request to send the resident to the hospital. The DON explained it was her understanding Resident #25 did not need to go to the hospital and she wanted orders to hold the next dose of anticoagulant for that night. She stated, “everything just happened so quickly”. The interview revealed the DON was in the facility on 01/20/26 when the incident occurred however she did not go into the room nor did she look at the wound to Resident #25’s left lower extremity.<br><br>On 02/23/26 at 2:27 PM, an interview was conducted with the Administrator. She stated she was notified after staff had addressed the incident on 01/20/26. She was informed that NA #1 had bumped Resident #25’s leg on the footboard. She stated the Nurse Practitioner was notified and a pressure dressing was applied.<br><br>On 02/24/26 at 10:17 AM, an interview was conducted with the Wound Care Nurse Practitioner. She stated she had evaluated Resident #25 weekly after the resident’s discharge from the hospital on 02/05/26. She confirmed Resident #25 sustained a hematoma requiring surgical intervention at the hospital. She explained large hematomas can result in pooled blood, which may become necrotic. After reviewing hospital records, she stated the hospital monitored the area for several days before surgically evacuating the hematoma, debriding necrotic tissue, and applying a wound VAC. Once Resident #25 returned to the facility she had received daily wound care with weekly evaluations. The Wound Care Nurse Practitioner stated the wound was improving; however, it would be difficult to fully heal due to the surface area. She stated she was considering an allograft (a type of tissue taken from a donor to replace damaged tissue) to cover the area to the residents left lower leg since it remained an open area and probability of skin healing was low.<br><br>On 02/25/26 at 11:11 AM an observation was conducted of Resident #25’s wound to the left lower leg. Resident #25 was observed to have a large reddened open area to her left lower extremity with areas of black (necrotic) tissue. Resident #25 was pre-medicated with pain medication prior to the wound care observation. The Wound Nurse was observed cleansing the left lower leg with normal saline solution, patting the area dry with gauze and applying santyl (a prescription medication used to remove dead tissue and promote healing) ointment to the necrotic areas of the wound, followed | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 30<br>by moisten gauze with dakins (antiseptic cleaning agent for wounds) solution. The area was covered with an abdominal pad and wrapped with kerlix.<br><br>The Administrator was notified of the immediate jeopardy on 02/24/25 at 2:00 PM.<br><br>The facility provided the following credible allegation of immediate jeopardy removal.<br><br>F689 Credible Allegation:<br><br>1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:<br><br>Resident #25 (on anticoagulant therapy) suffered a serious adverse injury following the incident on 1/20/26. Nurse Aide (NA) #1 completed a 1-person mechanical lift transfer prior to injury. While Nurse Aide (NA) #1 was maneuvering resident's wheelchair, NA#1 bumped residents' left leg on the foot board (that was damaged and the outer layer of material was gone and press board was exposed) of the bed causing a laceration, hematoma and pain to Resident #25's left lower leg. NA #1 received 1 on 1 education on 2/24/26 by the Director of Nursing (DON) on the expectation of following the mechanical lift policy that includes utilizing 2-person assistance with all mechanical lift transfers and safe movement of residents in their room and environment.<br><br>NA #1 immediately (1/20/26) applied pressure to the laceration on Resident #25's left lower leg and notified Nurse #1 of the incident. Nurse #1 assessed the wound, applied pressure dressing and notified Nurse Practitioner (NP) #1. NP #1 gave order for anticoagulant to be held and to monitor laceration on 1/20/26.<br><br>NP #1 was notified on 1/20/26 by Nurse #1 of the incident. Resident #25 notified her own Responsible Party (RP) via phone on 1/20/26 that she received an injury to her lower leg. Responsible party arrived at facility and discussed with nurse prior to resident going out via Emergency Medical Services (EMS).<br><br>Resident #25 was sent to the Emergency Department and admitted on 1/20/2026. Resident #25 was admitted to the hospital from 1/20/26-2/5/26. Resident #25's RP notified EMS of the need for transfer to the hospital. Nurse #1 notified NP #1 that resident was transferred to ED at the request of RP on 1/20/26. | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 31<br><br>Other residents on anticoagulants were at risk of serious adverse outcomes (e.g., uncontrolled bleeding, significant bruising) due to the identified practice gaps. On 2/24/26 the Assistant Director of Nursing (ADON) completed an audit of the electronic health record order listing report to identify all residents receiving anticoagulant therapy. 21 residents were noted to receive anticoagulant therapy. This is an ongoing audit that is updated with each admission.<br><br>All residents requiring mechanical lift transfers were at risk for serious injury due to a failure of staff to consistently perform required two person assist procedures and inadequate staff adherence to safe transfer practices prior to corrective actions. 100% audit of Resident Kardex (an electronic reference to individualized plan of care, to include method of transfer) was conducted by the Assistant Director of Nursing on 2-24-2026 to determine the residents who required a Mechanical lift and 35 residents were identified. Transfer status is evaluated by the Inter Disciplinary Team upon admission, readmission, significant change, and quarterly to establish safe transfer method at which time the resident care plan is updated as needed and populated to the Kardex by the Minimum Data Set Nurse (MDS) or designee.<br><br>A review of all incidents and accident log was conducted on 2/24/26 for the last 30 days by the DON to identify any other residents that may have sustained an injury while being maneuvered in their wheelchair in their environment. No other incidents were identified.<br><br>Resident #25's care plan was reviewed by MDS Nurse, Administrator, and DON on 2/24/26. No changes were needed at this time.<br><br>On 02/24/2026, the Maintenance Director inspected resident furniture for all residents —including the bed frame and bedside table—to ensure no rough edges or hazardous surfaces were present. No concerns were noted with any other bed frames or footboards. Resident #25's footboard was replaced on 2/23/26 by the Maintenance Director.<br><br>2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:<br><br>A Root Cause Analysis was completed on 2/24/26 that | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 32<br>included the DON, ADON, Administrator and MDS Coordinator. It was identified that NA #1 did not follow facility policy with 2-person mechanical lift transfers as well as lack of education with safely maneuvering residents in their environment. NA #1 had received prior education on the policy for 2 person mechanical lift transfer, however, continued to proceed with the transfer independently.<br><br>02/24/2026: All nursing staff, including nurses, nursing assistants as well as therapy department, and agency nurses and nurse aides, were in-serviced by the Director of Nursing (DON) on safe transfer requirements, emphasizing the mandatory two person assist for all mechanical lift transfers. All staff who did not receive education on 2-24-2026 will be educated prior to their next shift by the DON or designee. Education was provided in person and via electronic education system. New staff will be educated during orientation by the DON or designee. The DON was made aware of this responsibility on 2/24/26 by the Administrator. Education was provided using facility policy on Safe Lifting of Residents. Education included safe maneuvering of residents in wheelchairs while in their room with a focus on environmental surroundings and the ability to avoid bumping furniture in room, awareness of recognizing potential in room hazards, such as poor condition of furniture (exposed pressboard, sharp edges on furniture). Education was also provided on 02/24/26 on by the DON reporting any potential hazards or need for equipment changed via the TELS system (an electronic platform for reporting environmental and maintenance concerns directly to Maintenance Director). Once the Maintenance Director has received the TELS notification via electronic alert on cellular device, lap top and or desk top, as well as verbal communication of TELS entry, completion of repair is expected within the same day if it involves a resident safety concern.