DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER: Kannapolis Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 1810 Concord Lake Road , Kannapolis, North Carolina, 28083	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments The survey team entered the facility on 3/1/26 to conduct a recertification and complaint investigation survey and remained on site at the facility through 3/5/26. The survey team returned to the facility on 3/10/26 to validate the immediate jeopardy removal plan and complete the extended survey. Additional information was obtained on 3/13/26, 3/17/26, and 3/18/26. Therefore, the exit date was changed to 3/18/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 1F1DDA-H1.	E0000		03/31/2026
F0000	INITIAL COMMENTS The survey team entered the facility on 3/1/26 to conduct a recertification and complaint investigation survey and remained on site at the facility through 3/5/26. The survey team returned to the facility on 3/10/26 to validate the immediate jeopardy removal plan and complete the extended survey. Additional information was obtained on 3/13/26, 3/17/26, and 3/18/26. Therefore, the exit date was changed to 3/18/26. The following intakes were investigated: 851140, 851144, 851152, 851160, 2577661, 2624483, 2628515, 2628663, 2637736, 2642451, 2648197, 2662087, 2677432, 2677593, 2692563, 2707831, 2715459, 2720002, 2722925, 2725430, 2734446, 2736845, 2741177, 2743147, 2790308 and 2795142. 26 of the 75 complaint allegations resulted in deficiency. Intake 2648197 resulted in immediate jeopardy. Past noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity J. The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 5/6/25 and was removed on 5/9/25.	F0000		03/31/2026

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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F0000	Continued from page 1 An extended survey was conducted on 3/10/26.	F0000		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels.	F0584	On March 2, 2026, the Maintenance Director replaced Resident #58's bed with a new bed without frayed cords intact and functioning remote buttons. On March 17, 2026, the Maintenance Director inspected all beds for frayed electrical cords and missing buttons on remote. One bed motor was identified as malfunctioning and was replaced on March 17, 2026. On March 19, 2026, the Maintenance Director began in-servicing all staff to include contract staff on how to submit work orders in the binders located at both nursing stations. The Maintenance Director/ Maintenance Assistant will check binders daily for outstanding work orders. Once completed, the Maintenance Director/Maintenance Assistant will sign off on each work order. The Maintenance Director will ensure all staff will be educated March 31, 2026. The Maintenance Director will ensure newly hired staff to include contract staff will receive education during facility orientation. The Maintenance Director/Maintenance Assistant will monitor using a Quality Assurance tool for environment inspecting cords under beds and remotes for functionality. The monitoring will include beds on various halls. The QA monitoring will be conducted three times a week x 4 weeks, twice a week x 4 weeks, and then weekly x 4 weeks. The Maintenance Director/Maintenance Assistance will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	03/31/2026

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F0584 SS = D	Continued from page 2 This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews with residents and staff, the facility did not maintain a resident bed in safe working condition for 1 of 1 resident room reviewed for a safe and homelike environment on 1 of 4 halls (Resident #58). An initial observation of Resident #58's room on 03/01/2026 at 1:58PM, revealed Resident #58 was in a semi-private room and positioned in the bed near the door. Observation revealed the head of the bed was elevated in an upright position and the bed was positioned above its lowest setting. At the time of observation, the bed was unplugged. Electrical wiring was observed hanging beneath the bed. Multiple internal wires (white, blue, red, and yellow) were visible along with a gold-colored exposed wire. The exposed wiring appeared damaged and was not properly secured to the bed frame. A review of the facility maintenance work order logbook dated 09/15/2025 through 03/01/2026 revealed no documentation of a work order submitted regarding Resident #58's bed. The quarterly Minimum Data Set (MDS) dated 12/02/2025 revealed Resident #58 was cognitively intact and dependent on staff assistance for transferring in and out of bed. On 03/01/2026 at 2:38 PM, Resident #58 who resided in Room #315, was interviewed and stated her bed had not been functioning properly and reported the bed had not been working for several months. Resident #58 stated she reported her bed concerns to the Maintenance Director because she was unable to independently adjust or move the bed because the bed remote was not working. Resident #58 reported maintenance staff had come to look at the bed several times; however, she was unable to recall the specific dates. Resident #58 stated maintenance staff did not return after those visits, and the bed had not been repaired. Resident #58 further stated the bed remained partially elevated in a sitting position and caused back soreness and discomfort. Resident #58 reported the position was uncomfortable and made it difficult for her to remain asleep. On 03/02/2026 at 9:53 AM, an interview was conducted with Nurse Aide (NA) #1. NA #1 stated she typically provided care for Resident #58. NA #1 observed the resident's bed was in a high position and stated when care was not being provided the bed should be lowered	F0584		

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F0584 SS = D	Continued from page 3 to the near-lowest height. NA #1 stated Resident #58's bed appeared to be in the highest position. NA #1 also observed a frayed electrical cord and noted the bed was not plugged in. NA #1 reported the bed remote was missing the down button, preventing the bed from being lowered. NA #1 stated maintenance concerns were typically documented by staff in the maintenance logbook and reported she would notify the Maintenance Director. NA #1 stated she had not previously noticed the bed would not lower and reported Resident #58 had not voiced any concerns regarding the bed. NA #1 further stated Resident #58 preferred to remain in bed. On 03/02/2026 at 12:33 PM, an interview was conducted with a Housekeeper. The Housekeeper reported she typically cleaned Resident #58's room and she had not previously noticed concerns with Resident #58's bed. During the interview, the Housekeeper observed the bed remote appeared broken and the bed could not be lowered. On 03/02/2026 at 12:38 PM, an interview and observation were conducted with the Maintenance Director. The Maintenance Director stated he was not aware of any concerns regarding Resident #58's bed prior to 03/02/2026. The Maintenance Director inspected Resident #58's bed and observed exposed wiring beneath the bed. He stated the wiring appeared to have been pulled from the control box connected to the motor. The Maintenance Director further observed the bed was plugged in. The Maintenance Director examined the bed remote and observed one of the buttons was damaged and the internal wiring was exposed. He stated if someone attempted to press the button there was a potential risk of electrical shock. The Maintenance Director confirmed the bed could not be lowered and stated he would replace the bed himself. The Maintenance Director stated the facility had a system in place for reporting maintenance concerns. He reported staff were to document maintenance issues using the paper log located at the nurses' station. The Maintenance Director stated staff were expected to record repair concerns in the log for maintenance to review and address. On 03/04/2026 at 10:00 AM, an interview with the Administrator was conducted. The Administrator stated her expectation would be for staff to identify and report maintenance concerns promptly and ensure resident equipment was maintained in safe working conditions.	F0584		
F0585 SS = B	Grievances CFR(s): 483.10(j)(1)-(4)	F0585	On March 25, 2026, written notification with proper resolution was provided to Resident #52 for grievance dated 1-21-26 and Resident #39 grievance dated 1-19-26.	03/31/2026

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F0585 SS = B	Continued from page 4 §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example,	F0585	Continued from page 4 Resident #69 grievance dated 7-10-25 was resolved on March 30, 2026 with written notification of resolution. On March 25, 2026, the Social Services Director audited grievances filed from March 16, 2026, to ensure proper written notification of resolution was provided to resident and responsible party. Ten (10) grievances were identified without proper written notification and copies of the resolution were provided to the resident and/or responsible party. On March 4, 2026, the Administrator educated the Social Service Director on ensuring proper written notification of resolution is provided to resident and/or responsible party. On March 25, 2026, the Administrator educated all Department heads on ensuring proper written notification of resolution is provided to resident and/or responsible party. The grievance will be signed by the resident and/or responsible party and a copy provided to the person filing the grievance. The Administrator and/or Social Service Director will ensure newly hired Department Heads will be educated during facility orientation. The Administrator/Social Services Director will monitor using a Quality Assurance tool for grievance proper notification of resolution provided to resident and/or responsible party. The monitoring will audit grievances to ensure proper written notification of resolution was provided. The QA monitoring will be conducted weekly x 4 weeks, biweekly x 4 weeks, and monthly x one month. The Administrator/Social Service Director will report the results of the QA monitoring to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision. Completion Date: 03/31/2026	

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F0585 SS = B	Continued from page 5 the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and Resident Representative (RR), resident and staff interviews, the facility failed to indicate if grievances had been resolved, how the results were communicated to the complainant, when the results of the grievances had been provided to the complainant and also failed to provide a written grievance response summary for 3 of 3 residents reviewed for grievances (Residents #52, #69 and #39). The findings included:	F0585		

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F0585 SS = B	Continued from page 6 A review of the facility grievance policy, dated 11/14/25, included, in part, “In accordance with the resident’s right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum: The date the grievance was received. The steps taken to investigate the grievance. A summary of the pertinent findings or conclusions regarding the residents’ concern(s). A statement as to whether the grievance was confirmed or not confirmed. Any corrective action taken or to be taken by the facility as a result of the grievance. The date the written decision was issued. “ 1) Resident #52 was admitted to the facility on 11/17/14. An annual Minimum Data Set (MDS) assessment dated 1/2/26 indicated Resident #52 was cognitively intact. A review of the facility’s grievance logs from April 2025 to February 28, 2026, revealed a grievance report had been initiated on 1/21/26 by Resident #52, regarding a desire to have the change left over from a shopping trip deposited back into his resident funds. Review of the grievance form revealed it did not indicate if the grievance had been resolved, how the results of the investigation were communicated to the complainant, when the results were communicated to the complainant and no indication that a written summary was provided. An interview occurred with Resident #52 on 3/4/26 at 9:50 AM who had filed the grievance form on 1/21/26. He stated he couldn’t recall if anyone discussed the resolution with him and stated that he had never received nor been offered a written resolution of the grievance from the facility	F0585		

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F0585 SS = B	Continued from page 7	F0585		

The Business Office Manager was interviewed on 3/4/26 at 10:10 AM and stated that Resident #52's funds were deposited back into his account. She stated that she had spoken with Resident #52 to let him know the money had been deposited but didn't provide anything for him in writing.

A phone interview was conducted with Social Worker #2 on 3/4/26 at 11:04 AM. She reported that she had been employed at the facility for approximately seven months and that her last day was 2/5/26. She stated she maintained the grievance logs and provided resolutions by phone or in person when they had not already been addressed by other management staff. She added that she had not been issuing written grievance resolutions because she was unaware this was required. Social Worker #2 could not recall if she had spoken with Resident #52 or if someone else did.

The Administrator was interviewed on 3/3/26 at 3:10 PM and stated that she felt the grievance for Resident #52 had been resolved. She added that she was not aware a written resolution to grievances was required and that the facility had only been discussing the resolution with the RR or resident via phone or in person.

She acknowledged that the facility needed to complete the portion of the grievance form to indicate when the grievance was resolved, if the complainant was satisfied, and how the investigation results were communicated. The Administrator stated it was her expectation for the facility to adhere to the regulatory guidelines regarding written grievance response summaries.

2) Resident #69 was admitted to the facility on 8/27/24.

A review of the facility's grievance logs from April 2025 to February 28, 2026, revealed the following grievance reports were initiated by Resident #69's RR:

A grievance report initiated on 7/10/25 regarding missing clothes. This grievance form had a check mark that the grievance was resolved. There was no indication of how the results of the investigation were communicated to the RR, when the results of the

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F0585 SS = B	Continued from page 8 investigation were communicated to the RR and no indication a written summary was provided. A grievance report initiated on 9/10/25 regarding concerns of notification. This grievance form did not indicate if the grievance was resolved, how the results of the investigation were communicated to the RR, when the results of the investigation were communicated to the RR and no indication a written summary was provided. A grievance report initiated on 10/23/25 regarding showers, room cleanliness and receiving statements. There was an attachment of a nursing progress note from the former Director of Nursing dated 10/24/25 where she met with Resident #69's RR regarding her concerns. The grievance form did not indicate if the grievance had been resolved, how the results of the investigation were communicated to the RR and no indication that a written summary was provided. A quarterly MDS assessment dated 2/4/26, indicated Resident #69 had moderately impaired cognition. A phone interview occurred with Resident #69's RR on 3/3/26 at 5:01 PM. She explained that when she had a concern, the facility would normally talk to her on the phone or when she visited her husband. She stated she had never received anything in writing regarding the resolution of her grievance concerns and was not always satisfied with the resolutions. A phone interview was conducted with Social Worker #2 on 3/4/26 at 11:04 AM. She reported that she had been employed at the facility for approximately seven months and that her last day was 2/5/26. Social Worker #2 stated that each time Resident #69's RR had a concern it was addressed by the nursing department either via phone or face to face. She stated she maintained the grievance logs and provided resolutions by phone or in person when they had not already been addressed by other management staff. She added that she had not been issuing written grievance resolutions because she was unaware this was required. The Administrator was interviewed on 3/3/26 at 3:10 PM and stated that she was not aware a written resolution to grievances was required and that the facility had only been discussing the resolution with the RR or	F0585		

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F0585 SS = B	Continued from page 9 resident via phone or in person. She acknowledged that the facility needed to complete the portion of the grievance form to indicate when the grievance was resolved, if the complainant was satisfied, and how the investigation results were communicated. The Administrator stated it was her expectation for the facility to adhere to the regulatory guidelines regarding written grievance response summaries. 3. Resident #39 was admitted to the facility on 04/23/25. A review of the facility grievance policy, dated 11/14/25, included, in part, “In accordance with the resident’s right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation.” A quarterly Minimum Data Set (MDS) assessment dated 12/12/25 indicated her cognition was intact. A review of the facility’s grievance logs from April 2025 to February 28, 2026, revealed a grievance report had been initiated on 1/19/26 by Resident #39, regarding her not receiving incontinence care on 01/18/26. The grievance form did not indicate if the grievance was resolved, how the results of the investigation were communicated to the complainant or when the results were communicated to Resident #39. An interview occurred with Resident #39 on 03/02/26 at 11:57 AM. The resident explained when she had a concern, the facility would normally talk to her about the results. She stated she had never received anything in writing regarding the resolution of her grievance concerns. A phone interview was conducted with Social Worker #2 on 03/04/26 at 11:04 AM. She reported she had been employed at the facility for approximately seven months and that her last day of employment with the facility was 02/05/26. Social Worker #2 stated when Resident #39 or her emergency contact had a concern it was addressed by the nursing department either via phone or face to face. She stated she maintained the grievance logs and provided resolutions by phone or in person when they had not already been addressed by other management staff. She added that she had not been issuing written grievance resolutions because she was unaware this was required. An interview was conducted on 03/03/26 at 3:10 PM with the Administrator. She stated she was not aware a	F0585		

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F0585 SS = B	Continued from page 10 written resolution to grievances was required and that the facility had only been discussing the resolution with the resident or Resident Representative (RR), via phone or in person. The Administrator stated it was her expectation for the facility to adhere to the regulatory guidelines regarding written grievance response summaries.	F0585		
F0607 SS = A	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure their abuse prevention policy was implemented when the facility failed to report an	F0607		03/31/2026

