

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345143	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/13/2026
NAME OF PROVIDER OR SUPPLIER Siler City Center			STREET ADDRESS, CITY, STATE, ZIP CODE 900 W Dolphin Street , Siler City, North Carolina, 27344	
(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 02/22/26 to conduct a recertification and complaint investigation survey and exited on 02/27/26. Additional information was obtained on 03/12/26 and 03/13/26. Therefore, the exit date was changed to 03/13/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1E4877- H1.	E0000		03/27/2026
F0000	INITIAL COMMENTS The survey team entered the facility on 02/22/26 to conduct a recertification and complaint investigation survey and exited on 02/27/26. Additional information was obtained on 03/12/26 and 03/13/26. Therefore, the exit date was changed to 03/13/26. The following intakes were investigated: 2801961, 2718242, 2691298, 2682977, 2682514, 2667931, 2662252, 2662220, 2649358, and 2638531. 2 of the 22 complaint allegations resulted in deficiency.	F0000		03/27/2026
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation, resident, staff, and Medical Director interviews the facility failed to assess a resident's ability to keep steroid nasal spray at bed side for self-administration for 1 of 1 resident reviewed for self-administration of medications (Resident #138). The findings included: Resident #138 was admitted to the facility on 12/7/21.	F0554	F 554 Resident Self-Admin Meds Fluticasone Propionate nasal suspension was removed from the bedside of resident #138 by Nurse #1 on 2/24/2026. An attempt was made to assess resident #138 for self administration of medications. Resident #138 declined assessment and did not wish to self administer medications. Resident #138 was discharged from the facility on 3/26/2026. An audit was completed on current resident rooms in the facility on 3/29/26 by the Nursing Supervisor to ensure no medications are being stored at bedside without a clinical assessment and physician orders. Any medications without corresponding assessments for self administration were removed . Education was initiated on 3/31/26 by Nurse Practice Educator for all licensed nurses to include (Full-time,	04/08/2026

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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F0554 SS = D	<p>Continued from page 1 Physician order dated 4/15/25 revealed an order for fluticasone propionate nasal suspension (steroid nasal spray for allergies) 50 micrograms 2 sprays in both nostrils twice a day for allergies.</p> <p>The quarterly Minimum Data Set (MDS) dated 2/3/26 revealed Resident #138 was cognitively intact.</p> <p>Resident #138's care plan dated 2/17/26 did not include any goals or interventions for self-administering medications.</p> <p>Review of Resident #138's medical record did not show an assessment for self-administration of medication.</p> <p>Resident #138 was interviewed on 2/23/26 at 11:16am. During the interview an observation was made of Resident #138's prescribed bottle of nasal spray sitting on the resident's overbed table. Resident #138 stated the nurse had left it in her room, but she was unable to state which nurse. Resident #138 stated she should not have the nasal spray in her room but that it made it easier for her to use when needed.</p> <p>An observation was made on 2/23/26 at 3:52pm of Resident #138's room. The observation revealed the bottle of nasal spray remained on her overbed table.</p> <p>Another observation was made on 2/24/26 at 10:38am of Resident #138's room. The bottle of nasal spray was observed on her overbed table.</p> <p>Nurse #1 was interviewed on 2/24/26 at 3:01pm and confirmed she was assigned to Resident #138 on 2/24/26. Nurse #1 discussed not being sure what the process was for a resident who self-administered medication because there were no residents on the 400 hall who could self-administer medication. She stated if she saw any medication left in a resident room, she would remove it immediately and clarified she had not seen any medication in any resident rooms today (2/24/26). Nurse #1 also clarified that she provided Resident #138's medication while the resident was in her room 2/24/26. During the interview an observation of Resident #138's room was conducted and Nurse #1 found the bottle of nasal spray on the resident's overbed table behind a box of tissue. The Nurse discussed when she provided Resident #138 her medication in the morning (2/24/26), she did not notice the bottle of nasal spray. Nurse #1 was observed removing the nasal spray from Resident #138's room.</p> <p>An interview occurred with the Medical Director on 2/26/26 at 2:40pm. The Medical Director discussed</p>	F0554	<p>Continued from page 1 Part-time, PRN and Agency) on following the Policy and Procedure for self administering medications. Education included that residents must have a physician order to keep medication at bedside, a self administering of medication evaluation indicating the resident is safe to administer and store medications, and a care plan must be in place indicating the resident is approved to self administer medications along with secured storage. Any licensed nurse (Full-time, Part-time, PRN, and Agency) that cannot be reached within the initial reeducation time frame of 24 hours will not take an assignment until they have received this reeducation by the Director of Nursing/ designee. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation period by the Director of Nursing/designee.</p> <p>Director of Nursing, Assistant Director of Nursing, and Nurse Manager/designee will audit 5 resident rooms three times per week x 4 weeks to monitor for medications in resident rooms; then 5 resident rooms two times weekly x 4 weeks, then 5 resident rooms weekly x 4 weeks. The Director of Nursing will report the findings of the audits to the monthly Quality Assurance and Performance Improvement (QAPI) Meeting to ensure compliance x 3 months. The QAPI committee is responsible for ongoing compliance.</p> <p>Date of compliance: 4/8/26</p>	