<br><br>Hoyer Lift competencies were completed on 02/24/2026 for all on duty nursing staff (nurses and Nurse Aides) by the DON and Rehab Director. Any staff not present on 02/24/2026 are required to complete their competency prior to their next scheduled shift. Competency Evaluations will be completed by DON, ADON and Unit managers. DON/ADON will be responsible for tracking and maintaining education record to ensure that staff receive this education prior to start of their next shift. The DON and ADON were made aware of this responsibility on 2/24/26 by the Administrator. | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 33<br>NA #1 was re-educated on the Kardex with emphasis on location of resident transfer on 2/24/26. Education was provided by the DON. All Na's, including agency, were educated on 2/24/26 by the DON on where to locate the Kardex in the Point of Care platform that details resident care specific information, including transfer status, and reviewing of Kardex at the beginning of their shift. All NA's not educated on 2/24/26, including agency and new hires, will be educated prior to the start of their next shift and during the orientation process by the DON, ADON, or Unit Manager. The DON was made aware of this responsibility by the facility Administrator on 2/24/26. The DON made ADON and Unit Manager aware of this responsibility on 2/24/26.<br><br>An ad hoc QAPI was held on 2/24/26 with the facility Administrator, DON, Medical Director, and Nurse Managers to review the deficient practice and plan of correction.<br><br>Maintenance will be responsible for assessing, repairing, or replacing damaged foot boards with visible hazards of press board immediately upon notification via TELS. The Administrator notified Maintenance Director of this responsibility on 2/24/26.<br><br>The Administrator is responsible for the execution of this plan of Credible Allegation.<br><br>Date of IJ removal: 2-25-2026<br><br>The facility's credible allegation of immediate jeopardy removal was validated on 3/02/26. An interview conducted with the DON revealed she and the Rehabilitation Director provided education to nurses and NAs on the facility's policy regarding safe resident transfers and had them perform return demonstration using the mechanical lift to ensure all competencies were met on the skills checklist which included reviewing the Kardex to verify a resident's transfer status, review of the mechanical lift skills checklists that were completed for nurses and NAs on 2/24/26 revealed all competencies were marked as met and no concerns were identified. Interviews conducted with nurses and NAs revealed they received education on the facility's safe resident transfer policy and were observed performing return demonstrations using the mechanical lift. An interview conducted with the Maintenance Director revealed on 2/23/26 and 2/24/26 he completed an audit of all the residents' rooms and any furniture that was damaged or broken was immediately replaced. Observations conducted in the residents' | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 34<br>rooms revealed no broken or damaged headboards or footboards on the beds, the furniture was in good repair, and there were no safety concerns identified. An observation conducted of two NAs transferring a resident using the mechanical lift revealed the facility's safe transfer policy was followed and no concerns were identified.<br><br>The facility's IJ removal date of 2/25/26 was validated on 3/02/26.<br><br>2. Resident #20 was admitted to the facility on 9/9/2021 with diagnoses which included rheumatoid arthritis, generalized muscle weakness and diabetes mellitus.<br><br>A comprehensive Minimum Data Set (MDS) assessment dated 4/21/2025 indicated Resident #20 was cognitively intact. Resident #20 was her own responsible party. Resident #20 required supervision to minimum assistance with bathing, dressing and transfers from bed to wheelchair. Resident #20 used a wheelchair for mobility and could propel herself independently.<br><br>Resident #20's care plan dated 4/23/2025 had a focus area which indicated Resident #20 had a risk to fall due to impaired physical mobility, lower extremity weakness, psychoactive medication (medication that can alter mood, cognition, and behavior and can cause sedation or altered consciousness) use and visual impairment. Goals included Resident #20 would not have any falls through the review period. Interventions included staff to anticipate Resident #20's needs as able (hunger, thirst, toileting, and temperature), keep the bedside table/personal items within reach, place the bed in low position, and remind Resident #20 to use the call light when assistance was needed.<br><br>An interview on 2/22/2026 at 2:12 PM with Resident #20 revealed she had worked with Physical Therapy (PT) and Occupational Therapy (OT) during April 2025 while preparing for discharge to the community. On 4/24/2025, she went to the shower room on the East hallway of the facility with OT #1 and PT #1 to be checked off on showering as part of her discharge goals. Resident #20 did not recall the exact time but knew the shower took place in the morning approximately around 10:00 AM. Resident #20 stated the shower had been going well and PT #1 left to go get Resident #20's clothes from her room just down the hallway. OT #1 asked Resident #20 to stand to rinse off. Resident #20 reported when she touched the shower grab bar it moved a little and she stated to OT #1, "This is loose." Resident #20 stated OT #1 did not respond and asked her to rinse off. | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 35<br>Resident #20 stood up and when she pulled on the shower grab bar, the bar moved quite a bit which scared her and she fell back, hit the edge of the shower chair with her buttocks and then slid onto the floor onto her buttocks. Resident #20 stated she could not get up with the help of OT #1 and PT #1 due to chronic knee/leg weakness and the floor was wet and slippery. The therapists notified nursing of the fall. The therapists used the mechanical lift to get her up and into her wheelchair. Resident #20 stated she finished the therapy session in her room and was able to dress herself. Resident #20 reported she did not feel any new pain at the time of the fall as she had chronic knee, leg and back pain until later in the day. Resident #20 went to the hospital on 4/24/2025 for an evaluation. Resident #20 indicated she had a sprain in her knee but no fractures. Resident #20 stated after the fall she was scared to use the grab bar in the shower room to stand. Resident #20 was aware the grab bar had been repaired but since the fall only gave herself seated basin baths in the shower room.<br><br>An Occupational Therapy (OT) note dated 4/24/2025 at 1:06 PM created by OT #1 revealed Resident #20 completed bathing with supervision (no hands on assistance) and was seated 80% of the time for energy conservation. Resident #20 had a fall when standing due to a loose grab bar in the shower room. Resident #20 required the mechanical lift to get off the floor. OT #1 had discussed the fall with Nurse #2 and the Director of Nursing (DON). Resident #20 completed dressing with supervision after the fall.<br><br>A signed statement created by OT #1 dated 4/24/2025 (no time indicated) revealed OT #1 had assisted Resident #20 in the shower approximately at 10:00 AM on 4/24/2025 to prepare for a safe discharge home. Resident #20 transferred into the shower chair prior to entering the shower for energy conservation. Resident #20 completed most of the shower seated. The shower chair was locked and when Resident #20 stood up in front of the grab bar to dry off, she fell and landed on her bottom. OT #1 was in the shower room as PT #1 had left to obtain the reacher from Resident #20's room. Nursing staff was notified immediately. Resident #20 was unable to get up using fall recovery strategies due to arthritis in her knees. OT #1 and PT #1 used the mechanical lift to place Resident #20 back in the wheelchair. Resident #20 stated that she was okay and had no pain after the fall. Following the fall, the grab bar was noted to be loose. Resident #20 completed all dressing tasks with minimal assistance and transferred herself back into her wheelchair with no complaints of pain. OT #1 asked Resident #20 again if | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 36<br>she was okay and Resident #20 reported having some minimal back pain which she experienced often.<br><br>An interview was conducted on 2/24/2026 at 9:21 AM with OT #1. OT #1 reported Resident #20 was at the last stage of OT treatment and preparing to discharge home. OT #1 was asked by Resident #20 to assess shower independence. OT #1 stated on 4/24/2025 she had Resident #20 in the shower room, seated on a shower chair with the wheels locked. Resident #20 had completed 90% of the shower on her own and was getting ready to stand to rinse off. PT #1 went to get Resident #20's clothes from the room. OT #1 removed the gait belt for Resident #20 to rinse off. When Resident #20 stood up, she used the grab bar, her right foot slipped and she fell. Resident #20 ended up seated on floor on her buttocks. OT #1 and PT #1 notified nursing of the fall. OT #1 and PT #1 used the mechanical lift to get resident off the floor due to chronic knee weakness and back pain. Resident #20 returned to her room and dressed herself. Resident #20 did not complain of any new pain after the fall. OT #1 did not recall Resident #20 stating the shower grab bar was loose. OT #1 did not recall any issues with the shower grab bar moving or being loose. OT #1 reviewed the note written on 4/24/2025 at 1:06 PM but did not remember any issues with the grab bar. OT #1 stated it was standard practice to remove the gait belt for shower rinsing especially since Resident #20 had showered with supervision and no hands-on assistance. OT #1 stated she had not checked the grab bars in the shower room on the unit prior to use.