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F0607 SS = A	Continued from page 11 allegation of sexual abuse to the State Survey Agency within the required two-hour timeframe as mandated by facility policy for allegation for 1 of 3 residents reviewed for abuse (Resident #58). The findings included: Review of the facility's abuse policy stated in section VII that the facility would report all allegations of abuse immediately, but not later than 2 hours, after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. Resident #58 was admitted to the facility on 5/7/22 with diagnoses of anxiety and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated 12/9/25 stated that Resident #58 was cognitively intact. A review of the investigation folder showed two copies of the Initial Allegation Report, each with a fax cover sheet. The report stated the Administrator was notified that on 2/11/26 at 11:30 PM, Resident #6 alleged a male caregiver had sexually abused her. It showed the facility became aware of the staff to resident abuse allegation at 11:30 PM on 2/11/26, and police were notified at 12:07 AM on 2/12/26. The first fax confirmation for the report was timestamped on 2/12/26 at 5:05 AM. The second confirmation, was timestamped on 2/12/26 at 3:33 PM, included corrections such as a revised staff name. Both fax confirmations and their associated reports were filed outside the required two hour timeframe. During an interview on 3/2/26 at 2:55 PM, the Director of Nursing (DON) said she knew the State Agency required notification within 2 hours of becoming aware of an allegation of abuse. During an interview on 3/2/26 at 8:50 AM with the Administrator she stated that when the facility had reasonable suspicion of a crime, she notified police and then notified the State Agency within two hours. During a follow up interview on 3/4/26 at 2:05 PM the Administrator stated that the facility had 24 hours to report Resident #58's allegation of abuse because the 2 hour requirement applied only to suspicion of a crime involving serious bodily injury. The Administrator could not provide confirmation showing the facility sent the report within two hours of becoming aware of	F0607		

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F0607 SS = A	Continued from page 12 the allegation.	F0607		
F0628 SS = C	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with	F0628	The facility failed to provide the resident and responsible party with a written notice of transfer including the reason for the hospital transfer for Residents #33, #53, #69, and #31. Residents #33, #53, #69, and #31 currently reside in the facility. On March 19, 2026, the Director of Nursing reviewed recent hospital transfers to ensure written notice including the reason was provided to the resident and responsible party. Three residents were identified and written notificatio n with reason of hospital transfer was provided to the resident and responsible party. On March 19, 2026, the Director of Nursing/Unit Manager began educating all current licensed staff and the Administrator educated the Social Services Director and Department of Sales/Marketing (DSM) on the discharge process to include providing the resident and responsible party with written notice and reason for hospital transfer. At the time of non-emergent transfers, the licensed nurse will provide alert and oriented residents with written notification of transfer. The facility will mail written notice of transfer to the responsible parties of residents with cognitive impairment. The interdisciplinary team will review hospital transfers daily during stand-up meetings Monday through Friday. The Social Service Director will follow up on written notification. The DSM will follow up during hospital bedside visits to ensure residents receive written notification. The Director of Nursing/Designee will ensure all current Licensed nursing staff who have not received this education by March 31, 2026, will not be allowed to work until education is completed. The Director of Nursing/Designee will ensure newly hired licensed staff will receive education during facility orientation in person or via telephone prior to working. The Director of Nursing/Designee will monitor using a Quality Assurance tool for the discharge process on providing the resident and responsible party written notice and reason for hospital transfer. The QA monitoring will be conducted weekly x 4 weeks, biweekly x 4 weeks, and monthly x one month. The Administrator/Social Service Director will report the results of the QA monitoring to the Quality Assurance Performance Improvement (QAPI)	03/31/2026

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F0628 SS = C	Continued from page 13 paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and	F0628	Continued from page 13 committee for continued compliance and/or revision. Completion Date: 03/31/2026	

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F0628 SS = C	Continued from page 14 submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-	F0628		

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F0628 SS = C	Continued from page 15 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and interviews with Responsible Party (RP), residents, and staff, the facility failed to provide the resident and RP with a written notice of transfer including the reason for the hospital transfer for 4 of 4 residents reviewed for hospitalization (Residents #33, #53, #69 and #31).	F0628		

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F0628 SS = C	Continued from page 16 The findings included: 1) Resident #33 was admitted to the facility on 6/5/24. Review of the medical record revealed a family member was listed as Resident #33's RP. Resident #33 was transferred to the hospital on 5/20/25 for shortness of breath, 9/9/25 for shortness of breath, 11/16/25 for nausea and vomiting, 11/27/25 for abdominal pain and 12/26/25 for abdominal pain. Resident #33 was readmitted to the facility after each hospitalization. There was no documentation that a written notice of transfer was provided to the RP and resident, for each of the dates the resident was transferred to the hospital, including the reason for the transfers. A quarterly Minimum Data Set assessment dated 1/19/26 indicated Resident #33 was cognitively intact. A phone interview was completed with Resident #33's RP on 3/2/26 at 5:05 PM. She stated she was always informed by phone when Resident #33 was transferred to the hospital but had not received anything in writing from the facility. On 3/3/26 at 2:34 PM, an interview was conducted with Unit Manager #1, who stated when a resident was transferred to the hospital, a copy of the face sheet, medication list, any Do Not Resuscitate information, other pertinent information and the Bed Hold policy was sent with them. The RP was notified by phone of the change and reason for the hospital transfer. The Unit Manager did not know who was responsible for the written notice of transfer when a resident was transferred to the hospital. Social Worker #1 was interviewed on 3/3/26 at 2:40 PM and explained that she had worked at the facility for approximately three weeks but was not working at the facility from May 2025 to December 2025. Social Worker #1 was unable to explain why a written notice of transfer including the reason for the hospital transfer was not sent to the RP when Resident #33 was transferred to the hospital. Social Worker #1 stated she was unaware of a written notice of transfer including the reason for the hospital transfer was	F0628		

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F0628 SS = C	Continued from page 17 required when a resident was transferred to the hospital. An interview occurred via phone on 3/4/26 at 11:04 AM, with the former Social Worker #2 who stated that she worked at the facility for about seven months and her last day there was 2/5/26. She stated she was not working at the facility in May 2025. Social Worker #2 stated that she was unaware a written notice of transfer including the reason for the hospital transfer was required when a resident was transferred to the hospital and had not been informed to provide this document for Resident #33's transfers to the hospital on 9/9/25, 11/16/25, 11/27/25 or 12/26/25. The Administrator was interviewed on 3/3/26 at 2:53 PM and stated she had been employed at the facility since 11/21/25. She stated she was not aware a written notification was required to the resident and/or RP when a resident was transferred to the hospital. 2) Resident #53 was admitted to the facility on 5/29/23. Review of the medical record revealed a family member was listed as Resident #53's RP. Resident #53 was transferred to the hospital on 7/30/25 following a fall, 1/4/26 for altered mental status and 2/18/26 for altered mental status. Resident #53 was readmitted to the facility after each hospitalization. There was no documentation that a written notice of transfer was provided to the resident and RP, for each of the dates the resident was transferred to the hospital, including the reason for the transfers. A quarterly Minimum Data Set assessment dated 1/16/26 indicated Resident #53 had moderately impaired cognitive skills for daily decision making. Attempts to interview Resident #53's RP were unsuccessful. On 3/3/26 at 2:34 PM, an interview was conducted with Unit Manager #1, who stated when a resident was transferred to the hospital, a copy of the face sheet, medication list, any Do Not Resuscitate information,	F0628		

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F0628 SS = C	Continued from page 18 other pertinent information and the Bed Hold policy was sent with them. The RP was notified by phone of the change and reason for the hospital transfer. The Unit Manager did not know who was responsible for the written notice of transfer when a resident was transferred to the hospital. Social Worker #1 was interviewed on 3/3/26 at 2:40 PM and explained that she had worked at the facility for approximately three weeks but was not working at the facility from July 2025 to January 2026. Social Worker #1 was unable to explain why a written notice of transfer including the reason for the hospital transfer was not sent to the RP when Resident #53 was transferred to the hospital, prior to her employment. Social Worker #1 stated she was unaware of a written notice of transfer including the reason for the hospital transfer was required when a resident was transferred to the hospital, therefore one was not provided to Resident #53's RP on 2/18/26. An interview occurred via phone on 3/4/26 at 11:04 AM, with the former Social Worker #2 who stated that she worked at the facility for about seven months and her last day there was 2/5/26. Social Worker #2 stated that she was unaware of a written notice of transfer including the reason for the hospital transfer was required when a resident was transferred to the hospital and had not been informed to provide this document for Resident #53's transfers to the hospital on 7/30/25, or 1/4/26. The Administrator was interviewed on 3/3/26 at 2:53 PM and stated she had been employed at the facility since 11/21/25. She stated she was not aware a written notification was required to the resident and/or RP when a resident was transferred to the hospital. 3) Resident #69 was admitted to the facility on 8/27/24. Review of the medical record revealed a family member was listed as Resident #69's RP. Resident #69 was transferred to the hospital on 12/26/25 for shortness of breath. Resident #69 was readmitted to the facility after the hospitalization. There was no documentation that a written notice of transfer was provided to the RP and resident, including	F0628		

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F0628 SS = C	Continued from page 19 the reason for the transfer. A quarterly Minimum Data Set assessment dated 2/4/26 indicated Resident #69 had moderately impaired cognition. A phone interview was completed with Resident #69's RP on 3/1/26 at 5:52 PM. She stated she had been informed by phone when Resident #69 was transferred to the hospital but had not received anything in writing from the facility. On 3/3/26 at 2:34 PM, an interview was conducted with Unit Manager #1, who stated when a resident was transferred to the hospital, a copy of the face sheet, medication list, any Do Not Resuscitate information, other pertinent information and the Bed Hold policy was sent with them. The RP was notified by phone of the change and reason for the hospital transfer. The Unit Manager did not know who was responsible for the written notice of transfer when a resident was transferred to the hospital. Social Worker #1 was interviewed on 3/3/26 at 2:40 PM and explained that she had worked at the facility for approximately three weeks but was not working at the facility in December 2025. Social Worker #1 was unable to explain why a written notice of transfer including the reason for the hospital transfer was not sent to the RP when Resident #69 was transferred to the hospital. Social Worker #1 stated she was unaware of a written notice of transfer including the reason for the hospital transfer was required when a resident was transferred to the hospital. An interview occurred via phone on 3/4/26 at 11:04 AM, with the former Social Worker #2 who stated that she worked at the facility for about seven months and her last day there was 2/5/26. Social Worker #2 stated that she was unaware of a written notice of transfer including the reason for the hospital transfer was required when a resident was transferred to the hospital and had not been informed to provide this document for Resident #69's transfer to the hospital on 12/26/25. The Administrator was interviewed on 3/3/26 at 2:53 PM and stated she had been employed at the facility since	F0628		

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F0628 SS = C	Continued from page 20 11/21/25. She stated she was not aware a written notification was required to the resident and/or RP when a resident was transferred to the hospital. 4. Resident #31 was admitted to the facility on 07/31/22. Review of the medical record revealed Resident #31 was listed as her own Responsible Party (RP). Resident #31 was transferred to the hospital on 01/26/25 with complaints of shortness of breath and low oxygen saturation. Following the hospitalization, Resident #31 was readmitted to the facility. Review of the medical record revealed no documentation that a written notice of transfer, including the reason for the transfer, was provided to Resident #31 and/or her emergency contact. An annual Minimum Data Set (MDS) assessment dated 02/17/26 indicated Resident #31's cognition was intact. Resident #31 was hospitalized and was not available for an interview during the survey time. Attempts to interview Resident #31's emergency contact were unsuccessful. On 03/03/26 at 2:34 PM, an interview was conducted with Unit Manager #1 who explained when a resident was transferred to the hospital, a copy of the face sheet, medication list, any Do Not Resuscitate information, the Bed Hold policy and other pertinent information and was sent with them. The RP was notified by phone of the change and reason for the hospital transfer. Unit Manager #1 did not know who was responsible for the written notice of transfer when a resident was transferred to the hospital. An interview occurred via phone on 03/04/26 at 11:04 AM, with former Social Worker #2 who stated that she worked at the facility for about seven months and her last day there was 02/05/26. Social Worker #2 stated that she was unaware a written notice of transfer including the reason for the hospital transfer was required when a resident was transferred to the hospital and had not been informed to provide this document for Resident #31's transfer to the hospital on 01/26/25. The Administrator was interviewed on 03/03/26 at 2:53 PM and stated she had been employed at the facility since 11/21/25. She stated she was not aware that a	F0628		

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F0628 SS = C	Continued from page 21 written notification was required to be given to the resident and/or RP when a resident was transferred to the hospital.	F0628		
F0640 SS = A	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly	F0640		03/31/2026

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F0640 SS = A	Continued from page 22	F0640		

assessment.

(vi) Quarterly review.

(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.

(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.

This REQUIREMENT is NOT MET as evidenced by:

Based on record review and staff interviews, the facility failed to complete a discharge Minimum Data Set (MDS) assessment (Resident #12) and failed to complete an Entry tracking record for a resident who returned to the facility after being hospitalized (Resident #53). This was for 2 of 4 residents reviewed for discharge.

The findings included:

1. Resident #12 was admitted to the facility on 01/21/26 with diagnoses that included multiple fractures and chronic respiratory failure.

Resident #12’s admission Minimum Data Set (MDS) dated 01/27/26 had been completed.

Review of Resident #12’s medical record revealed on 02/05/26 Resident #12 had transferred to another facility. There was no discharge MDS found in Resident #12’s medical record.

An interview with the MDS Coordinator was conducted on 03/04/26 at 11:00 AM. The MDS Coordinator reviewed the medical record and confirmed Resident #12 had been discharged to a sister facility on 02/05/26 and a discharge MDS had not been completed. It was further revealed discharges were discussed in morning meetings and this had been missed.

An interview with the Administrator on 03/04/26 at 11:20 AM revealed she was not aware that Resident #12’s discharge MDS had not been transmitted. It was further revealed she expected the MDS Coordinator to complete discharge MDS assessments.