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F0554 SS = D	<p>Continued from page 2 Resident #138 being cognitively intact and stated he would not be concerned about the nasal spray being left at the resident's bedside. However, he explained the medication should not be left in a resident's room without an order/assessment and stated the nasal spray would not cause harm if taken more frequently than ordered.</p> <p>During an interview with the Director of Nursing (DON) on 2/24/26 at 3:11pm, the DON explained if a resident wanted to self-administer their medication, the facility would need to do an assessment to ensure the resident was safe to self-administer their medication. She stated once a resident was able to self-administer their medication, a lock box was placed in their room, and the resident would have a plan of care to self-administer their medication. The DON stated she did not believe there were any residents down hall 400 who self-administered their own medication. She explained Resident #138 had the potential to self-administer her own medication due to the resident's cognition. The DON stated if a nurse saw medication at a residents' bedside, she would want the medication removed, a conversation to be held with the resident about self-administering, an assessment to be completed, and an order obtained.</p> <p>The Administrator was interviewed on 2/24/26 at 3:38pm. The Administrator stated he was not sure if there were any residents in the facility who self-administered their own medication. He explained if a resident wanted to self-administer their medication, the nurse would need to complete an evaluation. The Administrator discussed if a nurse saw medication at a residents' bedside, he would want the medication removed and then an evaluation completed to see if the resident was safe to self-administer.</p>	F0554		
F0600 SS = D	<p>Free from Abuse and Neglect</p> <p>CFR(s): 483.12(a)(1)</p> <p>§483.12 Freedom from Abuse, Neglect, and Exploitation</p> <p>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p>	F0600	<p>F600 - Free from Abuse and Neglect</p> <p>On 10/19/25 an allegation of resident to resident abuse was reported between resident #93 and resident #86. Both residents were immediately separated and placed on 1:1 monitoring. Psych evaluations were completed. Room change completed for resident #86. On 12/2/25 an allegation of resident to resident abuse was reported between resident #86 and resident #14. Both residents were immediately separated and placed on 1:1 monitoring. Resident #86 moved to a private room. On 12/24/25 an allegation of resident to resident abuse was reported between resident #86 and resident #54. Both residents were immediately separated and placed on 1:1 monitoring. Resident #86 was sent to the emergency</p>	04/08/2026