<br><br>A Physical Therapy (PT) note dated 4/24/2025 at 8:22 PM created by PT #1 reported Resident #20 used the rollator to move about in the room to gather clothes and shower utensils. Resident #20 used the rollator to walk to her wheelchair then proceeded to propel herself to the shower room. Resident #20 transferred with supervision into a rolling shower chair with the wheels locked and performed shower tasks with supervision. PT #1 left the shower room to retrieve the reacher for dressing. When PT #1 returned, Resident #20 had fallen due to reaching forward for the grab bar and the grab bar was noted to be loose. Nursing was notified. Resident #20 did not report any injury but needed the mechanical lift to get up and into her wheelchair. Once returned to her room, Resident #20 completed dressing with supervision from OT #1.<br><br>A signed statement dated 4/24/2025 (no time indicated) created by PT #1 stated she arrived at Resident #20's room at 10:03 AM on 4/24/2025 to prepare for the shower session. Once Resident #20 was actively showering and | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 37<br>seated on the shower chair, PT #1 left to retrieve the reacher for dressing from Resident #20's room. When PT #1 returned to the shower room, Resident #20 was sitting on the floor on her bottom. PT #1 did not witness the fall. Resident #20 reported no unusual pain from the fall. Nursing was notified. Resident #20 was unable to get up with assistance from OT #1 and PT #1. Resident #20 expressed embarrassment that she was unable to get up and had to use the mechanical lift. After returning to her room, Resident #20 stated again she was not hurt, just sore. Resident #20 was able to stand unsupported and get dressed. Approximately at 1:30 PM, PT #1 saw Resident #20 in the hallway and Resident #20 reported she was still doing okay, just a little sore.<br><br>An interview on 2/24/2026 at 9:00 AM with PT #1 revealed she worked with Resident #20 and OT #1 in the shower on 4/24/2025 but typically does not do the showers. Resident #20 had completed most of her shower while seated on a shower chair. As OT #1 was preparing Resident #20 to stand up to rinse off, PT #1 reported she left the shower room to go to Resident #20's room get something needed for the shower. PT #1 could not recall exactly what had been required but thought it could have been Resident #20's clothes. OT #1 was with Resident #20 the shower room. When PT #1 returned to shower room, Resident #20 was on the floor sitting on her buttocks. PT #1 did not witness the fall. Resident #20 stated she was embarrassed about the fall but was not injured. PT #1and OT #1 notified nursing immediately. Due to the wet, slippery floor and resident's baseline arthritic pain in her knees and chronic back pain, PT #1and OT #1 used the mechanical lift to get Resident #20 off the floor and into the wheelchair. PT #1 did not know shower grab bar was loose prior to the fall. Resident #20 proceeded to go back to the room and dressed herself. PT #1 checked on Resident #20 throughout the day and Resident #20 reported no pain. Resident #20 went to the hospital later on 4/24/2025 upon family request. PT #1 stated she did not feel the fall had changed Resident #20's functional level.<br><br>A fall report dated 4/24/2025 at 10:50 AM created by Nurse #2 reported Resident #20 had a witnessed fall in the shower room with therapy present. No injuries were observed at the time of the incident. Resident #20 was alert, and oriented to time, place, situation and person during the event. The provider and Resident #20's emergency contact were notified. Maintenance was notified of the loose shower grab bar. Resident #20 complained of generalized pain and stated, "I am hurting but I always hurt." Pain medication was | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 38<br>administered with relief noted in one hour.<br><br>A nursing note dated 4/24/2025 at 11:00 AM created by Nurse #2 stated she had been notified by a Nurse Aide (NA) that Resident #20 had fallen in the shower room while transferring with therapy. Resident #20 reported she grabbed the shower bar; it was loose and she fell and landed on her buttocks. Nurse #2 assessed Resident #20 and no injuries were noted and vital signs were stable. Therapy used the mechanical lift to get Resident #20 off the floor and into the wheelchair. Nurse #2 notified the provider. Nurse #2 reported the loose shower grab bar to maintenance.<br><br>A nursing note dated 4/24/2025 at 6:18 PM created by Nurse #2 stated the Nurse Practitioner (NP) provided orders for Resident #20 to be sent out to the hospital for evaluation due to increased right leg/knee and lower back pain complaints. A family member was present with Resident #20.<br><br>A telephone interview was conducted on 2/24/2026 at 11:05 AM with Nurse #2 who stated she was agency staff and no longer worked at the facility. Nurse #2 recalled Resident #20 and that she had fallen in the shower room with therapy. Nurse #2 could not recall if an NA or one of the therapists had notified her of the fall. Nurse #2 assessed Resident #20 and there were no obvious injuries noted. Resident #20 had chronic pain and Nurse #2 reported Resident #20 did not complain of any new pain after the fall. Nurse #2 believed Resident #20 was given pain medication before therapy. Resident #20 appeared to be at her baseline after the fall. Nurse #2 notified the provider and emergency contact of the fall. Nurse #2 noted the loose shower grab bar and notified maintenance immediately that it required repair. Nurse #2 was unsure if that particular shower room stall had been used earlier in the day and had not heard anything about the grab bar being loose prior to the incident. Nurse #2 recalled Resident #20 went out to the hospital later on 4/24/2025 and had no fractures.<br><br>A hospital physician note dated 4/24/2025 at 10:44 PM revealed Resident #20 underwent a computed tomography (CT) scan of the lumbar spine, a CT of the right knee, an x-ray of the lumbar spine, an x-ray of the right knee and an x-ray of both hips. All CT scans and x-rays were negative for acute fracture. The CT of the lumbar spine showed degenerative changes (a chronic condition where protective cartilage breaks down, causing bones to rub together) but no acute injury. The x-ray of the right knee showed mild degenerative changes, mild subcutaneous edema (an abnormal accumulation of fluid | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 39<br>in the tissue layer directly beneath the skin) and mild joint effusion (an excess of fluid in and around a joint). Resident #20 was sent back to the facility with prescriptions for cyclobenzaprine, 10 milligram (mg) tablet, twice daily by mouth as needed for muscle spasms; methylprednisolone 4 mg tablet, 6 day dose pack by mouth for inflammation; and naproxen 500 mg tablet twice daily by mouth for 7 days for pain. The hospital physician note reflected Resident #20's right knee had been placed in an immobilizer for comfort and the hospital physician recommended follow up with orthopedics.<br><br>A nursing note dated 4/25/2025 at 12:55 AM stated Resident #20 had returned from the hospital and had a right knee immobilizer in place. Resident #20 denied pain.<br><br>A signed statement dated 4/24/2025 (no time indicated) created by the Maintenance Director stated the shower grab bar was loose but still mounted on the wall. He further reported the grab bar appeared to have been loosened by extreme force. The Maintenance Director reinforced the grab bar and secured it to the wall to ensure stability and safety. The Maintenance Director reported he immediately conducted an inspection of all the mounted grab bars in the facility on 4/24/2025 and found no other issues.<br><br>A Nurse Practitioner (NP) note dated 4/28/2025 at 12:06 PM indicated a follow up visit was conducted with Resident #20. Resident #20 was seen seated in her wheelchair with the right knee immobilizer in place. Resident #20 had no complaints of pain and verbalized no concerns.<br><br>An interview conducted on 2/24/2026 at 10:45 AM with the Maintenance Director revealed he began working in the facility in April 2025. The Maintenance Director recalled being notified by nursing on 4/24/2025 about the loose shower grab bar in the East hallway shower room. The Maintenance Director stated the grab bar appeared to have been loosened by extreme force and he had received no notification before 4/24/2025 of any issues. The Maintenance Director immediately repaired the grab bar and completed an inspection of all the mounted grab bars in the facility on 4/24/2025. No other issues were noted and audits were on going at this time.<br><br>An observation of the two shower rooms on the East hallway was conducted on 2/24/2026 at 8:45 AM. All of the grab bars in the East hallway shower rooms were noted to be secured to the wall with no movement when | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 40<br>used.