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F0640 SS = A	Continued from page 23 2. Resident #53 was admitted to the facility 5/29/23. A discharge return anticipated MDS dated 2/18/26 documented Resident #53 was discharged to the hospital. A nursing note dated 2/23/26 documented Resident #53 was readmitted to the facility after hospitalization. Review of the medical record for Resident #53 revealed no MDS Entry tracking record documenting his return to the facility was completed. The MDS Nurse was interviewed on 3/4/26 at 11:06 AM. The MDS Nurse reported for a resident who had been discharged to the hospital and returned that an MDS Entry tracking record would be completed. The MDS Nurse reported during the morning meeting that the residents who were discharged, sent to the hospital or returned from the hospital were discussed and the MDS Nurse would make a note of those residents and initiate the appropriate assessment. The MDS Nurse reported she also reviewed the dashboard of the electronic documentation system and would get an alert for MDS assessments that were due. The MDS Nurse reviewed the dashboard for the electronic documentation system and revealed that Resident #53 was on the dashboard to have an MDS Entry tracking record completed, but she missed it. The MDS Nurse reported missing the Entry tracking record was an error. The Administrator was interviewed on 3/4/26 at 12:16 PM. The Administrator reported she expected the MDS Nurse to keep track of discharges and readmissions and complete the appropriate MDS assessments.	F0640		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation, and interviews with resident and staff, the facility failed to ensure a resident who was dependent on staff assistance for incontinence care (Resident #18) and for changing soiled clothing (Resident #87) received assistance when needed for 2 of 11 residents reviewed for activities of daily living (Residents #18 and #87).	F0677	Incontinent care was provided for resident #18 on March 2, 2026, by the direct care staff. The Director of Nursing/Unit Manager completed rounds to assess residents in need of staffs' assistance with incontinent care on March 2, 2026. Residents requiring assistance were provided care by their certified nursing assistants. On March 2, 2026, Resident #87 soiled clothing was changed by the direct care staff. On March 2, 2026, the Director of Nursing/Unit Manager completed observation rounds of residents for soiled clothing, and none were identified. The facility has determined all residents' dependent on staffs' assistance for incontinent care and changing soiled clothes have the potential to be affected. On March 19, 2026, the Director of Nursing/Unit Manager began educating all licensed nurses and certified	03/31/2026

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F0677 SS = D	Continued from page 24 The findings included: 1. Resident #18 was admitted to the facility on 09/24/25 with diagnoses that included dementia. The resident's active care plan, last updated on 10/03/25, identified incontinence as a focus area. Interventions included cleansing the perineal area with each incontinence episode, monitoring and documenting intake and output per facility policy, and monitoring/documenting for signs and symptoms of urinary tract infection. Resident #18's quarterly Minimum Data Set (MDS) assessment dated 12/30/25 indicated his cognition was severely impaired and he did not refuse any care. Resident #18 was independent with bed mobility, he required supervision or touching assistance to walk 50 feet with two turns, and he required partial/moderate assistance with transfers. Resident #18 required substantial/maximal assistance to shower/bathe self, and personal hygiene, and he was dependent on staff for toileting hygiene. He was always incontinent with bowel and bladder. On 03/02/26, a continuous observation was conducted from 1:03 PM to 1:25 PM. During this period, Resident #18 was observed lying in bed on his left side with his eyes closed. He was wearing black, thin pants, and his brief was visibly exposed above the waistline. The bed sheet beneath him displayed a straw colored wet area extending approximately 10 inches around his lower body, with an additional yellowish brown dried border extending about 3 inches beyond the wet area. No nursing assistants were present or available on the hall at any point during the observation period. An interview was conducted on 03/02/26 at 2:01 PM with Nursing Assistant (NA) #6. She confirmed she was the direct care NA for Resident #18 and that she was accompanied by an orientee. NA #6 reported that she provided incontinence care to Resident #18 between 8:15 AM and 8:30 AM. She stated that she returned to check on him at 11:30 AM and noted that his brief was wet and required changing, at which time the resident refused care. She reported notifying Nurse #2 of the refusal. NA #6 stated that she did not return to Resident #18's room after the 11:30 AM check. She further stated she went to lunch at 1:30 PM and did not change the resident prior to leaving for lunch. When asked why, she replied, "because I had to get food, I was starving." NA #6 also reported that she completes incontinence rounds every two hours and as needed. At	F0677	Continued from page 24 nursing assistants on providing assistance for dependent residents with activities of daily living to include incontinent care and changing of soiled clothes. The Director of Nursing/Designee will ensure newly hired licensed nurses and certified nursing assistants will receive education during facility orientation. The Director of Nursing/Unit Manager/Supervisor will monitor incontinent residents during observation rounds on various shifts ensure care is provided and residents clothes aren't soiled clothes. The Director of Nursing Services/Unit Manager/Supervisor will conduct a random audit of five (5) residents on various halls and shifts per week x 4 weeks, three (3) residents per week x 4 weeks, then two residents per week x 4 weeks. The Director of Nursing/Unit Manager will report the results of the QA monitoring to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	

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F0677 SS = D	Continued from page 25 the time of the interview she had not been back to Resident #18's room. An observation and interview were conducted on 03/02/26 at 2:14 PM with Nursing Assistant (NA) #7. He confirmed that he had been orienting with NA #6 throughout the day. NA #7 stated they provided incontinence care to Resident #18 at approximately 8:30 AM. He reported they entered the resident's room again prior to lunch, though he was unable to recall the exact time. According to NA #7, Resident #18 stated he was tired and requested that they return later to complete the change. NA #7 further stated that neither he nor NA #6 returned to Resident #18's room after that visit prior to lunch. He also reported that he was not aware of NA #6 notifying Nurse #2 that Resident #18 had refused incontinence care at any point during the day. During an observation and interview conducted on 03/02/26 at 1:30 PM, the Director of Nursing (DON) confirmed that Resident #18's clothing, brief, and bed linens were wet and that the resident required changing. She stated that her expectation was for staff to provide incontinent care before a resident's clothing or bedding becomes wet or soiled. The DON further indicated she was unaware that Resident #18 had not received the necessary incontinence care. An observation and interview were conducted on 03/02/26 at 1:40 PM with Nursing Assistant (NA) #5. NA #5 removed and confirmed that Resident #18's clothing, brief, and linens were wet with urine. Resident #87's skin was intact with no redness noted. She stated that although she was not assigned as Resident #18's direct care NA for the day, the Director of Nursing requested her assistance in changing the resident. An interview was conducted on 03/02/26 at approximately 4:05 PM with Nurse #2. She confirmed she was the direct care nurse for Resident #18 on this date. Nurse #2 stated that Nursing Assistant #6 did not notify her at any time on 03/02/26 that Resident #18 had refused incontinent care. 2. Resident #87 was admitted to the facility on 06/21/19 with diagnoses that included intermittent explosive disorder (a mental health condition characterized by recurrent, impulsive, and intense outbursts of aggression or violence that are grossly disproportionate to the situation) and vascular dementia. Resident #87's quarterly Minimum Data Set (MDS) assessment dated 02/17/26 indicated his cognition was	F0677		

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F0677 SS = D	Continued from page 26	F0677		

severely impaired and he exhibited no behaviors. He usually understood others and he had highly impaired hearing. Resident #87 required set-up/clean-up with eating and required supervision or touching with oral hygiene. He required partial/moderate assistance with personal hygiene and substantial/maximum assistance with dressing.

Resident #87's active care plan, last revised on 02/28/26, included the focus area of an activity of daily living (ADL) self-care deficit. The interventions included for staff to assist with dressing and undressing and to assist him to choose simple comfortable clothing that enhances his ability to dress self.

An observation was conducted on 03/01/26 at 11:43 AM of Resident #87 lying in bed wearing a plain blue long-sleeved shirt. The shirt contained dried food particles and dried white and tan-colored spill marks. Resident #87 was eating his lunch at the time of the observation and stated, "I'm okay."

An observation was conducted on 03/01/26 at 2:52 PM of Resident #87 lying on his bed wearing a long sleeved shirt. The shirt had dried food particles and dried spill marks present.

An observation was conducted on 03/02/26 at 10:00 AM of Resident #87 lying on his bed wearing the same soiled long sleeved shirt observed the previous day. The shirt continued to have dried food particles and dried spill marks. When asked if he knew how long he had been wearing the shirt, Resident #87 stated, "It's been 3 days; it needs to be changed." He was unsure whether he had asked anyone to change the soiled shirt.

An observation and interview were conducted on 03/02/26 at 10:25 AM with Medication Aide (MA) #1. She accompanied this surveyor to Resident #87's room and confirmed that the resident's shirt was soiled with crumbs, dried and hardened food spots, and dried white colored beverage spills. She further verified that this was the same soiled shirt Resident #87 had been wearing on 03/01/26. MA #1 stated she would notify the Nursing Assistant (NA) assigned to Resident #87 that his clothing needed to be changed. She also confirmed she was the direct care MA for Resident #87 on both 03/01/26 and 03/02/26. MA #1 reported that she assumed the assigned NA would have changed the resident's shirt during morning care or after lunch on 03/01/26.

An interview was conducted on 03/02/26 at 1:50 PM with

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F0677 SS = D	Continued from page 27 Nursing Assistant (NA) #5. NA #5 confirmed that she was the direct care NA for Resident #87 on this date. She stated she had not provided morning care to Resident #87 at the time Medication Aide (MA) #1 notified her, around 10:30 AM, that the resident's shirt was soiled and had been worn since the previous day. NA #5 reported that she then entered the room at that time and provided morning care to Resident #87. Unsuccessful attempts were made to interview the direct care Nursing Assistant assigned to Resident #87 on 03/01/26 for the 7:00 AM to 7:00 PM and the 7:00 PM to 7:00 AM shifts. An interview was conducted on 03/04/26 at 2:03 PM with the Director of Nursing (DON). The Director of Nursing stated that residents were expected to remain neat, clean, and dressed in clean garments, with their activities of daily living (ADL) needs met. She explained that staff were expected to change residents' clothing after meals if soiling occurs. She also reported she was not aware that Resident #87's ADL had not been met.	F0677		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and interviews with family, staff, Nurse Practitioner, and Physician, the facility failed to provide the necessary supervision for a resident who was severely cognitively impaired, had difficulty swallowing, and was on a mechanical soft diet (foods that are naturally soft or altered [chopped, ground, mashed, or pureed] to require minimal chewing, making them safer and easier to swallow) with nectar thickened liquids (thickened consistency to slow the flow of the liquid to prevent choking and aspiration by allowing more time for the airway to close). Resident #103's family member, Family	F0689	"Past Noncompliance - no plan of correction required"	03/31/2026

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F0689 SS = SQC-J	Continued from page 28 Member #1, was repeatedly observed by staff bringing the resident food items that were not consistent with his ordered diet and the facility failed to implement effective interventions to protect the resident from an avoidable accident. On 5/6/2025 Nurse #1 observed Family Member #1 bring the resident a burger, chicken nuggets, french fries, and sweet tea. Nurse #1 explained to Family Member #1 that Resident #103 was on a modified diet and should not eat the food brought in due to the risk of choking. Family Member #1 did not comply and they set the food up for the resident to eat in his room and left the facility at approximately 9:53 pm. Nurse #1 was aware Family Member #1 exited the facility, and she (Nurse #1) knowingly left the resident unsupervised with the food in front of him. Nurse #1 indicated she checked on the resident at 9:59 pm and then instructed Nurse Aide #3 to check on the resident. At approximately 10:14 pm when Nurse Aide #3 went to the resident's room to check on him, she observed Resident #103 with food in his mouth, a hamburger in his hand that was partially eaten and he was pale, unresponsive, and had a very faint pulse. Cardiopulmonary Resuscitation (CPR) was initiated and Emergency Medical Services (EMS) were called. Upon EMS arrival they continued CPR but resuscitation efforts were unsuccessful. Resident #103 was pronounced deceased at 11:20 pm. Additionally, the facility failed to provide incontinence care in a safe manner when a resident was rolled out of bed hitting the floor. The resident was on an air mattress that was raised to the highest position. The resident sustained a two-centimeter (cm) laceration to his left forehead and was transferred to the Emergency Department for treatment and returned to the facility the same shift. This was for 2 of 7 residents reviewed for supervision to prevent accidents (Resident #103 and Resident #53). Findings included: 1. Resident #103 was admitted to the facility on 11/22/2024 diagnoses of difficulty swallowing, dementia, and stroke. Resident #103's face sheet indicated Family Member #1 was his emergency contact and Resident #103 was his own responsible party. Speech Therapy Notes for January 2025 revealed Resident #103 was treated by Speech Therapy for dysphagia (difficulty swallowing) and he was discharged from services on 1/28/2025 with a mechanical soft diet with thin liquids. Speech Therapy notes for March 2025 revealed services	F0689		

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F0689 SS = SQC-J	Continued from page 29 were initiated for Resident #103 on 3/27/2025 when he returned from the hospital on a regular diet with thin liquids. The Speech Therapist note for 3/27/2025 stated Resident #103's dietary order was changed to pureed with regular liquids due to pocketing (held food in his mouth) and choking during his initial evaluation. A Physician's Order dated 3/27/2025 indicated Resident #103 was a full code (desired resuscitative measure to be used if his breathing or heart stopped). Resident #103's quarterly Minimum Data Set assessment dated 4/1/2025 indicated he was severely cognitively impaired, had no behaviors, required moderate assistance with eating, and he was on a mechanically altered and therapeutic diet. The assessment did not document any chewing or swallowing issues. On 4/4/2025 a Speech Therapy Discharge Summary written by the Speech Therapist stated Resident #103 was upgraded to a mechanical soft diet with regular liquids and specified regular consistency bread products and pureed fruit. A Physician's Order dated 4/4/2025 indicated Resident #103 should receive a mechanical soft diet with nectar thick liquids. The Physician's Order also indicated Resident #103 should have pureed fruit and no straws, and may have the following regular consistency foods: pancakes, muffins, biscuits, sliced bread, rolls, cake, cookies, crackers, coffee cake, pimento cheese, and peanut butter and jelly sandwiches. A progress note written by Director of Nursing (DON) #2 on 4/9/2025 at 10:53 pm indicated Resident #103's family brought water that was not nectar thick and regular consistency foods to Resident #103 and the family wanted staff to feed Resident #103 a regular diet. The note further stated it was explained to the family member (Family Member #1) that Resident #103 was seen by the Speech Therapist and it was not safe for him to eat a regular diet at this time because he was at risk of choking. A Physician's Order for a Speech Therapy evaluation and treatment dated 4/10/2025 stated Resident #103 should receive treatment for dysphagia to include diet modifications, safety and tolerance, laryngeal exercises (utilized to improve swallowing), and patient	F0689		