<br><br>An interview was conducted on 2/25/2026 at 8:09 AM with the Director of Rehabilitation who reported therapy staff did not use the shower rooms on the units frequently as the facility's therapy department had their own shower room for shower/bathing sessions. The Director of Rehabilitation stated Resident #20 had requested to use one of the East unit shower rooms for an OT shower assessment as she felt the water was hotter on the unit. The Director of Rehabilitation indicated Resident #20 was already showering without hands on assistance but had requested a therapy check off to be sure she was showering safely. The Director of Rehabilitation stated staff should do a visual check of the equipment in the shower room and then a closer inspection if something did not look correct. The Director of Rehabilitation reported the gait belt could be removed safely for shower rinsing as Resident #20 was already supervision with showers.<br><br>A telephone interview on 2/24/2026 at 12:15 PM with the former DON indicated she recalled Resident #20 was in the shower room on 4/25/2025 with two therapists who were completing a session preparing Resident #20 for discharge home. Resident #20 stood up, used the grab bar which loosened and Resident #20 sat down on the floor. The former DON could not recall if Resident #20 fell or if therapy assisted Resident #20 to the floor. The former DON reported Resident #20 had no visible injuries, reported no new pain complaints but went out to the hospital on 4/24/2025 for imaging and all results were negative. The former DON recalled the hospital physician recommended Resident #20 continue to follow-up with the orthopedic physician as she was already established with orthopedics due to the rheumatoid arthritis. The former DON stated maintenance repaired the grab bar immediately and conducted a facility wide check of all the mounted grab bars.<br><br>An interview on 2/25/2026 at 12:11 PM with the Medical Director indicated he thought the facility followed best practices when trying to prevent falls. He was not working at the facility when Resident #20 fell. The Medical Director stated maintenance should be involved in checking the status of grab bars regularly and making sure all were safe and working properly.<br><br>An interview on 2/24/2025 at 10:53 AM with the Administrator indicated she was not working at the facility during the time Resident #20 fell. The Administrator noted from past records that the facility investigated the fall and the loose shower grab bar. The Maintenance Director repaired the loose grab bar | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 41<br>immediately and inspected all of the mounted grab bars in the facility. The Administrator stated the loose grab bar should have been identified during routine environmental rounds and the stability of the grab bar verified by OT #1 prior to having Resident #20 stand.<br><br>3. Resident #18 was admitted to the facility on 7/26/2024 with diagnoses which included a history of a cerebral infarction (blocked blood flow to the brain, leading to tissue death and oxygen deprivation), and congestive heart failure.<br><br>A review of the Smoking Policy dated 10/1/2021 and revised on 10/20/2022 read in part: “Residents who desire to smoke may not keep smoking related materials [i.e. cigarettes, electronic smoking devices (e-cigarettes), refill cartridges/fluid, cigars, pipes, tobacco, lighter, lighter fluid, match, etc.] on their person when not smoking or in their room. For safety purposes, all smoking related materials, devices, and tobacco products must be stored in a safe place in the facility, such as the nurses’ station.” The Smoking Policy also stated that when residents were found or suspected to be non-compliant with the facility safe smoking practices, the facility would notify the attending physician/provider, the responsible party and document the concern in the medical record. The resident would be re-educated on the safe smoking policy/practices and the facility staff would continue to monitor the resident’s compliance. The facility could also advise the resident of the facility’s desire to conduct a resident room and should the resident refuse, law enforcement may be contacted to assist with the search. The facility may initiate discharge planning for a violation of any part of the smoking policy and for any unsafe smoking practice that poses a risk to residents or for repeated non-compliance. A thirty day discharge notice may be initiated.<br><br>Resident #18’s care plan dated 7/25/2025 had a focus area for tobacco use as Resident #18 smoked cigarettes and vaped. Goals included Resident #18 would smoke safely through the review period. Interventions included Resident #18 would be educated on the facility smoking policy including location, times, and safety; and Resident #18 was an unsupervised smoker.<br><br>A quarterly Minimum Data Set (MDS) assessment dated 11/27/2025 indicated Resident #18 was moderately cognitively impaired. Resident #18 required supervision to minimum assistance with transfers to the wheelchair. Resident #18 was independent with wheelchair mobility.<br><br>A Smoking Safety Evaluation dated 12/19/2025 at 3:39 PM | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 42<br>stated Resident #18 was safe to smoke unsupervised.<br><br>A Consent and Release for Smoking form was signed by Resident #18 on 2/11/2026. The form read in part: "Residents are not allowed to smoke/vape inside the facility and must have smoking related items and materials stored in a safe place designated by the facility." The Consent and Release for Smoking form also stated residents who violated the smoking policy by smoking inside or keeping smoking materials inside (in their room) would be subject to smoking privileges being revoked and/or a 30 day discharge notice. There was no other documentation noted that Resident #18 had previously signed a Consent and Release for Smoking form prior to 2/11/2026.<br><br>An observation on 2/22/2026 at 3:37 PM noted Resident #18 in his room and seated in his wheelchair. Resident #18 had an unlit cigarette in his hand.<br><br>During an interview on 2/22/2026 at 3:38 PM, Resident #18 reported he was going out to smoke. Resident #18's roommate was observed to have a pack of opened cigarettes on his bed. Resident #18 stated his roommate had given him a cigarette. Resident #18 reported he usually had his own smoking materials but was currently out of cigarettes. Resident 18's lighter was observed in his right hand as he placed it in the right pocket of his pants. Resident #18 stated he was an unsupervised smoker. Resident #18 went on to say he had kept his smoking materials in his room since admission. Resident #18 stated he went out to smoke whenever he desired.<br><br>An observation of the smoking patio on 2/22/2026 at 3:50 PM revealed a clear, acrylic like plastic lockbox for resident smoking materials had been installed in the afternoon on 2/22/2026. The lockbox contained individual compartments with doors, each with its own combination lock for resident smoking material storage.<br><br>An observation on 2/23/2026 at 9:00 AM was conducted of Resident #18 smoking safely on the patio.<br><br>During a follow up interview on 2/23/2026 at 9:03 AM, Resident #18 reported he was currently out of cigarettes/lighters (had borrowed from his roommate) so had not placed any smoking materials in the box. Resident #18 stated he recalled the facility held a meeting to review the smoking policy and he understood the policy regarding not keeping smoking supplies in the room.<br><br>An interview was conducted on 2/24/2026 at 8:15 AM with | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 43<br>the East Unit Manager who reported the smoking policy had been reviewed with the residents on 2/11/2026 as the facility found out residents including Resident #18 were keeping smoking materials in their rooms. The East Unit Manager indicated all smoking materials were to be stored at the nurses' station. There was also a lockbox in the smoking area for each resident.<br><br>An interview on 2/24/2026 at 8:31 AM with NA #2 indicated residents were to keep their smoking materials at the nurses' station in the past but now there was a lockbox in the smoking area for residents' smoking materials. NA #2 reported she did not know that Resident #18 had kept smoking supplies in his room.<br><br>An interview on 2/25/2026 at 3:50 PM with the DON stated the facility allowed smoking after a smoking safety evaluation was completed. The DON stated the facility realized in early February 2026 that the residents had their smoking materials in their possession when reviewing policies and procedures in preparation for the yearly facility recertification survey. The facility noted that the residents were not storing their smoking supplies at the nurse's station. The DON indicated the Administrator reviewed the smoking policy with the residents at a meeting on 2/11/2026. The DON reported that the residents who smoked signed Consent and Release for Smoking forms and smoking materials were to be held at the nurses' station until the lockbox arrived and was installed. The DON stated it had been difficult to obtain compliance to the smoking policy from the residents. The DON acknowledged requiring the residents to place their smoking materials in the lockbox was a transition for the residents, but no resident should have their smoking materials in their possession any longer. The lockbox had been installed on 2/22/2026 and the expectation was that the residents would store their smoking supplies there. The DON stated she was not aware that Resident #18 had any smoking supplies in his room currently and should have stored these at the nurses' station.<br><br>An interview on 2/25/2026 at 4:05 PM with the Administrator revealed she had held a meeting on 2/11/2026 to discuss the smoking policy with the residents. The Administrator stated the facility realized in early February 2026 that the residents were keeping their smoking supplies in their rooms as the facility was reviewing policies and procedures in preparation for the yearly recertification survey. Residents were advised by the Administrator that they could not keep their smoking materials in their rooms any longer and should keep them at the nurses' station | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 44<br>until the smoking materials lockbox arrived and was installed. The Administrator indicated the smoking materials lockbox had been installed and residents should be following the policy. The Administrator stated she was not aware Resident #18 had any smoking supplies in his room. The Administrator indicated she would immediately speak with Resident #18 and have him place any smoking supplies in his possession in the lockbox.<br><br>4. Resident #65 was admitted to the facility on 3/19/2021 with diagnoses which included chronic obstructive pulmonary disease, chronic kidney disease, diabetes mellitus and a history of a cerebral infarction (blocked blood flow to the brain, leading to tissue death and oxygen deprivation).<br><br>A review of the Smoking Policy dated 10/1/2021 and revised on 10/20/2022 read in part: “Residents who desire to smoke may not keep smoking related materials [i.e. cigarettes, electronic smoking devices (e-cigarettes), refill cartridges/fluid, cigars, pipes, tobacco, lighter, lighter fluid, match, etc.] on their person when not smoking or in their room. For safety purposes, all smoking related materials, devices, and tobacco products must be stored in a safe place in the facility, such as the nurses’ station.” The Smoking Policy also stated that when residents were found or suspected to be non-compliant with the facility safe smoking practices, the facility would notify the attending physician/provider, the responsible party and document the concern in the medical record. The resident would be re-educated on the safe smoking policy/practices and the facility staff would continue to monitor the resident’s compliance. The facility could also advise the resident of the facility’s desire to conduct a resident room and should the resident refuse, law enforcement may be contacted to assist with the search. The facility may initiate discharge planning for a violation of any part of the smoking policy and for any unsafe smoking practice that poses a risk to residents or for repeated non-compliance. A thirty day discharge notice may be initiated.<br><br>Resident #65’s care plan dated 7/21/2025 had a focus area for tobacco use as Resident #65 smoked cigarettes and vaped. Goals included Resident #65 would smoke safely through the review period. Interventions included Resident #65 would be educated on the facility smoking policy including location, times, and safety; and Resident #65 was an unsupervised smoker.<br><br>A quarterly Minimum Data Set (MDS) assessment dated 1/15/2026 indicated Resident #65 was moderately | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 45<br>cognitively impaired. Resident #65 was dependent with transfers to the wheelchair. Resident #65 was independent with wheelchair mobility.<br><br>A Smoking Safety Evaluation dated 12/19/2025 at 4:02 PM stated Resident #65 was safe to smoke unsupervised.<br><br>A Consent and Release for Smoking form was signed by Resident #65 on 2/11/2026. The form read in part: “Residents are not allowed to smoke/vape inside the facility and must have smoking related items and materials stored in a safe place designated by the facility.” The Consent and Release for Smoking form also stated residents who violated the smoking policy by smoking inside or keeping smoking materials inside (in their room) would be subject to smoking privileges being revoked and/or a 30 day discharge notice. There was no other documentation noted that Resident #65 had previously signed a Consent and Release for Smoking form prior to 2/11/2026.<br><br>An observation on 2/22/2026 at 3:37 PM noted Resident #65 in his room and seated in his wheelchair. Resident #65 had a pack of opened cigarettes on his bed.<br><br>During an interview on 2/22/2026 at 3:42 PM, Resident #65 reported he was going out to smoke. Resident #65 reported he had his own smoking materials and lighter in his room and was an unsupervised smoker. Resident #65 stated he had always kept his own smoking supplies and went out to smoke whenever he desired.<br><br>An observation on 2/23/2026 at 10:15 AM was conducted of Resident #65 smoking safely on the patio while wearing a smoking apron.<br><br>An interview was conducted on 2/24/2026 at 8:15 AM with the East Unit Manager who reported the smoking policy had been reviewed with the residents on 2/11/2026 as the facility found out residents including Resident #65 were keeping smoking materials in their rooms. The East Unit Manager indicated all smoking materials were to be stored at the nurses’ station. There was also a lockbox in the smoking area for each resident.<br><br>An interview on 2/24/2026 at 8:31 AM with NA #2 indicated residents were to keep their smoking materials at the nurses’ station in the past but now there was a lockbox in the smoking area for residents’ smoking materials. NA #2 reported she did not know that Resident #65 had kept smoking supplies in his room.<br><br>An interview on 2/25/2026 at 3:50 PM with the DON stated the facility allowed smoking after a smoking | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 46<br>safety evaluation was completed. The DON stated the facility realized in early February 2026 that the residents had their smoking materials in their possession when reviewing policies and procedures in preparation for the yearly facility recertification survey. The facility noted that the residents were not storing their smoking supplies at the nurse's station. The DON indicated the Administrator reviewed the smoking policy with the residents at a meeting on 2/11/2026. The DON reported that the residents who smoked signed Consent and Release for Smoking forms and smoking materials were to be held at the nurses' station until the lockbox arrived and was installed. The DON stated it had been difficult to obtain compliance to the smoking policy from the residents. The DON acknowledged requiring the residents to place their smoking materials in the lockbox was a transition for the residents, but no resident should have their smoking materials in their possession any longer. The lockbox had been installed on 2/22/2026 and the expectation was that the residents would store their smoking supplies there. The DON stated she was not aware that Resident #18 had any smoking supplies in his room currently and should have stored these at the nurses' station.<br><br>An interview on 2/25/2026 at 4:05 PM with the Administrator revealed she had held a meeting on 2/11/2026 to discuss the smoking policy with the residents. The Administrator stated the facility realized in early February 2026 that the residents were keeping their smoking supplies in their rooms as the facility was reviewing policies and procedures. Residents were advised by the Administrator that they could not keep their smoking materials in their rooms any longer and should keep them at the nurses' station until the smoking materials lockbox arrived and was installed. The Administrator indicated the smoking materials lockbox had been installed and residents should be following the policy. The Administrator stated she was not aware Resident #65 had any smoking supplies in his room. The Administrator indicated she would immediately speak with Resident #65 and have him place any smoking supplies in his possession in the lockbox.<br><br>5. A review of the Smoking Policy dated 10/1/2021 and revised on 10/20/2022 read in part: "Residents who desire to smoke may not keep smoking related materials [i.e. cigarettes, electronic smoking devices (e-cigarettes), refill cartridges/fluid, cigars, pipes, tobacco, lighter, lighter fluid, match, etc.] on their person when not smoking or in their room. For safety purposes, all smoking related materials, devices, and | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 47<br>tobacco products must be stored in a safe place in the facility, such as the nurses' station." The Smoking Policy also stated that when residents were found or suspected to be non-compliant with the facility safe smoking practices, the facility would notify the attending physician/provider, the responsible party and document the concern in the medical record. The resident would be re-educated on the safe smoking policy/practices and the facility staff would continue to monitor the resident's compliance. The facility could also advise the resident of the facility's desire to conduct a resident room and should the resident refuse, law enforcement may be contacted to assist with the search. The facility may initiate discharge planning for a violation of any part of the smoking policy and for any unsafe smoking practice that poses a risk to residents or for repeated non-compliance. A thirty-day discharge notice may be initiated.<br><br>Resident #8 was admitted to the facility on 2/1/24 with diagnoses which included acute systolic heart failure, diabetes, and atrial fibrillation.