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F0689 SS = SQC-J	Continued from page 30 and caregiver education. The Speech Therapist's consultation notes indicated Resident #103 had a Bedside Swallow Exam on 4/10/2025 and required a mechanical soft diet with nectar thickened liquids. The swallowing exam on 4/10/2025 indicated Resident #103 had pocketing of food and coughing and choking with an increased diet texture. During a telephone interview with the Speech Therapist on 3/5/2026 at 12:00 pm she stated she evaluated Resident #103 on 4/10/2025 because nursing reported he was pocketing food and Family Member #1 had complained because she wanted him to receive a regular diet. She explained that when she attempted to upgrade the resident's diet he coughed and choked and she did not upgrade it. The Speech Therapist stated Resident #103 was on a mechanical soft diet with regular liquids and no straw in January 2025 and then his diet changed to a mechanical soft diet with nectar thick liquids, and at some point prior to May 2025 Resident #103's diet changed to mechanical soft with nectar thick liquids and no straws. The Speech Therapist stated Resident #103 could feed himself if he was given the consistency that was ordered for him. The Speech Therapist also stated Family Member #1 was noncompliant and would give Resident #103 a regular diet after she spoke with her regarding the risk of choking if Resident #103 did not follow his ordered diet. The Speech Therapist stated she was not aware of a waiver being signed for Resident #103 to eat a regular diet or any other interventions regarding Resident #103 receiving food from the family that was inconsistent with his dietary order. The Speech Therapist stated she notified Family Member #1 each time the diet order was changed. The Speech Therapist stated Resident #103 would not have understood the dangers of eating foods that were not prescribed for him. Resident #103's Physician Order for 4/24/2025 indicated Resident #103 should receive a mechanical soft diet with nectar thickened liquids consistency with no raw vegetables and pureed fruit and continue with no straw. On 4/29/2025 at 7:45 pm a Nurses' Progress Note written by Nurse #7 stated Resident #103 was discharged to the hospital due to altered mental status. A Hospital Discharge Summary dated 5/6/2025 at 1:15 pm stated Resident #103's diagnoses during his hospitalization were anemia due to gastrointestinal	F0689		

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F0689 SS = SQC-J	Continued from page 31 bleeding and there was no documentation of a diet order on the discharge summary from the hospital. On 5/6/2025 a Physician's Order stated Resident #103's diet was a mechanical soft diet with nectar thickened liquids. Resident #103's active care plan on readmission 5/6/2025 included a care plan for nutritional risk related to dementia and malnutrition that was initiated on 11/22/2024. This care plan indicated Resident #103's family brought in foods that were not conducive with his diet order despite education regarding choking hazards. The interventions, also initiated on 11/22/2024, included that the resident required supervision and assistance with meals; and for difficulty swallowing, choking, coughing, drooling, and holding food in his mouth to be reported. The interventions did not specify who the signs of difficulty swallowing should be reported to. Resident #103's active care plan did not include any aggressive or combative behaviors. The only behavioral issue noted in the care plan was wandering. Unit Manager #2 was interviewed by phone on 3/5/2026 at 2:36 pm and stated she remembered having conversations with Family Member #1 on two occasions (she did not recall the dates) regarding the risk of Resident #103 choking if he ate food that was not on his prescribed diet. Unit Manager #2 explained that she had not observed Family Member #1 giving Resident #103 foods that he should not have; but Family Member #1 would come to her and complain that Resident #103 had not received a regular diet and that she had brought him regular food. Unit Manager #2 stated Family Member #1 was still insistent that Resident #103 could eat a regular diet. Unit Manager #2 stated Family Member #1 usually visited Resident #103 every other week. Unit Manager #2 stated she did not realize she had not written progress notes regarding her conversations with Resident #103's Family Member pertaining to the risk of choking if he ate foods that were not on his ordered diet. Unit Manager #2 stated Resident #103 would have been fine to eat the diet he was ordered (mechanical soft with nectar thick liquids) but he would have needed to be supervised if he was eating a regular diet since he would be at risk of choking. The Assistant Director of Nursing (ADON) was interviewed on 3/5/2026 at 11:27 am and stated the	F0689		

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F0689 SS = SQC-J	Continued from page 32 facility had several meetings with Resident #103's family member, Family Member #1, regarding the importance of following Resident #103's diet orders to prevent choking. The ADON stated she did not know why there were no progress notes regarding the meetings the facility had with Family Member #1. The ADON stated she was not aware of the facility obtaining a waiver to allow Resident #103 to eat foods that were not on his diet. The ADON stated Family Member #1 brought Resident #103 food that was not consistent with the resident's diet frequently. She further stated she had observed Family Member #1 bringing hard candy, beef stew, and cheese puffs on different occasions. The ADON stated when Family Member #1 brought in foods for Resident #103 that were not consistent with the resident's ordered diet she (the ADON) re-educated Family Member #1 on the risk of choking for Resident #103. Resident #103's medical record from 1/17/2025 through 5/6/2025 revealed no evidence of care plan meetings or other meetings (as referenced by the ADON in interview) held with Resident #103's Family Member related to education /interventions pertaining to the risk of choking if the resident ate foods that were not on his ordered diet. The only reference related to conversations with Family Member #1 during this time period (1/17/2025 through 5/6/2025) was in the 4/9/2025 note written by DON #2. A Nurse's Progress Note written by Nurse #1 on 5/7/2025 at 9:43 am stated Resident #103 refused his evening meal on 5/6/2025 and his family member (Family Member #1) brought him a burger, chicken nuggets, french fries, and a tea. Nurse #1 had tried to explain to Family Member #1 that Resident #103 was on a mechanical soft diet with nectar thick liquids and should not eat the meal Family Member #1 brought because of the risk of choking, but Family Member #1 insisted the resident could eat a regular diet. Family Member #1 gave the resident the foods she brought (hamburger, chicken nuggets, french fries, and a tea) and left Resident #103 sitting up in bed at 9:53 pm on 5/6/2025. Nurse #1 indicated she checked on Resident #103 after Family Member #1 left and asked Nurse Aide #3 to check on Resident #103; and at 10:14 pm Nurse Aide #3 found Resident #103 was pale, unresponsive, and had a very faint pulse. Nurse #1 immediately began CPR and she instructed Nurse Aide #3 to call for EMS. EMS arrived within a few minutes and continued CPR and Resident #103 was pronounced expired at 11:20 pm.	F0689		

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F0689 SS = SQC-J	Continued from page 33 Nurse Aide #3 was interviewed by phone on 3/4/2026 at 6:36 pm and she stated she was familiar with Resident #103 but she was not usually assigned to him. She indicated she was aware Family Member #1 would bring food in for the resident that was not consistent with Resident #103's diet. Nurse Aide #3 stated if she had observed Family Member #1 giving Resident #103 food that was not consistent with his diet she would notify the nurse assigned to him. Nurse Aide #3 stated she was not assigned to Resident #103 on the evening shift (3:00 pm to 11:00 pm) of 5/6/2025 but she was told by Nurse #1, at approximately 10:00 pm on 5/6/2025, to check on the resident because Family Member #1 gave him food that was not consistent with his mechanical soft diet with nectar thick liquids. Nurse Aide #3 stated Nurse #1 instructed her to check on Resident #103 because Nurse #1 was taking a break. Nurse Aide #3 revealed she checked on Resident #103 shortly after 10:00 pm and found him pale and unresponsive. Nurse Aide #3 further revealed that Resident #103 had food in his mouth and a hamburger in his hand that was partially eaten, and he was sitting up in bed. Nurse Aide #3 stated she did not see any vomit, just food in Resident #103's mouth when she checked on him. Nurse Aide #3 stated she immediately called for Nurse #1, and the nurse came and assessed him and began CPR. Nurse Aide #3 stated Resident #103 was not breathing when she called for Nurse #1. During a telephone interview on 3/5/2026 at 11:42 am with Nurse #1 she stated on 5/6/2025 Resident #103 was readmitted to the facility from the hospital before her shift began at 3:00 pm and she was assigned to Resident #103 on the 3:00 pm to 11:00 pm shift on 5/6/2025. Nurse #1 stated she cared for Resident #103 frequently before he discharged to the hospital and returned on 5/6/2025. Nurse #1 stated Resident #3 would refuse his meal trays at time, and she would assist him with eating after the refusal and he would eat when assisted. Nurse #1 stated Family Member #1 had brought in food that was not consistent with the resident's mechanical soft diet with nectar thick liquids before the incident on 5/6/2025. Nurse #1 stated she would try to remove the food or drink and would tell Family Member #1 that Resident #103 was at risk of choking if she fed him a regular diet or fluids that were not thickened. She indicated when Resident #103 received his dinner tray on 5/6/2025, which included his mechanically soft diet with nectar thick liquids, he had refused his tray. Nurse #1 stated Family Member #1 arrived at 9:43 pm and she (Nurse #1) told Family Member #1 that Resident #103 had refused his dinner tray. Family Member #1 stated that Resident #103 did	F0689		

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F0689 SS = SQC-J	Continued from page 34 not need a mechanically soft diet and nectar thick liquids and she brought him a burger, chicken nuggets, french fries, and a tea with a straw. Nurse #1 stated she explained to Family Member #1 that Resident #103 was at risk of choking if Resident #103 ate a regular consistency meal and did not follow his ordered mechanically soft diet with nectar thick liquids; but Family Member #1 set the resident up with the food she brought. Nurse #1 stated Family Member #1 left the facility at 9:53 pm and she (Nurse #1) went to the resident's room at 9:59 pm and attempted to remove the food Family Member #1 brought. She explained that Resident #103 was adamant he wanted the food and she thought he would become combative if she took the food away. Nurse #1 stated she did not add thickener to the tea or remove the meal. Nurse #1 reported she left the room after she attempted to remove the food. Nurse #1 stated at 10:00 pm while she was on her way to break she asked Nurse Aide #3 to check on Resident #103 while she (Nurse #1) took a break. Nurse #1 stated Nurse Aide #3 went to check on Resident #103 at 10:14 pm and found him pale, unresponsive, and he had a very faint pulse. Nurse #1 indicated she called a code and moved Resident #103 to a mattress and back board on the floor (because he was on an air mattress), began CPR immediately, and sent Nurse Aide #3 to call for EMS. She stated EMS arrived and took over CPR for Resident #103, and he was pronounced dead at 11:20 pm on 5/6/2025. A follow up interview was conducted by phone with Nurse #1 on 3/17/2025 at 1:46 pm and she stated that DON #2 had instructed her to re-educate Resident #103's family on the danger of the resident choking if the family brought in food that was not consistent with Resident #103's ordered diet and to refer Family Member #1 to the Speech Therapist when she insisted he should have a regular diet. She was unable to specify when this instruction from DON #2 was received. Nurse #1 reported Family Member #1 would insist each time she came in (Nurse #1 did not remember any dates) that Resident #103 should be on a regular diet. She revealed she was not given any other interventions to implement for when Family Member #1 brought in foods that were not consistent with Resident #103's diet. Nurse #1 stated she did try to take the hamburger, chicken nuggets, french fries and tea (which had a straw) from Resident #103 on the evening of 5/6/2025 but he refused and she was afraid he would become combative if she attempted to take the food because he was holding onto the food and would not allow her to take it. An EMS Report dated 5/6/2025 indicated a call was	F0689		

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F0689 SS = SQC-J	Continued from page 35 received at 10:19 pm in response to a cardiac arrest and they arrived on scene at Resident #103 at 10:26 pm. Resident #103 was on a mattress on the floor with a back board under him, receiving CPR by Fire Department personnel. It was reported that the resident was last seen between 10-15 minutes prior to the call to 911. It was also reported that Resident #103 was eating when he was last seen. Fire Department personnel found food near the resident. The report indicated that EMS believed the resident went into cardiac arrest after possibly choking on food. The resident was pale, not breathing, pulseless, and still warm to touch. Fire Department personnel were suctioning the resident's airway of vomit. EMS began treating the resident with CPR and the resident continued to vomit. EMS opted to secure the airway with Endotracheal Tube (placing a flexible tubing into the windpipe to ensure a clear, protected, and controlled passage for oxygen to reach the lungs) though it was difficult and took multiple attempts for success and constant suctioning was needed to remove large amounts of vomit from the resident's airway. After 45 minutes or more into the arrest, EMS consulted the physician and resuscitation efforts were discontinued. The resident's time of death was 11:20 pm. Multiple attempts were made to contact EMS for interview, but they were unable to be reached. A review of Resident #103's death certificate dated 5/6/2026 revealed his immediate cause of death was heart attack and his secondary causes of death were chronic anemia and dementia. During a phone interview with Family Member #1 on 3/18/2026 at 10:28 am she stated that on 5/6/2025 in the evening she went to see Resident #103 after he was readmitted from the hospital. She indicated she brought takeout food for the resident (a burger, french fries, and tea). She stated when she left the facility that evening the resident had 2 more bites of his cheeseburger left and she told Nurse #1 he was finishing his meal. Family Member #1 indicated Nurse #1 stated she would check on Resident #103. She stated that on that evening, she was not informed by staff that Resident #103 could not have a regular diet. She reported she spoke with EMS after Resident #103 passed away and they indicated the resident had vomited and they suctioned a "small amount" of hamburger from his esophagus (tube through which food passes from the throat to the stomach) and that he had vomited before they (EMS) arrived. Family Member #1 stated she had 2 care plan meetings during Resident #103's stay at the	F0689		

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F0689 SS = SQC-J	Continued from page 36 facility, the first one was on admission and the second was just before Easter 2025 (4/20/2025) and they discussed her (Family Member #1's) issues with the resident's care but no one had talked to her about his diet or the risk of choking with her related to foods she brought in for the resident. She indicated that Resident #103 had been on a regular diet in the hospital during his admission from 4/29/2025 through 5/6/2025, so she had assumed he was still on a regular diet and no one told her he was on a mechanical soft diet with thickened liquids. She stated she had a conversation with the DON #2 the day after Resident #103 died (5/7/2025) and the DON told her the resident should not have had a regular diet because the Speech Therapist had evaluated him and put him on a mechanical soft diet with thickened liquids. A phone interview was conducted with Family Member #2 on 3/18/2026 at 10:06 AM. She stated that the family just did not understand why Resident #103 could eat a regular diet in the hospital and then when he returned to the facility he would be placed back on a mechanical soft diet with thickened liquids. Family Member #2 stated the facility did not have any meetings with her where they discussed the dangers of feeding Resident #103 a regular diet. She revealed that she had brought Resident #103 food several times which included cheeseburgers, french fries, chicken sandwiches, and tea. Nurse Practitioner #1 was interviewed on 3/5/2026 at 10:45 am and she stated she did not recall having a conversation with Resident #103's family regarding his diet or that he should eat a mechanical soft diet with nectar thickened liquids. Nurse Practitioner #1 stated Resident #103 should not have been left alone, and staff should have supervised him when he was given food that was not consistent with his ordered diet as it put the resident at risk of choking. The Physician was interviewed on 3/5/2026 at 12:20 pm and stated he was not made aware Resident #103 received foods that were inconsistent with his dietary orders and had not spoken with Family Member #1 regarding Resident #103's diet. The Physician stated he should have been made aware of Family Member #1 bringing in foods that could have caused Resident #103 to choke. The Physician stated the facility should have provided supervision for Resident #103 when he was given a regular diet by Family Member #1 because he was at high risk for choking. The Physician stated Resident #103 would not have understood that the hamburger, french fries, chicken nuggets, and tea he was given by Family Member #1 would have put him at risk of choking.	F0689		

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F0689 SS = SQC-J	Continued from page 37 On 3/4/2026 at 11:35 am DON #2, who no longer worked at the facility, was interviewed by telephone and stated she remembered Resident #103 was on an altered diet and Family Member #1 constantly brought in foods that were not consistent with his diet. DON #2 stated she spoke with Family Member #1 multiple times and educated her on the risk of choking if the resident ate foods that were not on his diet, but the family member continued to bring in foods Resident #103 should not have. She stated Family Member #1 was not receptive to the diet and insisted he could eat a regular diet. DON #2 stated the Physician was not involved with speaking with Family Member #1 regarding the risks of choking if he ate a regular diet, but Nurse Practitioner #2 was involved with speaking with the family. DON #2 stated Family Member #1 visited Resident #103 about once every two weeks and she brought him food each time. DON #2 stated she had not witnessed Resident #103 choking or coughing when he was eating and he was not resistant to his ordered diet consistency. DON #2 indicated Resident #103 usually ate in the dining room for all meals, but would eat in his room when Family Member #1 brought him food which usually was during the evening meal. DON #2 stated Resident #103 was able to eat his ordered diet without assistance but should not have been left unsupervised when staff were aware Family Member #1 gave food that was not consistent with his diet as he was at risk of choking. During a follow-up interview by phone with DON #2 on 3/13/2026 at 3:10 pm she stated when Family Member #1 first brought foods that were not consistent with Resident #103's diet she educated the nursing staff to educate the family. DON #2 was unable to recall the date of the staff education, but indicated Family Member #1 had been bringing in food for the resident since the resident's admission (11/22/2024). She was not able to provide any evidence of this education. DON #2 stated they had care plan meetings with Family Member #1 regarding the risk of choking when she gave Resident #103 foods that were not on his diet. She did not recall the dates of these meetings and could not provide documentation of the care plan meetings. DON #2 stated they did not remove the food Family Member #1 brought if Resident #103 stated he wanted it because she felt that would be misappropriation and Resident #103 would become aggressive if it was removed. DON #2 stated Resident #103 had a history of aggressive and combative behaviors at times. DON #2 stated she did not know what the facility had failed to do since they had educated Family Member #1 when she brought in the food Resident #103 should not have had. She stated the facility did not obtain a waiver for Resident #103 to	F0689		

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F0689 SS = SQC-J	Continued from page 38 eat the foods Family Member #1 brought to him and when asked if the facility notified Adult Protective Services (APS) of Family Member #1 bringing in foods that were not consistent with Resident #103's ordered diet she indicated she did not call them because she thought they would not have returned her call. Nurse Practitioner #2 was interviewed by phone on 3/13/2026 at 3:03 pm and stated she did not remember Resident #103 and did not remember having a conversation with Family Member #1 regarding the resident being brought food that was not consistent with his ordered diet. She stated if she had a conversation with Family Member #1 she would have written a progress note. (Nurse Practitioner #2 was identified by DON #2 as the Nurse Practitioner who had a meeting with Family Member #1 regarding the risk of choking if she fed Resident #103 a regular diet.) Nurse Practitioner #2 stated if Resident #103 was severely cognitively impaired the facility should have met with Family Member #1 and the provider to develop interventions and to make sure the resident was aware of the risk of choking. Nurse Practitioner #2 stated if Resident #103 did not understand the risk of choking that Family Member #1 should have obtained a Health Care Power of Attorney to make decisions for Resident #103. On 3/3/2026 at 4:43 pm a phone interview was conducted with Administrator #2, the Administrator on 5/6/2025, and he stated he did not remember the incident regarding Resident #103 choking. He stated DON #2 would have done a plan of correction and would remember the incident. Administrator #1, the facility's current administrator, was interviewed by phone on 3/17/2025 at 1:39 pm and stated during this current survey she had requested the Health Care Power of Attorney (HC POA) records for Resident #103 from the previous owners of the facility and there was no HC POA on file for Resident #103. Administrator #1 stated she had also requested the care plan meeting notes for Resident #103 and there were no care plan notes that indicated the facility's Interdisciplinary Team met with Family Member #1 to discuss interventions regarding her bringing him food that was not consistent with his diet. The Administrator was notified of immediate jeopardy on 3/5/2026 at 4:15 pm. The facility provided the following corrective action plan:	F0689		

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F0689 SS = SQC-J	Continued from page 39 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 5/6/25, the facility failed to remove food and/or provide supervision when a severely cognitively impaired resident (Resident #103) readmitted to the facility with a history of dementia, stroke, and difficulty swallowing, was on a mechanical soft diet with nectar thickened liquids was provided a hamburger, chicken nuggets, French fries, and a sweet tea by his daughter. Resident #103's nurse made the resident's daughter aware during her visit, Resident #103 refused his dinner and spit out his medications. The daughter asked the nurse, "is it that mashed food, he won't eat that" referring to dinner. At 9:53pm prior to leaving, the family member communicated to the nurse she brought food for the resident and set the food up on his bedside table. The nurse informed the daughter Resident #103 couldn't have that food. When the nurse attempted to remove the food, Resident #103 refused for it to be taken away. After the nurses' failed attempt to remove the food, the nurse exited the room failing to provide supervision while Resident #103 consumed the food. At 9:59pm, the nurse checked on the resident and he did not appear to be choking or having difficulty swallowing the food. The nurse asked the NA to provide frequent checks on Resident #103. At 10:14pm, the NA made the nurse aware Resident #103 was exhibiting a change in his condition. Upon assessment, Resident #103 was found to be pale, unresponsive with a faint pulse. The Nurse assessed and there was no food present in Resident #103's mouth. Resident #103 was a full code and CPR was initiated. Emergency Medical Services (EMS) was called at 10:20pm, arriving at 10:23pm and took over the chest compressions and artificial ventilation efforts (CPR). Resuscitation efforts were unsuccessful, and Resident #103 was pronounced deceased at 11:20pm. The resident's daughter returned to the facility and was present during the code and pronouncement. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with modified diets to include mechanical soft, puree, and thickened liquids have the potential to be affected by the deficient practice.	F0689		

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F0689 SS = SQC-J	Continued from page 40 On 5/7/25 The Director of Nursing and the Assistant Director of Nursing conducted an audit of all current residents with modified diets to include mechanical soft, puree, and thickened liquids. Ten residents were identified to be on a pureed diet, twenty-two residents were identified to be on a mechanical soft diet, and five residents were on thickened liquids. The Director of Nursing and the Assistant Director of Nursing continued their audit of mechanically altered diets and thickened liquids to ensure tray tickets matched diet orders. No discrepancies were noted. On 5/7/25, the Director of Nursing and Assistant Director of Nursing interviewed staff to identify residents on mechanically altered diets and/or thickened liquids to ascertain residents consuming foods and/or liquids inconsistent with physician diet orders. No concerns were identified. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 5/7/25 The Director of Nursing and/or Assistant Director of Nursing began educating all nursing staff on the immediate removal of food/drink inconsistent with physician diet orders and notification to licensed nurses. Licensed nurses will educate residents and/or family on risks versus benefits at that time. On 5/7/25, the Director of Nursing educated the Director of Rehab (DOR) who communicates with their team after clinical meetings. During daily clinical meetings, new admits and/or physician orders of therapeutic diets are communicated and Social Worker, along with the IDT, is responsible for scheduling care plan meetings to review informed care decisions. During daily clinical meetings and review of progress notes, change of conditions and Situation Background Assessment Recommendation (SBAR), care plan meetings will be scheduled through the Social Worker with residents and/or family as needed to obtain informed care decision consents, as well as a referral to speech therapy. An interfacility communication form will be completed and provided to the Director or Rehab (DOR) for speech referrals and the Certified Dietary Manager for physician diet order changes. Speech therapy inputs physician orders regarding recommendations which are reviewed daily during clinical meetings. If residents and/or family refuse to have food removed, facility will provide continuous supervision and immediately notify the physician, Director of Nursing, and Administrator. As of 5/8/25, any nursing staff not present will be educated prior to working their shift. All new hires will receive	F0689		

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F0689 SS = SQC-J	Continued from page 41 education from the Director of Nursing and/or Assistant Director of Nursing during orientation. On 5/7/25, a letter was provided by mail to responsible parties of cognitively impaired residents and in person to Residents who are cognitively intact on mechanically altered diets/thickened liquids regarding risks and consequences of consuming foods inconsistent when a resident has a modified diet order, and if the family member is unsure, they should check with the nurse. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. On 5/8/26, the Director of Nursing and/or Assistant Director of Nursing will monitor non-compliant residents and/or families through observations of food consumption and care plan meetings with education on the risks versus benefits via informed care decisions and referrals to speech therapy three times a week to ensure they're compliant with prescribed diet and education. The Director of Nursing and/or Assistant Director of Nursing will interview two random nursing staff weekly, to include interviewing staff from all 3 shifts, to ensure they have not observed and failed to report immediately residents consuming food/liquids inconsistent with their prescribed diet, or that they failed to immediately report family members bringing in food for a resident which was inconsistent the resident's prescribed diet for 12 weeks. On 5/8/25, the Director of Nursing, Assistant Director of Nursing, and Social Worker will follow-up with Residents and/or responsible parties on further education to ensure understanding of risk versus benefits, scheduling of care plan meetings for Residents and/or responsible parties, and/or appropriate referrals to speech therapists and/or physicians for evaluation and possible diet upgrade. An ADHOC Quality Assurance Performance Improvement Committee consisting of the interdisciplinary team Medical Director, the Administrator, the Director of Nursing, unit manager, Minimum Data Set Nurse, Activity Director, and Dietary Manager and Medical Director was held on 5/7/25 to discuss the identified deficient practice of Resident #103 receiving food items, and liquids, not consistent with his prescribed diet. No residents were identified needing informed care decision consents and referral to speech therapy. Audit results of non-compliant residents and/or families consuming diets inconsistent with their	F0689		

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F0689 SS = SQC-J	Continued from page 42 physician diet orders, care plan meetings, and speech referrals will be reviewed in Quality Assurance Committee consisting of the Medical Director, the Administrator, the Director of Nursing, unit manager, Minimum Data Set Nurse, Activity Director, and Dietary Manager meetings for three months, and negative trends will be addressed with additional education or family/visitor education as indicated. Audit results and corrective actions will be documented and maintained. The Quality Assurance Committee reserves the right to modify/resolve the plans as they deem necessary. Immediate jeopardy removal date 5/9/25. The corrective action plan was validated on 03/10/2026. Education for nursing staff related to resident safety and feeding practices was reviewed. Interviews were conducted with nursing assistants regarding residents with altered diets and outside food items. Staff reported residents' diet orders and care plans are reviewed in the electronic health record (EHR) prior to meal service to ensure the food provided matches the ordered diet texture. Staff also reported residents are not permitted to have outside food unless it has been approved by the dietitian and included in the resident's care plan. Observation was conducted in the dining room during lunch service. On 03/10/2026 at 11:37 AM, thirteen residents were observed in the dining room during the lunch meal service. No outside food items were observed in the dining room. A review of resident diet orders in the electronic health record confirmed residents had diet orders in place consistent with the meals served. The immediate jeopardy removal date of 05/09/2025 was validated. 2. Resident #53 was admitted to the facility on 5/29/2023 with diagnoses of dementia and stroke. An annual Minimum Data Set assessment dated 5/10/2025 indicated Resident #53 was moderately cognitively impaired, had no behaviors recorded, required maximum assistance with bed mobility, was frequently incontinent of bladder and always incontinent of bowel, had falls in the assessment period, and did not receive blood thinners.	F0689		

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F0689 SS = SQC-J	Continued from page 43 Resident #53's Activities of Daily Living care plan dated 5/22/2025 stated he required staff assistance with bed mobility as necessary and a care plan for incontinence which indicated he required perineal care after each incontinent episode. Nurse Aide #8 was interviewed by telephone on 3/3/2026 at 3:45 pm and she stated she did care for Resident #53 on 7/30/2025 on the 3:00 pm to 11:00 pm shift. Nurse Aide #8 stated she knew Resident #53 was supposed to be a two-person assist for bed mobility, but she could not find anyone to assist her. Nurse Aide #8 stated she rolled Resident #53 away from her on the bed, which had an air mattress, and she had one hand on Resident #53's hip and when she reached for the wipes to clean him, Resident #53 rolled forward and went off the bed to the floor. Nurse Aide #8 stated the bed was in the highest position. She stated she was suspended immediately and gave her statement to the Director of Nursing #2. Nurse Aide #8 stated she no longer works for the facility. A Nurse's progress note dated 7/30/2025 at 8:14 pm, written by Director of Nursing (DON) #2 stated Resident #53 was being provided with incontinence care by Nurse Aide #8 on 7/30/2025 when she turned him away from her and he rolled out of the bed and fell to the floor. Resident #53 sustained a laceration on his left forehead and was sent to the Emergency Department for evaluation and returned to the facility during the same shift on 7/30/2025 and the wound was closed with adhesive strips in the Emergency Department. An Emergency Department Note dated 7/30/2025 indicated Resident #53 was seen in the Emergency Department after a fall with a 2-centimeter laceration to his left forehead. Resident #53 had a Computed Tomography (CT) scan while in the Emergency Department and no evidence of fracture was found. Resident #53's 2-centimeter laceration to his left forehead was cleaned and steri-strips (a thin adhesive bandage) were applied, and he returned to the facility. During an observation of Resident #53 on 3/1/2026 at 11:35 am he was in bed with the head of the bed elevated and was on an air mattress. Resident #53 did not respond when spoken to. DON #2, who was no longer employed with the facility, was interviewed by phone on 3/3/2026 at 3:39 pm. She stated Resident #53 was sent to the Emergency Department on 7/30/2025 due to a fall from the bed when Nurse Aide #8 was providing incontinence care. DON #2 explained she was working when the fall occurred and she was the nurse that responded to the Resident. DON	F0689		

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F0689 SS = SQC-J	Continued from page 44 #2 stated Resident #53 was sent back to the facility shortly afterward with steri-strips to the laceration he sustained to his left forehead. DON #2 stated Nurse Aide #8 was suspended after the incident while she investigated. DON #2 further stated Nurse Aide #8 was interviewed and stated she was rushing and did not get assistance from another staff member and Resident #53 rolled out of the bed when she turned him away from her. A follow-up interview was conducted with DON #2 on 3/4/2026 at 11:35 am and she stated Nurse Aide #8 should have asked for assistance when turning Resident #53 in bed and should not have turned him away from her since he was on an air mattress. DON #2 stated the facility required two staff members to turn any resident that had an air mattress because the mattress is slick and it is easier to slide a resident off the bed. DON #2 also stated she immediately began an investigation and developed a plan of correction for Resident #53's fall. The Physician was interviewed on 3/6/2026 at 2:36 pm and stated Nurse Aide #8 should have asked for assistance with turning Resident #53 in the bed since the Kardex indicated he was a two person assist for turning in bed. The Physician also stated Resident #53 had an abrasion to his left forehead which required steri-strips to be applied in the Emergency Department and no other injuries were indicated in the hospital report. During an interview by phone with Administrator #2, the previous administrator, on 3/3/2026 at 4:43 pm he stated he did not remember Resident #53 having a fall that sent him to the hospital. The facility provided the following corrective action plan: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to provide supervision to prevent accidents when Resident #53, who was moderately cognitively impaired and required extensive assistance with bed mobility, was turned in the bed by a nurse aide without assistance of other staff and fell from the bed to the floor and resulted in a visit to the emergency department and required closing of the laceration with steri-strips. Resident #53 was admitted to the facility on 5/29/2023	F0689		