<br><br>A review of Resident #8's care plan, revised on 8/18/25, revealed she preferred to smoke cigarettes. The goal was for Resident #8 to smoke safely through the review date. Interventions included smoking assessment as needed, supervising with smoking as Resident #8 required assistance to propel wheelchair in and out of smoking area, and educating on the facility smoking policy including smoking location, times and safety concerns.<br><br>A review of Resident #8's annual Minimum Data Set (MDS) assessment dated 12/18/25 revealed Resident #8 was cognitively intact and required staff assistance to complete activities of daily living (ADLs) except eating. The MDS indicated Resident #8 utilized a wheelchair for mobility and was coded for tobacco use.<br><br>A smoking assessment completed by the MDS Coordinator dated 12/19/25 revealed Resident #8 was designated as a supervised smoker due to her requiring assistance with propelling her wheelchair to the smoking area.<br><br>A Consent and Release for Smoking form was signed by Resident #8 on 2/11/2026. The form read in part: "Residents are not allowed to smoke/vape inside the facility and must have smoking related items and materials stored in a safe place designated by the facility." The Consent and Release for Smoking form also stated residents who violated the smoking policy by smoking inside or keeping smoking materials inside (in their room) would be subject to smoking privileges | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 48<br>being revoked and/or a 30-day discharge notice. There was no other documentation noted that Resident #8 had previously signed a Consent and Release for Smoking form prior to 2/11/2026.<br><br>An observation was conducted in Resident #8's room on 2/22/26 at 12:02 PM. Resident #8 was asleep in her bed and a lighter filled halfway with lighter fluid and a partially burned cigarette were observed on the bedside table to the right of Resident #8's bed.<br><br>An interview with Nurse #3 on 2/22/26 at 12:10 PM revealed nursing staff kept all residents' smoking materials including their lighters and cigarettes on the medication cart. After being told about the lighter and partially burnt cigarette Nurse #3 stated she did not know where the cigarette or lighter came from in Resident #8's room.<br><br>An observation and interview with Resident #8 on 2/22/26 at 12:15 PM revealed she would not smoke in her room, and the cigarette was supposed to go in the garbage. Resident #8 was observed attempting to put the cigarette and lighter in her purse. Resident #8 did not answer when asked where her smoking materials were typically stored.<br><br>An interview with Nurse Aide (NA) #9 on 2/22/26 at 12:19 PM revealed she was new to the facility and had assisted Resident #8 with a bed bath earlier that morning. She stated she did not observe the lighter or cigarette on the table during the bed bath earlier that morning but saw the lighter and cigarette on the bedside table later when she entered the room approximately 15 minutes earlier. She stated she alerted Nurse # 3 and had not witnessed Resident #8 with any smoking supplies in her room before the morning of 2/22/26.<br><br>An observation on 2/23/26 at 12:36 PM revealed the Maintenance Director installing a clear storage box with locked compartments in the outdoor hall area leading to the designated smoking area.<br><br>An additional observation of Resident #8 smoking in the designated smoking area occurred on 2/23/26 at 1:08 PM. She was assisted out to the smoking area in her wheelchair by the Business Office Manager (BOM) and the BOM assisted her with lighting her cigarette.<br><br>A telephone interview with the BOM on 2/25/26 at 3:06 PM revealed he would get the smoking materials from the nursing staff and assist residents out in the smoking area during designated smoking times. He stated nursing | F0689 | | |

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| F0689 SS = SQC-J | Continued from page 49<br>staff kept the smoking materials on the medication cart prior to the installation of the smoking materials box.<br><br>A telephone interview with the MDS Coordinator on 2/25/26 at 2:30 PM revealed she completed some of the smoking assessments for residents. She and the BOM when they were working, would often assist residents outside in the smoking area and retrieve their smoking materials from the Nurse on duty. The MDS Coordinator explained if she or the BOM were not working, nursing staff members were expected to assist residents with smoking and retrieving their materials from the nurse's medication cart and returning them to the same medication cart. The MDS Coordinator stated Resident #8 was a supervised smoker because she needed assistance getting to and from the smoking area as she could not propel herself in her wheelchair and could not move away from a potential fire from a dropped cigarette outside. She stated staff supervision was for her safety while smoking.<br><br>A follow-up telephone interview with Nurse #3 on 2/26/26 at 1:22 PM revealed she never saw any smoking materials in Resident #8's room before 2/22/26. She stated she would give Resident #8 her lighters and cigarettes when she wanted to smoke in the smoking area. Nurse #3 revealed NAs would assist Resident #8 with getting to and from the smoking area and with her smoking materials and the materials would be returned to her by staff.<br><br>A combined telephone interview with the Director of Nursing (DON) and Administrator on 2/26/26 at 10:37 AM revealed the residents had destroyed the previous smoking materials storage box outside and it needed to be replaced. The Administrator stated the new box had been delivered but had not been installed when the survey team arrived on 2/22/26. The Administrator stated they had a meeting with all residents who smoked on 2/11/26 and reviewed the smoking policy and had them sign a document to acknowledge the policy. The Administrator stated Resident #8 doesn't always finish her cigarettes, but all her smoking materials should have been returned to the nurse's medication cart by whichever staff member assisted her when Resident #8 came back from the smoking area. The DON stated she would have expected nursing staff to take the cigarette and lighter and hold onto it when Resident #8 returned from smoking, and she added that any nursing staff member could supervise residents smoking outside. | F0689 | | |
| F0761 SS = D | Label/Store Drugs and Biologicals<br><br>CFR(s): 483.45(g)(h)(1)(2) | F0761 | 1. The facility failed to secure medications when resident #8's medications were found at bedside. On 2/22/26 the unsecured medication found at Resident #8's | 02/25/2026 |

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| F0761 SS = D | Continued from page 50<br><br>§483.45(g) Labeling of Drugs and Biologicals<br><br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§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.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observations, record review and resident, staff and Nurse Practitioner interviews, the facility failed to secure medications found at the bedside for 1 of 2 residents reviewed for medication storage (Residents #8).<br><br>The findings included:<br><br>Resident #8 was admitted to the facility on 2/1/24 with diagnoses which included acute systolic heart failure.<br><br>An annual Minimum Data Set (MDS) assessment dated 12/18/25 indicated Resident #8 was cognitively intact.<br><br>A review of Resident #8's physician's orders revealed an order dated 2/10/26 for a 20 milliequivalents (mEq) potassium oral capsule (Potassium Citrate) one time a day for hypokalemia. Additionally, Resident #8 did not have any past or current physician's orders to self-administer medications.<br><br>A review of Resident #8's Electronic Medical Record (EMR) revealed no care plan areas or assessments for | F0761 | Continued from page 50<br>bedside was removed and disposed of, and Nurse #3 was provided education regarding medication safety by the Nurse Manager.<br><br>2. On 2/22/26 an audit of all resident rooms was conducted by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) to ensure no other medications were left at bedside. No other medications were noted to be at bedside.<br><br>3. Beginning 2/23/26 the DON and ADON provided education to all licensed nurses on medication safety, which included not leaving medications at bedside. Any licensed nurse not educated on 2/23/26, including agency, will receive this education prior to the start of their next shift by the DON/designee. All newly hired licensed nurses and agency nurses will receive this education during the orientation process by the DON/designee.<br><br>4. An Ad Hoc Quality Assurance Performance Improvement (QAPI) was held on 2/22/26, which included the facility Administrator, DON, ADON, Nurse Managers, Medical Director, Social Service Director, and Activity Director to review the deficient practice and improvement plan. To ensure compliance is maintained the DON, ADON, and Nurse Managers will conduct audits of resident rooms beginning 2/23/26, 3 times a week for 4 weeks, then 2 times a week for 4 weeks, and then weekly for 4 weeks to ensure medications are not left at bedside. The results of these audits will be reviewed in the monthly QAPI meeting for 4 months or until substantial compliance is maintained.<br><br>5. Date of compliance is 2/25/26. | |