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F0689 SS = SQC-J	Continued from page 45 with dementia, stroke, osteoarthritis, and malignant neoplasm of the prostate. Resident #53's most recent cognitive score indicated he was severely cognitively impaired. On 7/30/2025 Nurse Aide #8 was performing incontinence care for Resident #53. The bed was raised and there were no rails present. Nurse Aide #8 turned Resident #53 when he rolled away from her falling out of the bed. Resident #53 was assessed by two nurses and sustained an abrasion over his left eye. The Physician was notified and Resident #53 was sent to the emergency department by emergency transport for evaluation. Resident #53 received steri-strips to the abrasion over his left eye and returned to the facility. Nurse Aide #8 was suspended on 7/30/2025 by the Director of Nursing pending an investigation into the accident and after the investigation was completed Nurse Aide #8 elected to terminate her employment. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Director of Nursing and designee performed a 100% audit on resident mobility status on 8/1/2025 to identify if one-or-two-person assistance were needed. The Director of Nursing and designee also performed a 100% audit of the Kardex to ensure accurate mobility status was listed for each resident. No areas of concern were identified. Address what measures will be put into place or systemic changes made to ensure the deficient practice will not recur: The Director of Nursing and designee started education on 7/30/25 with all nursing staff to address resident safety and mobility status during incontinent care. This education included knowing the resident's mobility status prior to care, having a second person present to assist with care if a need was indicated, and providing for safety while the resident is being provided with care. Education was also started on 7/31/25 assured all certified nursing staff were competent in locating the resident Kardex and verifying the mobility status. The Director of Nursing and designee observed with return demonstration incontinence care, turning and repositioning in bed, and bed mobility with all certified nursing assistants to ensure that they were competent. These observations were completed by 8/1/25. Nursing staff not currently working in the facility were educated via phone by the Director of Nursing	F0689		

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F0689 SS = SQC-J	Continued from page 46 and/or designee by 8/1/25 and will not be allowed to work until they have received this education. This education will be provided to new hires during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: An ADHOC QAPI meeting was held on 8/1/25 with the Interdisciplinary Team and the QAPI committee determined to put a plan of correction in place and monitor. The Director of Nursing and/or designee will observe care being provided to 5 residents weekly for 4 weeks and monthly for 4 months to ensure residents' safety during care when a resident is in bed. The Medical Director was notified by the Director of Nursing on 7/31/25 regarding the incident, interventions put into place, and the plan of correction to prevent further incidents or accidents. The Interdisciplinary team will review and provide recommendations on the audit results provided by the Director of Nursing and/or designee during the QAPI meeting for the next 3 months to ensure sustained compliance. If noncompliance is identified during these three months, immediate correction, re-education of staff and an ADHOC QAPI meeting will be held to address the noncompliance and make recommendations for adjustments to the plan. The Administrator and Director of Nursing will ensure the corrective action plan is implemented. Date of Compliance is 8/2/25. The corrective action plan was validated on 03/10/2026. The facility provided an initial audit completed by the Director of Nursing on 8/1/2025 of all residents' mobility status to identify if one-or-two-person assistance was needed and an audit of all residents' Kardex to ensure accurate mobility status and number of staff that should assist were listed. Documentation was provided of in-service education with the staff by the Director of Nursing by 8/1/2025 regarding reviewing the Kardex and ensuring the number of staff needed to care for a resident was completed on 8/1/2025. The nursing staff were interviewed during the survey and were able to verbalize understanding of the in-service education. The nursing staff were observed providing incontinence care for residents that required two-person assistance during the survey with no issues observed. The facility provided documentation of the in-service education for resident mobility and Kardex review added to the facility's orientation of newly hired staff. The facility's audits for Kardex review and observation of	F0689		

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F0689 SS = SQC-J	Continued from page 47 staff providing care were reviewed. The facility provided minutes of Quality Assurance Performance Improvement meetings which included review of the plan of correction being completed on 8/1/2025 and monthly for 3 months. The corrective action plan compliance date of 8/2/25 was validated.	F0689		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to store a plastic syringe used for enteral water flushes (water flushes are essential to maintain gastrostomy/feeding tube patency, prevent clogging and support hydration), dry and with the plunger separated from the syringe and free from moisture for 1 of 2 residents reviewed for enteral feeding management (Resident #27). This practice had the potential for bacterial growth and contamination. Findings included: Resident #27 was admitted to the facility on 12/06/25 with diagnoses of muscle weakness, malnutrition, adult	F0693	On March 3, 2026, The Director of Nursing discarded Resident #27's outdated syringe and provided a new syringe. Nurse #4 was educated by the Director of Nursing on March 3, 2026, regarding tube feeding management. On March 3, 2026, the Director of Nursing audited the syringes of the two tube fed residents to ensure the syringe was stored dry with the plunger separated, free from moisture, and changed within 24 hours. The night nurse will be responsible for changing the syringes daily labeling with residents' name and date. On March 19, 2026, the Director of Nursing/Unit Manager began educating all current Licensed nursing staff on storing syringes dry, with the plunger separated, free from moisture, and changed daily with residents' name and date. The Director of Nursing/Unit Manager will ensure all current Licensed nursing staff who have not received this education by April 2, 2026, will not be allowed to work until education is completed. The Director of Nursing/Unit Manager will ensure newly hired licensed nursing staff will receive education during facility orientation in person or via telephone during prior to working. The Director of Nursing/Unit Manager will monitor using a Quality Assurance tool for tube feeding management to include ensuring the syringe is stored dry with the plunger separated from the syringe and free from moisture. The monitoring will include Residents with tube feeding management requiring syringes. The QA monitoring will be conducted three times a week x 4 weeks, twice a week x 4 weeks, and then weekly x 4 weeks. The Director of Nursing/Unit Manager will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	04/02/2026

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F0693 SS = D	Continued from page 48 failure to thrive, gastrostomy status (indicates the presence of a gastrostomy tube/feeding tube, which is surgically placed to provide direct access to the stomach for nutrition and hydration when oral intake is insufficient or unsafe), and dysphagia. Review of admission Minimum Data Set (MDS) dated 12/16/25 revealed Resident #12 was cognitively intact and was coded for tube feeding. The MDS confirmed Resident #12’s average fluid intake per day by IV fluids or tube feeding was 501 cc/day or more per day. Review of Resident #27’s order dated 01/07/26 revealed the resident was ordered to receive water flush of 60 milliliters (ml) four times a day. During observation and interview with Resident #27 on 03/02/26 at 10:10 AM the syringe used for enteral water flushes was observed with the plunger in the syringe which was wet with clear condensation. The syringe was stored in a plastic bag on the bedside table dated 02/26/26. Resident #27 stated that around 9:00 AM that day Nurse #4 gave his ordered water flush and put the syringe back together and laid it on his bedside table. Resident #27 indicated nursing staff rarely left syringe apart to allow it to air dry. Review of Resident #12’s Medication Administration Record (MAR) dated 03/02/26 revealed Nurse #4 had signed off Resident #12’s morning flush at 9:00 AM. An interview with Nurse #4 on 03/02/26 at 10:15 AM revealed she was not aware the syringe required to be dried before placing the syringe back in the storage bag. Nurse #4 indicated she was aware the plastic syringe and plunger should be washed if residue was left in the syringe but was not aware the plunger should be separated to air dry to prevent any bacterial growth in the syringe. Nurse #4 confirmed she had given Resident #27’s his water flush through his feeding tube earlier this shift on 03/02/26. An interview and observation on 03/03/26 at 9:40 AM revealed the Director of Nursing (DON) in Resident #27’s room. The DON observed Resident #27’s syringe at bedside which was wet with the plunger inside the syringe. The DON revealed the plastic syringe, and plunger should be washed and the plunger should be left out of the syringe to allow it to air dry to prevent any bacterial growth. The DON discarded the syringe and further revealed nurses had been educated on this protocol and all new hires had been educated during orientation. The DON revealed the facility’s policy was that plastic syringes were to be discarded every 24	F0693		

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F0693 SS = D	Continued from page 49 hours and for the plunger to be taken out of the plastic syringe after use to air dry. An interview with the Administrator on 03/04/26 at 9:30 AM stated Nurse #4 should have washed the plastic syringe and allowed them to dry completely to prevent any bacterial growth.	F0693		
F0694 SS = D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and staff and Medical Director interviews, the facility did not administer intravenous (IV) fluids (give fluids through a vein) according to physician orders for 1 of 2 residents reviewed for intravenous therapy (Resident #6). The findings included: Resident #6 was admitted to the facility on 8/8/18 with a diagnosis of chronic pain. The annual Minimum Data Set (MDS) assessment dated 2/11/26 indicated Resident #6 was cognitively intact. Resident #6 had a verbal order from the Medical Director that was received and transcribed by Unit Manager #2 on 2/27/26 at 8:52 AM and stated 0.9% sodium chloride intravenous solution was to be administered at 80 milliliters/hour (mL/hr.) for a total of 2 liters for dehydration. Review of Resident #6's medication administration record (MAR) for February 2026 included an order dated 2/27/26 for the administration of sodium chloride intravenous fluids to be infused at 80 mL/hr. for a total of 2 liters. The MAR included a confirmation space for each 8 hour shift (day, evening and night shift). A checkmark indicated administered, "2" indicated refused, and "9" indicated other/see nurses' notes. Review of the MAR for 2/27/26 revealed the evening and night shifts and were coded as	F0694	On 3/2/2026 the Medical Director confirmed no concerns related to adverse reaction to Resident #6 as a result of receiving D5W. On March 2, 2026, the Director of Nursing completed a medication error form. The Director of Nursing educated Nurse #2 on March 2, 2026, on IV fluids to include ensuring the correct fluids are given according to physician orders. On March 4, 2026, the Director of Nursing audited for any other residents receiving IV fluids. No other residents were identified. On March 19, 2026, the Director of Nursing/Unit Manager began educating all current Licensed nursing staff on ensuring IV fluids are provided according to physician orders. The Director of Nursing/Unit Manager will review physician orders daily identifying residents requiring IV fluids. The Director of Nursing/Unit Manager will observe IV fluids hung to ensure they are provided according to physician orders. The Director of Nursing/Unit Manager will ensure all current Licensed nursing staff who have not received this education by March 31, 2026, will not be allowed to work until education is completed. The Director of Nursing/Unit Manager will ensure newly hired Licensed staff will receive education during facility orientation in person or via telephone during prior to working. The Director of Nursing/Unit Manager will monitor using a Quality Assurance tool for IV fluids to include ensuring the physicians orders are followed. The monitoring will include Residents with IV Fluids. The QA monitoring will be conducted three times a week x 4 weeks, twice a week x 4 weeks, and then weekly x 4 weeks. The Director of Nursing/Designee will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	03/31/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0694 SS = D	Continued from page 50 administered. Review of the MAR for 2/28/26 revealed the day and evening shifts and were coded as administered. The 2/28/26 night shift was coded as other/see nurses notes. The MAR note created on 2/28/26 at 11:21 PM by Nurse #3 stated Resident #6 refused IV fluids for the night shift. Review of Resident #6's MAR for March 2026 included an order dated 2/27/26 for the administration of sodium chloride intravenous fluids to be infused at 80 mL/hr. for a total of 2 liters. The 3/1/26 MAR had Nurse #2's initials and a checkmark symbol for day and evening shifts indicating the IV fluids were administered. The 3/1/26 MAR had an entry by Nurse #3 at 7:44 AM that "IV fluid D5NS infusing due to no sodium chloride 0.9% available." The 3/1/26 MAR entry for night shift was coded by Nurse #3 on 3/1/26 at 8:07 AM with a "9" and it stated "IV D5 0.9 NS infusing at 80mL/hr." On 03/01/2026 at 3:42 PM, an observational interview of Resident #6 seated in her manual wheelchair revealed she had a saline lock (a small, flexible tube placed in the hand or arm vein that acted like a port for medicine and fluids) in her forearm. A one-liter bag of 5% dextrose (sugar) and 0.9% sodium chloride was infusing. The bag of IV solution of 5% dextrose and 0.9% sodium chloride (D5NS) was connected by thin transparent tubing to the saline lock in Resident #6's forearm. The bag was labeled "3/1" and had no initials. Resident #6 had received approximately one half of the one-liter bag of IV fluids. Resident #6 reported that she was getting IV fluids because she was "dehydrated and needed some more fluids." Resident #6 stated she didn't like to drink so the fluids were helping her. Resident #6 was unable to identify the type of fluids infusing and reported that she had been receiving IV fluids all day. During an interview on 3/2/26 at 10:44 AM, Nurse #2 stated she received report during the 3/1/26 morning shift at approximately 7:00 AM that Resident #6's IV fluids had completed infusing during the night and that a new bag had been hung just before shift change. Nurse #2 stated she did not complete the visual inspection of the IV fluid bag or tubing during her initial medication pass on 3/1/26 or at any time during the 3/1/26 day shift and therefore could not confirm which fluids had been given. She acknowledged she was required to visually confirm the fluid type, amount of fluid infused, and that the IV fluid's flow rate matched the provider's order but did not do it because she became distracted when passing medications for the units not go to check it afterward. She stated that the 0.9% sodium chloride fluid was usually available	F0694	Continued from page 50 Completion Date: 03/31/2026	

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F0694 SS = D	Continued from page 51 through the automated medication dispensing system. Nurse #2 stated she was aware that as a medication nurse, she was required to follow provider orders as written. She said she would begin the notification process with the provider regarding the IV fluid error. Attempts to conduct a telephone interview with Nurse #3 on 3/2/26 and on 3/3/26 to interview her regarding her two MAR entries on 3/1/26 that stated D5NS was infusing were unsuccessful. During an interview on 03/02/2026 at 2:15 PM, the Medical Director reported he was not yet informed that D5NS had been hanging for Resident #6 instead of the ordered sodium chloride IV solution. Medical Director stated he had no concerns about adverse outcomes from Resident #6 being administered the D5NS fluid. The Medical Director reported he was aware there had been a prior shortage of the IV fluid 0.9% sodium chloride and could not speculate as to why they did not administer the 0.9% sodium chloride fluids. The Medical Director stated he expected staff to notify the provider of any issues with medication administration. Medical Director stated he expected staff to notify the on call provider when he or another facility provider was not on site. He added that IV fluids were given for dehydration and, because Resident #6 was not diabetic, he believed the liter of D5NS was not harmful. In an interview on 3/2/26 at 2:55 PM, the Director of Nursing (DON) stated she was not aware that Nurse #2 and Nurse #3 had administered the wrong IV fluids to Resident #6. She reported that staff were expected to administer IV fluids according to the provider's orders. The DON stated that Nurse #2 acknowledged she did not check the fluids and later realized she had infused the wrong solution. The DON said that Nurse #2 should have notified the provider that the 0.9% sodium chloride solution was not available for Resident #6 and monitored the resident for any adverse. The DON explained that staff used an automated medication distribution system that dispenses the ordered fluids for each resident and that staff were required to use pharmacy supplied fluids. The DON stated the pharmacy sent IV fluids with labels for the individual resident that included resident identifiers, name of what was in the bag of fluids, flow rate, and expirations date. She added that some stock fluids were also available in the automated medication dispensing system if needed. During a follow up interview on 3/4/26 at 12:30 PM, the DON indicated she was not aware the nursing staff documented D5NS was used because the 0.9% sodium chloride solution was not available for Resident #6.	F0694		