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| F0761 SS = D | Continued from page 51<br>self-administering medications.<br><br>An observation on 2/22/26 at 12:02 PM revealed a large white pill in a cup on the bedside table to the left of Resident #8's bed. Resident #8 was lying in bed at the time of the observation.<br><br>An observation and interview with Nurse #3 on 2/22/26 at 12:08 PM revealed she was the medication nurse for Resident #8 and had administered Resident #8's medications that morning. She observed the medication cup with the large white pill on Resident #8's bedside and stated Resident #8 took all her other pills, but she wanted to wait a little bit on this one. Nurse #3 verified the large white pill was the potassium citrate capsule. Nurse #3 stated Resident #8 liked to take it later. Nurse #3 stated she did not normally leave the pill by the bedside and would always take the remaining pill back to her medication cart. Nurse #8 stated another staff member called her for a concern that morning and she left the pill next to Resident #8's bedside.<br><br>An interview with Resident #8 on 2/22/26 at 12:15 PM revealed she didn't like to take the large white pill with all her other medications, so she left it for later and Nurse #3 did not take it away.<br><br>An interview with the Nurse Practitioner (NP) on 2/24/26 at 1:57 PM revealed Resident #8 didn't like to take the potassium citrate, and she typically did not like to take a lot of medications at the same time. She stated Resident #8 has never had an order to self-medicate and she would not be able to self-medicate. The NP stated Nurse #3 should not have left the pill at Resident #8's bedside and the pill should have been returned to the medication cart when Resident #8 didn't take it. She stated no medications should ever be left at the bedside.<br><br>A combined telephone interview with the Director of Nursing (DON) and the Administrator on 2/26/26 at 10:44 AM revealed the Administrator had the expectation that Nurse #3 should have taken the pill back to the medication cart to be destroyed after Resident #8 refused it. The DON indicated Resident #8 did not have an order to self-medicate although she had a history of asking staff to leave her medications at her bedside all the time. The Administrator stated she had the expectation for Nurse #3 to follow the protocol for medication refusal, and the medication should have been destroyed and the DON notified. | F0761 | | |
| F0812 SS = D | Food Procurement,Store/Prepare/Serve-Sanitary | F0812 | The facility failed to maintain a sanitary kitchen | 02/26/2026 |

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| F0812<br>SS = D | Continued from page 52<br><br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br><br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(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.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observations, record review, and staff interviews, the facility failed to keep a fire compression tank clean of debris and keep the floor grout lines clean of greasy residue and food debris. These practices occurred in 1 of 2 food preparation areas and had the potential to affect food served to residents.<br><br>The findings included:<br><br>An initial tour of the main kitchen occurred 2/22/26 at 11:10 AM with the Head Cook. The following concerns were identified:<br><br>-Visible dirt and grime build-up present on a large fire suppression tank and its tubing. The tank and the associated equipment were attached to the wall and ceiling in a food preparation area above the toaster.<br><br>-Visible food debris and grease build-up was present in the grout lines of the floor tiles in front of the cooking range. | F0812 | Continued from page 52<br>environment when it was noted to have a fire compression tank with debris and floor grout lines were greasy and had food debris in them. On 2/22/26 dietary and housekeeping staff cleaned and sanitized the fire suppression system and floor grout.<br><br>On 2/23/26 all kitchen surfaces and food preparation areas were inspected by the Administrator and no further sanitation concerns were identified.<br><br>Certified Dietary Manager (CDM) provided education to all dietary and housekeeping staff, which included, clarifying cleaning schedules, new degreasing products, pressure washing schedules, and sanitation standards on 2/23/26. Any dietary and/or housekeeping staff not educated on this process will receive this education prior to the start of their next shift. All newly hired dietary and housekeeping staff will receive this education by the Dietary Manager during the orientation process.<br><br>An Ad-Hoc QAPI meeting was held with the Interdisciplinary Team on 2/24/26 to discuss this plan. Food Service Director or designee will complete an audit of kitchen sanitation audit weekly beginning 0n 2/24/26 for 4 weeks, then bi-weekly for 4 weeks, and then monthly for one month to ensure kitchen sanitation requirements are maintained. Results of audits will be brought to the Quality Assurance Improvement meeting monthly for 4 months to ensure substantial compliance is achieved<br><br>Date of compliance is 2/26/26 | |

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| F0812<br>SS = D | Continued from page 53<br>An interview with the Head Cook occurred on 2/22/26 at 11:25 AM. She stated the housekeeping department oversaw the cleaning of the floors in the kitchen, however, she was unsure of the cleaning schedule. The Head Cook stated grease and food debris would build up in the grout around the floor tiles and she was unaware of the visible dirt and grime build-up on the fire suppression tank.<br><br>An interview with the Housekeeping Supervisor was conducted on 2/23/26 at 2:10 PM. The Housekeeping Supervisor stated the kitchen floor was pressure washed on 2/20/26 and a new degreasing cleaning product was ordered with a new cleaning supply company. The Housekeeping Supervisor stated the old degreasing cleaning product they used didn't get everything as clean as it needed to be.<br><br>A telephone interview with the Administrator on 2/26/26 at 10:57 AM revealed the kitchen floors had just been pressure cleaned and the new cleaning products were ordered but had not come in yet. | F0812 | | |
| F0814<br>SS = F | Dispose Garbage and Refuse Properly<br><br>CFR(s): 483.60(i)(4)<br><br>§483.60(i)(4)- Dispose of garbage and refuse properly.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observations and staff interviews, the facility failed to close the trash receptacle door, remove loose garbage, boxes, and debris and failed to prevent standing water from around 1 of 1 trash receptacle and 1 of 1 recycling receptacle located outdoors behind the kitchen. This practice had the potential to impact sanitary conditions and attract pests and rodents.<br><br>The findings included:<br><br>An observation of the outdoor trash receptacle area with the Head Cook on 2/22/26 at 11:30 AM revealed three used disposable gloves and one clear trash bag which contained trash on the ground to the left of the trash receptacle and one clear trash bag which contained small amounts of trash hanging out of the open trash receptacle door. There were five collapsed cardboard boxes that were floating in standing water approximately 5 inches deep in the trash and recycling receptacles area, which was approximately 15 to 20 feet wide. One blue trash bag which contained trash was floating in the standing water between the trash | F0814 | F0814<br><br>Dispose Garbage and Refuse Properly<br><br>CFR(s): 483.60(i)(4)<br><br>§483.60(i)(4)- Dispose of garbage and refuse properly.<br><br>The facility failed to close the trash receptacle door, remove loose garbage, boxes, and debris and failed to prevent standing water from around 1 of 1 trash receptacle and 1 of 1 recycling receptacle located outdoors behind the kitchen. This practice had the potential to impact sanitary conditions and attract pests and rodents. On 2/22/26 all loose debris were removed, standing water cleared, receptacle doors secured, and the area verified clean by leadership.<br><br>On 2/23/26 all refuse areas were inspected and no additional issues were identified.<br><br>System changes included All staff (all housekeeping staff, all maintenance staff, all nursing staff both licensed and unlicensed, all management staff and all current and oncoming staffing agency employees) re education on refuse responsibility, cardboard handling, drainage response, vendor oversight, and pest | 02/26/2026 |