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F0694 SS = D	Continued from page 52 She stated staff should have notified the pharmacy, which would have provided clarification on why the sodium chloride was unavailable.	F0694		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and Nurse Practitioner (NP), resident, and staff interviews, the facility failed to obtain a physician's order for the use of continuous oxygen for 1 of 6 residents reviewed for respiratory care (Resident #16). The findings included: Resident #16 was admitted to the facility on 6/15/24 with diagnoses that included chronic obstructive pulmonary disease (COPD) and chronic respiratory failure. A physician's progress note dated 10/24/25 read that Resident #16 had chronic respiratory failure on 3 liters of oxygen via nasal cannula. A quarterly Minimum Data Set assessment dated 12/18/25 indicated Resident #16 was cognitively intact and was coded with the use of oxygen. Resident #16's active care plan, last reviewed 12/31/25 included a focus area for COPD, at risk for respiratory distress. The interventions included oxygen via nasal cannula as ordered. An NP progress note dated 1/17/26 read that Resident #16 utilized 3 liters of oxygen continuously.	F0695	On March 3, 2026, the Director of Nursing updated Resident #16 physician orders to include oxygen 3 liters continuously via nasal canula. On March 30, 2026, the Director of Nursing audited all current residents to ensure they were not receiving oxygen therapy without physician orders. On March 30, 2026, the Director of Nursing/Unit Manager observed during rounds and order listings Residents requiring oxygen therapy to ensure physician orders are in place. Thirteen Residents were identified as receiving oxygen therapy and physician orders were in place. No other affected residents at this time. On March 19, 2026, the Director of Nursing/Designee began educating all current Licensed nursing staff and Certified Medication Aides to ensure Residents receiving oxygen therapy have physician orders in place. The Director of Nursing/Unit Manager will ensure all current Licensed nursing staff and Certified Medication Aides who have not received this education by March 31, 2026, will not be allowed to work until education is completed. The Director of Nursing/Unit Manager will ensure newly hired licensed staff and Certified Medication aides will receive education during facility orientation in person or via telephone prior to working. The Director of Nursing/Unit Manager will monitor using a Quality Assurance tool for respiratory care. The monitoring will include observing Residents requiring oxygen therapy on various halls to ensure physician orders are in place. The QA monitoring will be conducted three time a week x 4 weeks, twice a week x 4 weeks, and weekly x 4 weeks. The Director of Nursing/Designee will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision. Completion Date: 03/31/2026	03/31/2026

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F0695 SS = D	Continued from page 53 A review of Resident #16’s nursing progress notes from 9/11/25 to 2/28/26 revealed he was using oxygen continuously. A review of Resident #16’s December 2025, January 2026, February 2026 and March 2026 Physician orders did not include an order for oxygen. In an observation, conducted in conjunction with an interview, on 3/1/26 at 11:30 AM, Resident #16 was lying in bed watching television. The meter on the oxygen concentrator showed oxygen was flowing at 2 liters via nasal cannula to the resident. Resident #16 stated he used oxygen continuously. Resident #16 did not present with any shortness of breath or distress during the interview and observation and was able to carry on a conversation. Resident #16 was observed lying in bed watching television on 3/2/26 at 12:32 PM. The meter on the oxygen concentrator showed oxygen was flowing at 2 liters via nasal cannula to the resident. Resident #16 was not short of breath during the observation. On 3/3/26 at 9:16 AM, Resident #16 was observed with the meter on the oxygen concentrator showing the oxygen was flowing at 2 liters via nasal cannula to the resident. Resident #16 was not short of breath during the observation. On 3/3/26 at 12:00 PM, an interview occurred with Medication Aide (MA) #1 who had been assigned to care for Resident #16 frequently. She confirmed Resident #16 utilized oxygen continuously and stated that she recalled he had used 2 liters of oxygen in the past and thought that’s what he still used. The MA verified there was no order in the resident’s medical record for the continuous use of oxygen but could not explain why one wasn’t present. In an interview on 3/3/26 at 2:48 PM, the Assistant Director of Nursing (ADON) stated Resident #16 required continuous oxygen for his COPD. The ADON verified there was no order for the continuous use of oxygen in the resident’s medical record and stated there should have been an order written for it. She felt it had been dropped off the order list at some time but was unable	F0695		

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F0695 SS = D	Continued from page 54 to definitively say when. The ADON stated she would contact the provider and ensure Resident #16 had an order for the prescribed amount of oxygen. A phone interview occurred with NP #2 on 3/3/26 at 4:50 PM. The NP explained that when she last assessed Resident #16 on 1/17/26, she had made no changes to his plan of care, which included the use of oxygen at 3 liters continuously. She stated she would expect the facility to have an order for Resident #16's use of oxygen at 3 liters via nasal cannula continuously.	F0695		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a	F0732	The facility failed to post the daily Nurse Staffing sheet on March 1, 2026, in addition to accurate information on subsequent postings, compare d to the daily staffing. All residents who reside in the facility have the potential to be affected by the alleged deficient practice. On March 6, 2026, the Administrator educated the Director of Nursing, Unit Manager, Scheduler and Supervisor on the requirements of daily nurse staffing sheet posting with accurate information as compared to daily staffing scheduled for licensed and unlicensed nursing staff. The Director of Nursing/Unit Manager will ensure newly hired Unit Mangers, Schedulers or Nursing Supervisory staff assisting with daily nurse staff posting will receive education during facility orientation in person or via telephone prior to working. The Director of Nursing/Unit Manager/Supervisor will monitor using a Quality Assurance tool for staff posting to include daily nurse staffing sheets posted daily with accurate information. The monitoring will include reviewing staff posting as compared to the daily staffing on various shifts, days and weekends for accuracy. The QA monitoring will be conducted three times a week x 4 weeks, twice a week x 4 weeks, and then weekly x 4 weeks. The Director of Nursing/Designee will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision. Date of Completion: 03/31/2026	03/31/2026

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F0732 SS = C	Continued from page 55	F0732		

daily basis at the beginning of each shift.

(ii) Data must be posted as follows:

(A) Clear and readable format.

(B) In a prominent place readily accessible to residents, staff, and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is NOT MET as evidenced by:

Based on record review, observations, and staff interviews, the facility failed to post the daily nurse staffing sheet daily for 1 out of 5 days observed (3/1/26). The facility also failed to post accurate daily staffing information as compared to the daily staffing schedules for licensed and unlicensed nursing staff for 22 out of 28 days reviewed (2/1/26, 2/2/26, 2/3/26, 2/4/26, 2/5/26, 2/6/26, 2/7/26, 2/9/26, 2/10/26, 2/11/26, 2/12/26, 2/13/26, 2/14/26, 2/15/26, 2/18/26, 2/19/26, 2/20/26, 2/24/26, 2/25/26, 2/26/26, 2/27/26, and 2/28/26).

The findings included:

1) The posted daily nursing staffing sheet was observed outside the Director of Nursing's (DON) office door on 3/1/26 at 10:40 AM and was dated 2/17/26.

The DON was interviewed on 3/2/26 at 1:10 PM and stated that she had been at the facility since 2/5/26 and was managing the schedule and daily posted nursing staffing sheets. The DON reported that she had failed to update the daily posted nurse staffing sheets, which was why the sheet dated 2/17/26 remained posted.

2) A review of the facility's daily posting for nursing

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F0732 SS = C	Continued from page 56 staff for the past 28 days (2/1/26 to 2/28/26) as compared to the daily staffing schedule included an inaccurate total of nursing staff worked, which included the following: a. The nursing schedule for 2/1/26 indicated that 5 Nurse Aides (NAs) worked from 7:00 AM to 3:00 PM and 9 NAs worked from 3:00 PM to 11:00 PM. The daily posted nurse staffing sheet for 2/1/26 documented that 6 NAs worked from 7:00 AM to 3:00 PM and 7 NAs worked from 3:00 PM to 11:00 PM. b. The nursing schedule for 2/2/26 indicated that 11 NAs worked 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/2/26 documented that 9 NAs worked 7:00 AM to 3:00 PM. c. The nursing schedule for 2/3/26 indicated that 12 NAs worked 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/3/26 documented that 10 NAs worked from 7:00 AM to 3:00 PM. d. The nursing schedule for 2/4/26 indicated that 10 NAs worked 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/4/26 documented that 9 NAs worked 7:00 AM to 3:00 PM. e. The nursing schedule for 2/5/26 indicated that 12 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/5/26 documented that 10 NAs worked 7:00 AM to 3:00 PM. f. The nursing schedule for 2/6/26 indicated that 9 NAs worked 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/6/26 documented that 8 NAs worked 7:00 AM to 3:00 PM. g. The nursing schedule for 2/7/26 indicated that 8 NAs worked 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/7/26 documented that 6 NAs worked 7:00 AM to 3:00 PM. h. The nursing schedule for 2/9/26 indicated that 10 NAs worked from 7:00 AM to 3:00 PM and 3 Licensed Practical Nurses (LPNs) worked 3:00 PM to 11:00 PM. The daily posted nurse staffing sheet for 2/9/26 documented	F0732		

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F0732 SS = C	Continued from page 57 that 9 NAs worked 7:00 AM to 3:00 PM and 4 LPNs worked 3:00 PM to 11:00 PM. i. The nursing schedule for 2/10/26 indicated that 11 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/10/26 documented that 9 NAs worked 7:00 AM to 3:00 PM. j. The nursing schedule for 2/11/26 indicated that 9 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/11/26 documented that 8 NAs worked 7:00 AM to 3:00 PM. k. The nursing schedule for 2/12/26 indicated that 9 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/12/26 documented that 7 NAs worked 7:00 AM to 3:00 PM. l. The nursing schedule for 2/13/26 indicated that 11 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/13/26 documented that 7 NAs worked 7:00 AM to 3:00 PM. m. The nursing schedule for 2/14/26 indicated that 9 NAs worked from 7:00 AM to 3:00 PM and 8 NAs worked 3:00 PM to 11:00 PM. The daily posted nurse staffing sheet for 2/14/26 documented that 8 NAs worked 7:00 AM to 3:00 PM and 6 NAs worked from 3:00 PM to 11:00 PM. n. The nursing schedule for 2/15/26 indicated that 8 NAs worked from 7:00 AM to 3:00 PM and 9 NAs worked 3:00 PM to 11:00 PM. The daily posted nurse staffing sheet for 2/15/26 documented that 7 NAs worked 7:00 AM to 3:00 PM and 8 NAs worked from 3:00 PM to 11:00 PM. o. The nursing schedule for 2/18/26 indicated that 11 NAs worked from 7:00 AM to 3:00 PM and 2 Registered Nurses (RNs) worked from 3:00 PM to 11:00 PM. The daily posted nurse staffing sheet for 2/18/26 documented that 9 NAs worked from 7:00 AM to 3:00 PM and 1 RN worked from 3:00 PM to 11:00 PM. p. The nursing schedule for 2/19/26 indicated that 10 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/19/26 documented that 9 NAs worked 7:00 AM to 3:00 PM.	F0732		

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F0732 SS = C	Continued from page 58 q. The nursing schedule for 2/20/26 indicated that 4 LPNs and 9 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/20/26 documented that 3 LPNs and 8 NAs worked 7:00 AM to 3:00 PM. r. The nursing schedule for 2/24/26 indicated that 11 NAs worked from 7:00 AM to 3:00 PM, 2 LPNs worked 3:00 PM to 11:00 PM and 7 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 2/24/26 documented that 9 NAs worked 7:00 AM to 3:00 PM, 1 LPN worked 3:00 PM to 11:00 PM and 6 NAs worked 11:00 PM to 7:00 AM. s. The nursing schedule for 2/25/26 indicated that 11 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/25/26 documented that 9 NAs worked 7:00 AM to 3:00 PM. t. The nursing schedule for 2/26/26 indicated that 10 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/26/26 documented that 9 NAs worked 7:00 AM to 3:00 PM. u. The nursing schedule for 2/27/26 indicated that 14 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/27/26 documented that 12 NAs worked 7:00 AM to 3:00 PM. v. The nursing schedule for 2/28/26 indicated that 3 LPNs and 10 NAs worked from 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 2/28/26 documented that 2 LPNs and 9 NAs worked 7:00 AM to 3:00 PM. On 3/4/26 at 9:35 AM, an interview occurred with the Director of Nursing who stated that she was managing the staffing schedule and daily postings. She was able to review the staffing schedules and daily postings and verified the number of staff working from 2/1/26 to 2/28/26 did not match. She stated that she had failed to count the Medication Aides (MAs) and Restorative Nurse Aides in the total number of NAs working, as well as had not updated the daily posted nurse staffing sheet when a staff member came in to cover a need.	F0732		