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| F0814<br>SS = F | Continued from page 54<br>receptacle and the recycling receptacle. One empty carboard carton was observed under the front of the recycling receptacle.<br><br>An interview with the Head Cook on 2/22/26 at 11:33AM revealed many staff members at the facility used the dumpster area and staff continuously forgot to close the receptacle doors. She stated that when it rained, water pooled under the dumpster area and didn't drain, which caused the standing water.<br><br>A second observation of the outdoor trash receptacle area was completed on 2/23/26 at 11:57 AM. One used purple glove was observed on the ground to the left of the trash receptacle. The trash receptacle door was open and one clear trash bag which contained trash hung out of the receptacle. Two collapsed cardboard boxes were floating in standing water approximately 3 inches deep (approximately 6 feet wide) between the trash receptacle and the recycling receptacle and one empty carton was observed under the front of the recycling receptacle.<br><br>An interview with Regional Housekeeping Supervisor on 2/23/26 at 2:10 PM revealed many staff members in multiple departments used the dumpster area and staff were continually reminded to keep the doors closed to the trash receptacle. She also stated the trash pick-up service which came a couple times a week caused a lot of the materials to fall out of the receptacles such as the collapsed cardboard boxes that were observed.<br><br>A tour and third observation of the trash receptacle area was completed with the Dietary Manager and Administrator on 2/23/26 at 2:53 PM and included interviews. The trash receptacle was not full, and the door was open and one clear trash bag which contained trash hung out of the door. Two collapsed cardboard boxes were observed in approximately an inch of standing water next to the recycling receptacle and an empty carton was under the front of the recycling receptacle. The Administrator stated she was not aware of the standing water, and she would have the area cleaned up to see if there was a drain present under the receptacles. The Administrator expected the area to be maintained by all staff who took out trash. The Dietary Manager revealed the trash pick-up company dumped items out of the dumpster when they picked up the trash and the items were not placed back in the receptacles by the trash pick-up company. | F0814 | Continued from page 54<br>prevention.<br><br>Monitoring by Maintenance which began on 2/23/2026 includes weekly refuse audits, consisting of checking dumpster area for standing water and doors being closed daily for four weeks and monthly audits for three months with QAPI review monthly.<br><br>Date of compliance is 2/26/26 | |
| F0880<br>SS = D | Infection Prevention & Control<br><br>CFR(s): 483.80(a)(1)(2)(4)(e)(f) | F0880 | The facility failed to follow their infection control policy and procedures for Enhanced Barrier Precautions (EBP) when Nurse #4 did not wear Personal Protective | 02/26/2026 |

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| F0880 SS = D | Continued from page 55<br><br>§483.80 Infection Control<br><br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or<br><br>infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv)When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br><br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or | F0880 | Continued from page 55<br>Equipment (PPE) while providing urinary catheter care for Resident #5. In addition, Nurse Aide (NA) #9 failed to wear PPE while providing urinary catheter care and transferring Resident #33 from wheelchair to bed. These deficiencies occurred for 2 of 10 staff members observed for infection control practices (Nurse #4 and NA #9). On 2/25/26 DON and ADON educated all staff on the importance of the enhanced barrier precautions sings and use of PPE as indicated when entering a room (all staff included: therapy staff, maintenance staff, housekeeping staff, culinary staff, management staff, and all licensed and unlicensed clinical staff). All clinical staff (licensed and Unlicensed) and central supply staff members were re educated on Enhanced Barrier Precautions with return demonstrations(knowing where the signs are located, and where the barrier cadies are, where to find supplies to restock said caddies) completed, and residents were assessed with no infection identified by DON and ADON.<br><br>On 2/25/26 all EBP rooms, signage, PPE availability, and staff assignments were reviewed (to ensure staff who provided deficient practice were educated first) and clarified by Director of Nursing and Assistant Director of Nursing.<br><br>System changes included reinforcement of EBP policy per Twin Pines/Hillvalley (home company of Plaza guidelines), standardized signage per CMS guidelines (DON ensured the appropriate colors of signs were out in appropriate rooms), staff education for all disciplines on location of signs and PPE, and real time supervisory oversight.<br><br>Monitoring by DON and ADON includes weekly PPE audits for four weeks beginning on 2/25/2026 and monthly audits thereafter with Quality Assurance Performance Improvement review. During the audits PPE and EBP will be audited for the right sign, correct use by staff, and right PPE and EBP products for the resident in need.<br><br>Date of compliance is 2/26/26. | |

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| F0880 SS = D | Continued from page 56<br>infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br><br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br><br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br><br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record reviews, observations and staff interviews, the facility failed to follow their infection control policy and procedures for Enhanced Barrier Precautions (EBP) when Nurse #4 did not wear Personal Protective Equipment (PPE) while providing urinary catheter care for Resident #5. In addition, Nurse Aide (NA) #9 failed to wear PPE while providing urinary catheter care and transferring Resident #33 from wheelchair to bed. These deficiencies occurred for 2 of 10 staff members observed for infection control practices (Nurse #4 and NA #9).<br><br>The findings included:<br><br>A review of the facility's policy that was undated titled "Enhanced Barrier Precautions," indicated:<br><br>· Enhanced Barrier Precautions (EBP) referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) by using gowns and gloves during high-contact resident care activities.<br><br>· High-contact activities included dressing, bathing, transferring, providing hygiene, changing linens or briefs, assisting with toileting, device care or use (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, | F0880 | | |

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| F0880 SS = D | Continued from page 57<br>Peripherally Inserted Central Catheter (PICC) lines, midline catheters, and wound care if deemed chronic by a medical provider or if MDRO was present.<br><br>a. An observation of urinary catheter care for Resident #5, provided by Nurse #4, was made on 2/25/2026 at 12:10 PM. Resident #5's room had an Enhanced Barrier Precautions (EBP) sign posted on the front of the door, and personal protective equipment (PPE) was hanging behind the door. The EBP sign located on Resident #5's door revealed gloves and a gown should be worn when providing high- contact care such as urinary catheter care. Nurse #4 entered the room without wearing a gown. She cleansed her hands with hand sanitizer gel and put on gloves. After completing Resident #5's urinary catheter care, she discarded any unused supplies and her gloves, then proceeded to wash her hands with soap and water at the sink.<br><br>An interview with Nurse #4 on 2/25/2026 at 12:30 PM revealed she was aware that Resident #5 was on Enhanced Barrier Precautions. Nurse #4 stated she was not aware she needed to wear a gown while providing urinary catheter care.<br><br>b. An observation of NA #9 transferring Resident #33 and emptying his urinary catheter was completed on 2/25/2026 at 1:35 PM. Resident #33's room had an Enhanced Barrier Precautions sign posted outside the door stating that staff should wear a gown and gloves for high-contact activities such as urinary catheter care and transfers. PPE was hanging on the back of Resident #33's door. NA #9 applied hand sanitizer to both hands and placed gloves on her hands. She did not put on a gown. NA #9 assisted Resident #33 with a stand-pivot transfer from his wheelchair to his bed. She then moved Resident #33's urinary catheter bag from the wheelchair to a hook on the side of the bed. NA #9 emptied the urinary catheter bag into a urinal and disposed of the urine in the toilet. She cleaned the urinal, disposed of her gloves, and washed her hands.<br><br>An interview with NA #9 at 2:00 PM on 2/25/2026 was completed. NA #9 stated she was not aware that Resident #33 was on Enhanced Barrier Precautions. She stated she did not notice the sign on Resident #33's door because it was a dark gray printed sign, and she was accustomed to the light blue Enhanced Barrier Precautions signs with red stop signs. NA #9 reported she was not aware that a gown was required to transfer and provide care for residents with urinary catheters.<br><br>An interview with the Director of Nursing (DON)/Interim | F0880 | | |

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| F0880 SS = D | Continued from page 58<br>Infection Preventionist was completed on 2/25/2026 at 3:52 PM. The DON stated that all employees were trained on infection control and proper use of PPE during orientation upon hire, and agency staff received infection control training online prior to working in the facility. The DON stated that staff should wear the appropriate PPE according to the enhanced barrier precaution signs posted for each resident.<br><br>An interview with the Administrator was completed on 2/25/2026 at 4:12 PM. The Administrator stated she expected all staff members to use the appropriate PPE according to the enhanced barrier precaution signs posted for each resident. | F0880 | | |