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F0732 SS = C	Continued from page 59 The Administrator was interviewed on 3/4/26 at 1:28 PM and stated that the daily staff schedule posting and the staffing schedule should match the number of staff worked on any given shift.	F0732		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record review and physician, resident and staff interviews, the facility failed to administer insulin in accordance with the physician's orders for 13 out of 30 days in June 2025 for 1 of 3 residents reviewed for significant medication error (Resident #33). The findings included: Resident #33 was originally admitted to the facility on 6/5/24 with diagnoses that included diabetes type 2. An annual Minimum Data Set (MDS) assessment dated 6/1/25 indicated Resident #33 was cognitively intact and received seven days of insulin injections during the seven-day look back period. Resident #33's care plan, last reviewed on 6/10/25 included a focus area for diabetes. The interventions included providing diabetic medication as ordered by the physician. A review of Resident #33's physician orders included the following: An order dated 5/27/25 for Humalog insulin. Inject 12 units subcutaneously (SQ) three times a day. An order dated 6/3/25 for Humalog Kwikpen. Inject per sliding scale before meals and at bedtime. The sliding scale was as follows: If fasting blood sugar is 0-250= 0 units. Notify physician if less than 70. 251-300= 6 units301-350= 8 units351-400= 10 units401-450= 12 unitsGreater than 450 give 15 units and recheck in 2 hours. Notify physician for continued result greater than 450. An order dated 6/17/25 for	F0760	Resident #33 had no adverse effects of missing insulin administration entries for the month of June 2025. On March 4, 2026, the Medical Director was made aware. On March 30, 2026, the Director of Nursing audited the Medication Administration Records of current residents receiving insulin. Eighteen residents were identified and their Medication Administration Records noted insulin was signed off as administered per physician orders. On March 19, 2026, the Director of Nursing/Unit Manager began educating licensed nursing staff on overseeing Certified Med Aides and signing off on the Medication Administrator Record after insulin is administered. A designated licensed nurse will be assigned to oversee CMA and indicated on assignment sheets. The Director of Nursing/Unit Manager will ensure all current Licensed nursing staff who have not received this education by March 31, 2026, will not be allowed to work until education is completed. The Director of Nursing/Unit Manager will ensure newly hired licensed staff will receive education during facility orientation in person or via telephone prior to working. The Director of Nursing/Unit Manager will monitor using a Quality Assurance tool for significant medication error to include ensuring insulin is signed off as administered on the Medication Administration Record. The monitoring will include reviewing Medication Administration Records to ensure insulin is signed off as ordered. The QA monitoring will be conducted three times a week x 4 weeks, twice a week x 4 weeks, and then weekly x 4 weeks. The Director of Nursing/Unit Manager will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	03/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kannapolis Health and Rehabilitation	**1810 Concord Lake Road , Kannapolis, North Carolina, 28083**

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F0760 SS = D	Continued from page 60 Lantus Solostar insulin. Inject 38 units SQ daily. A review of the June 2025 Medication Administration Record (MAR) revealed the following insulin was not signed off as given or refused by Resident #33: Humalog insulin. Inject 12 units SQ three times a day. Missing documentation for 6/2/25 at 5:00 PM, 6/6/25 at 11:00 AM, 6/8/25 at 5:00 PM, 6/13/25 at 5:00 PM, 6/16/25 at 5:00 PM, 6/17/25 at 5:00 PM, 6/19/25 at 11:00 AM, 6/20/25 at 5:00 PM, 6/25/25 at 11:00 AM, 6/26/25 at 5:00 PM, 6/28/25 at 6:00 AM and 11:00 AM, and 6/29/25 at 11:00 AM and 5:00 PM. Lantus Solostar insulin. Inject 38 units SQ daily at 9:00 AM. Missing documentation for 6/19/25, 6/25/25, 6/28/25 and 6/29/25. Humalog Kwikpen. Inject per sliding scale before meals and at bedtime. Missing documentation for 6/6/25 at 11:00 AM, 6/8/25 at 4:00 PM, 6/13/25 at 4:00 PM, 6/14/25 at 9:00 PM, 6/16/25 at 4:00 PM, 6/19/25 at 11:00 AM, 6/20/25 at 4:00 PM and 9:00 PM, 6/25/25 at 11:00 AM, 6/26/25 at 4:00 PM, 6/28/25 at 6:00 AM and 11:00 AM and 6/29/25 at 11:00 AM. A quarterly MDS assessment dated 1/19/26 indicated Resident #33 was cognitively intact and received six days of insulin injections during the seven-day look back period. Resident #33's active care plan, last reviewed 1/21/26, included a focus area for diabetes. The interventions included providing diabetic medications as ordered by the physician. An interview with Resident #33 was conducted on 3/1/26 at 11:57 AM. She recalled asking nursing staff about receiving her insulin injections in June 2025 but could not remember the specific dates or frequency. She stated that having to ask about her insulin occurred frequently and that she was always told that someone would give her the insulin injection. On 3/3/36 at 10:13 AM, an interview occurred with Medication Aide (MA) #1 who was assigned to care for Resident #33 on 6/6/25 for the 7:00 AM to 3:00 PM shift, 6/13/25 for the 3:00 PM to 11:00 PM shift, 6/19/25 for the 7:00 AM to 3:00 PM shift, 6/20/25 for the 3:00 PM to 11:00 PM shift, 6/25/25 for the 7:00 AM to 3:00 PM shift, 6/28/25 for the 7:00 AM to 3:00 PM shift and 6/29/25 for the 7:00 AM to 3:00 PM shift. She explained that an MA was not allowed to administer insulin and that one of the nurses would have done this for any resident requiring insulin, to include Resident	F0760		

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F0760 SS = D	Continued from page 61 #33. She indicated that she would have to ask a nurse to provide the insulin when it was due to be given. MA #1 indicated that the nurse would be either the floor nurse, the Assistant Director of Nursing (ADON) or the MDS nurse and that there was not a nurse assigned to administer insulin. MA #1 reviewed the June 2025 MAR and verified that the referenced dates were blank and did not indicate if the insulin was provided or refused by Resident #33. She was unable to recall which nurse would have administered the insulin as ordered to Resident #33. A phone interview occurred with MA #12 on 3/5/26 at 2:50 PM. He was assigned to care for Resident #33 on 6/8/25 for the 3:00 PM to 11:00 PM shift. MA #12 stated that as an MA he could not administer insulin injections and would have to ask a nurse to provide the insulin when it was due to be given. He was unable to recall which nurse would have administered Resident #33's insulin on the evening of 6/8/25. A phone interview was conducted with MA #9 on 3/4/26 at 11:54 AM, who explained that as an MA she could not administer insulin injections and would have to ask a nurse to provide the insulin when it was due to be given. She indicated that a nurse would administer Resident #33's insulin. The MAR was reviewed with MA #9 for missing insulin documentation on 6/14/25 at 9:00 PM. She was unable to recall which nurse would have administered Resident #33 with her insulin. On 3/4/26 at 11:58 AM, a phone interview occurred with MA #10, who explained that as an MA she was unable to administer insulin injections and would have to locate a nurse to provide the insulin when it was due to be administered. She indicated that either the floor nurse, unit manager or ADON would have provided insulin injections to Resident #33. MA #10 was assigned to Resident #33 on 6/2/25, 6/16/25, 6/17/25 and 6/29/25 for the 3:00 PM to 11:00 PM shift. She was unable to recall which nurse administered insulin injections to Resident #33 during the referenced dates. The ADON was interviewed on 3/3/26 at 4:18 PM and explained that when an MA was working on the medication cart, a nurse would come and administer insulin as needed for the residents. She indicated it would be whoever was available and there was no designated nurse responsible for insulin injections on any given shift. The ADON reviewed Resident #33's June 2025 MAR and	F0760		

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F0760 SS = D	Continued from page 62 verified the referenced dates were blank and did not indicate if the insulin was provided or refused by Resident #33. She was unable to state who would have administered the insulin injections. An interview was conducted with MDS Nurse #2 on 3/4/26 at 9:58 AM. She stated that she had been the Unit Manager for the area that Resident #33 resided in June 2025. She explained that an MA would not have been able to administer insulin injections and that it would have been either the floor nurse, ADON, unit manager or MDS nurse, but there was not a designated staff member to provide insulin injections. MDS Nurse #2 reviewed Resident #33's June 2025 MAR and verified there were multiple blank areas for Resident #33's insulin injections that did not indicate if the insulin was provided or refused by Resident #33. MDS #2 stated she couldn't recall if she had administered insulin to Resident #33 on the referenced dates in June 2025. A phone interview was completed with Nurse #5 on 3/4/26 at 11:47 AM. She stated that MAs were not allowed to administer insulin and that either she would assist with insulin injections when she worked at the facility, as well as the ADON, unit manager, or any nurse that was available. She was assigned as the floor nurse in the area that Resident #33 resided on 6/19/25, 6/25/25, 6/28/25 and 6/29/25 for the 7:00 AM to 3:00 PM shift. The dates were reviewed with Nurse #5, but she could not recall if she administered insulin to Resident #33 or another nurse. The Physician was interviewed on 3/4/26 at 12:42 PM and stated that he would expect nursing staff to document when insulin was provided as ordered. He reviewed Resident #33's medical record and indicated there was no ill effects if she had not received insulin on the referenced dates and that her accuchecks remained at her baseline. The Director of Nursing was interviewed on 3/4/26 at 1:28 PM. She indicated she had begun employment at the facility early part of February 2026. She stated that MAs were expected to request a nurse to provide the insulin when it was due. She indicated that it would be expected for nursing staff to document when insulin was provided or refused by any resident.	F0760		
F0761 SS = E	Label/Store Drugs and Biologicals	F0761	On March 1, 2026, the Assistant Director of Nursing discarded the expired insulins, and eye drops without	03/31/2026

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F0761 SS = E	Continued from page 63 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews, the facility failed to discard expired multi-use medications on 1 of 2 medication carts reviewed (Medication Cart 1/2/3) and failed to date multi-use medications upon opening, as required by manufacturer recommendations, on both medication carts reviewed (Medication Cart 1/2/3 and Medication Cart 4/5/6). These failures have the potential to result in the administration of expired or improperly labeled medications. Findings included: 1) An inspection was conducted on 03/01/26 at 11:10 AM of Medication cart 4/5/6 in the presence of Med Aide #1. The observation revealed no opened date on the following multi-dose medications: -Two multi-dose bottles of neo-polymyxin B eye drop with no opened date (according to the manufacturer's directions, this medication must be discarded 28 days after opening).	F0761	Continued from page 63 open dates. On March 1, 2026, the Directed of Nursing educated MA #1 and MA #2, labeling and medication storage to include open dates and expiration dates for eye drops. On March 30, 2026, the Director of Nursing audited four medication carts of current residents' insulin and eye drops. Eighteen residents' insulins and twenty-six residents eye drops noted. The Director of Nursing discarded one bottle of expired eye drops from the 100/200 hall cart. On March 19, 2026, the Director of Nursing/Unit Manager began educating licensed nursing staff and Certified Medication Aides on labeling open date, along with expiration date, on eye drops and multi-dose vials according to the manufacturer's guidelines. The Director of Nursing/Unit Manager will ensure all current Licensed nursing staff and Certified Medication Aides who have not received this education by March 31, 2026, will not be allowed to work until education is completed. The Director of Nursing/Unit Manager will ensure newly hired staff will receive education during facility orientation in person or via telephone prior to working. The Director of Nursing/Unit Manager will monitor using a Quality Assurance tool for labeling and drug storage. The monitoring tool will include inspection of medication carts for insulins and eye drops with open and expirations dates according to manufacturer's guidelines. The QA monitoring will be conducted three times a week x 4 weeks, twice a week x 4 weeks, and then weekly x 4 weeks. The Director of Nursing/Unit Manager will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	

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F0761 SS = E	Continued from page 64 -One multi-dose bottle of tobramycin 0.03 % eye drops with no opened date (according to the manufacturer's directions, this medication must be discarded 28 days after opening). -One multi-dose bottle of latanoprost ophthalmic solution 0.005 % eye drops with no opened date (according to the manufacturer's directions, this medication must be discarded 42 days after opening). - Three insulin glargine dial-a-dose pens (according to the manufacturer's directions, this medication must be discarded 28 days after opening). -Two insulin lispro insulin dial-a-dose pens (according to the manufacturer's directions, this medication must be discarded 28 days after opening). -One insulin aspart dial-a-dose pen (according to the manufacturer's directions, this medication must be discarded 28 days after opening). -One insulin degludec dial-a-dose pen (according to the manufacturer's directions, this medication must be discarded 56 days after opening). An interview was conducted on 03/01/26 at 11:20 AM with Medication Aide (MA) #1. She confirmed all multi-use medications should be dated upon opening, and she discarded the undated items discovered during the inspection. MA #1 explained she did not handle the insulin as that would be the nurse's responsibility. She stated if any insulin had to be administered today Nurse #2 would be administering them. She explained she normally checked the dates on the eye drops but she had not checked them on the day of the interview. She went on to say she did not realize the bottles of eye drops were not labeled with an open date. An interview was conducted on 03/01/26 at 11:23 AM with the Assistant Director of Nursing (ADON). She explained medication aides and nurses were to always write the open date and the expiration date on multi dose insulin vials/pens and the opened date on eye drops. She stated she was unaware the staff were not marking the open dates and expiration dates on the medications. The ADON discarded the insulin that was not dated on Medication cart 4/5/6. 2a) An inspection was conducted on 03/01/26 at 11:42 AM of Medication cart 1/2/3 in the presence of Med Aide #2. The observation revealed a multi-dose bottle of timolol eye drops with no open date (according to the	F0761		

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F0761 SS = E	Continued from page 65 manufacturer's directions, this medication must be discarded 28 days after opening). Med Aide #2 confirmed the medication should be dated upon opening and she discarded the bottle of eye drops. 2b) An inspection was conducted on 03/01/26 at 11:42 AM of Medication cart 1/2/3 in the presence of Med Aide #2. The observation revealed the following expired multi-dose medications: -One insulin glargine dial-a-dose pen opened 01/08/26 (according to the manufacturer's directions, this medication must be discarded 28 days after opening). -Two insulin lispro dial-a-dose pen, one with an open date of 01/24/26 and one with an open date of 01/09/26 (according to the manufacturer's directions, this medication must be discarded 28 days after opening). -Two bottles of neo-polymyxin eye drops opened on 01/03/26 and on 01/14/26 (according to the manufacturer's directions, this medication must be discarded 28 days after opening). -Tobram eye drops opened on 01/10/26 (according to the manufacturer's directions, this medication must be discarded 28 days after opening). -Four bottles of latanoprost eye drops opened 01/01/26, 01/02/26, 01/11/26, and the fourth bottle opened on 01/17/26 (according to the manufacturer's directions, this medication must be discarded 42 days after opening). On 03/01/2026 at 11:40 AM an interview was conducted with Medication Aide (MA) #2. She stated she didn't realize the eye drops were expired and/or did not have an open date on them. She went on to explain it was hard to take the time to figure out if the medication was expired because she felt she was always running out of time and that it was an oversight. A follow-up interview was conducted on 03/01/26 at 11:51 AM with the Assistant Director of Nursing (ADON). The ADON explained medication aides and nurses were to always write the open date and the expiration date on multi dose insulin vials/pens and the opened date on eye drops. She stated she was unaware the staff were not doing labeling medications with the open date. The ADON discarded the insulins that were expired on Medication cart 1/2/3. A follow-up interview was conducted on 03/01/26 at 12:10 PM with Medication Aide (MA) #2. One of the	F0761		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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F0761 SS = E	Continued from page 66 Latanoprost eye drops had an open date for 01/02/26 written on the bottom of the bottle and 02/29/26 on the lid of the medication bottle. When asked why there were two dates on the bottle MA #2 stated she did not see the date written on the bottom of the bottle and she had written 02/29/26 on the lid. She further explained she did not recall who came to her this morning (03/01/26) but they told her, “Everything in the medication cart should have a date on it.” The MA explained she went through and wrote 02/29/26 on the medications which did not have a date on them.	F0761		