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F0600 SS = D	<p>Continued from page 3</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to protect the residents' right to be from physical abuse when Resident #86 hit Resident #14 with a grabber (handheld device used to assist in obtaining items out of reach) on 12/2/25 which resulted in an abrasion to Resident #14's forehead and Resident #86 hit Resident #54 with an open hand across the face while Resident #86 was receiving one-on-one (1:1) supervision on 12/24/25. This for 1 of 4 residents reviewed for abuse (Resident #86).</p> <p>The findings included:</p> <p>Resident #86 was admitted to the facility on 6/5/25 with diagnosis that included dementia, insomnia, psychotic disturbance, mood disturbance, mild cognitive impairment and anxiety.</p> <p>Review of Resident #86 Minimum Data Set (MDS) assessment dated 8/8/25 revealed he was severely cognitively impaired with no upper or lower extremity impairments, only required set up for mobility and had no physical or verbal behaviors directed towards others.</p> <p>Review of Resident #86 Minimum Data Set (MDS) assessment dated 11/7/25 revealed he was severely cognitively impaired, had no upper or lower extremity impairments, only required set up for mobility and had no behaviors directed towards others during the look back period.</p> <p>Review of Resident #86 care plan dated 11/28/25 and revised 12/3/25 and 12/26/25 indicated he exhibited or had the potential to exhibit behaviors related to cognitive loss and dementia. The care plan reflected resident to resident incidents (hitting other residents) on 10/19/25, 12/2/25 and 12/24/25. The goal stated Resident #68 would not harm another resident. The interventions included evaluating nature and circumstances (i.e., triggers) of physical behavior with resident, evaluating need for psychological/behavioral health consultation, observing the resident for non-verbal signs of physical aggression (rigid body position, clinched fist, etc.), remove resident from the environment if needed and</p>	F0600	<p>Continued from page 3</p> <p>room for involuntary commitment. All resident care plans were updated to reflect interventions and possible triggers.</p> <p>An audit was completed on 4/01/26 by social services of current residents displaying behavior towards others and ensuring those behaviors are care planned along with possible triggers for those behaviors. Residents with BIMS of 13 and above were interviewed by social services on 3/31/26 to ensure that they had not witnessed or made aware of resident to resident abuse. Residents with BIMS of 12 and below had skin checks completed on 3/29/26 by licensed nurses to ensure no new skin issues. Care plans were adjusted as needed. No resident reports of abuse from interviews or skin checks were identified.</p> <p>Education was initiated on 3/31/26 by Nurse Practice Educator for current facility staff (Full-time, Part-time, PRN and Agency) on Abuse Prohibition, Enhanced Patient Supervision focusing on reasoning for 1:1 supervision and role of employee during the shift and Behavior Management of Symptoms including identifying triggers. All current staff (Full-time, Part-time, PRN, and Agency) that cannot be reached within the initial reeducation time frame of 24 hours will not take an assignment until they have received this reeducation by the Director of Nursing/ designee. Newly hired facility staff and agency staff will complete this education during their orientation period by the Director of Nursing/designee.</p> <p>The DON/designee will conduct audits of 1:1 supervision compliance 5 times per week for 4 weeks, 3 times weekly for 4 weeks, and then weekly for 4 weeks. Residents exhibiting behaviors toward others care plans will be audited to ensure that current and new behaviors are care plannednn by social services 5 times per week for 4 weeks, 3 times weekly for 4 weeks, and then weekly for 4 weeks. The Director of Nursing and social services will report the findings of the audits to the monthly Quality Assurance and Performance Improvement (QAPI) Meeting to ensure compliance x 3 months. The QAPI committee is responsible for ongoing compliance.</p> <p>5. Date of Compliance: 4/8/26</p>	

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F0600 SS = D	<p>Continued from page 4 diverting resident by giving alternative objects or activities. 1:1 supervision was written on the care plan 12/3/25.</p> <p>Resident #93 was admitted to the facility on 8/23/23 with a diagnosis that included mild dementia, major depressive disorder and agitation.</p> <p>Review of Resident #93's quarterly MDS assessment dated 8/27/25 revealed he was moderately cognitively impaired, had no upper or lower extremity impairments and had no physical behavior directed towards others.</p> <p>Review of the care plan dated 6/20/25 revealed Resident #93 exhibited physical behaviors of grabbing, pushing and being physically aggressive towards others related to dementia with behaviors. The goal stated Resident #93 would not harm others. The interventions included encourage resident to seek staff support for distressed mood, observe for non-verbal signs of physical aggression to include rigid body positioning, clenched fist etc., and remove resident from environment if needed.</p> <p>Care plan dated 6/20/25 and last revised 9/23/25 revealed Resident #93 exhibited verbal behaviors of threatening, cursing, agitation, delusions at times, screaming and accusing others related to dementia with behaviors. The goal stated Resident #93 would not exhibit verbal outbursts directed towards others. The interventions included, evaluate the nature and circumstances (i.e., triggers) of verbal behavior, provide consistent trusted caregiver and structured daily routine when possible; and divert resident by giving alternative objects or activities.</p> <p>The Initial Allegation Report dated 10/19/25 revealed resident-to-resident abuse. The facility became aware of the allegation on 10/19/25 at 4:30PM. The allegation details stated Resident #86 had made contact with Resident #93 in his face. Both residents were separated immediately and placed on 1:1 monitoring for residents' safety. According to the report there were no mental or physical injuries noted, and the incident was reported to law enforcement. The Initial Allegation Report was completed by the Director of Nursing (DON).</p> <p>Review of the facility Investigation Report dated 10/21/25 revealed resident-to-resident abuse occurred on the 500 hall. The report was signed by the DON. The attached investigative summary stated on 10/19/25 nursing assistant (NA #11) was sitting at the nursing station on the 500 hall at approximately 4:30PM, when</p>	F0600		

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F0600 SS = D	<p>Continued from page 5 she witnessed Resident #93 approach the desk smiling. She at the same time noticed Resident #86 in the hallway by his bedroom door. NA #11 asked Resident #93, "what did he do?" Resident #93 responded that Resident #86 hit him and knocked him down. At this time Resident #86 was coming up the hall in his wheelchair, pointing and fussing that we better keep Resident #93 out of his room. Nurse #10 stated Resident #86 was visibly upset and fussing in his native language (Spanish) while pointing his finger at the nurse. The nurse reported Resident #86 stated "he is gonna get what he deserves". The NA stated at this time Resident #86 hit Resident #93 on his left cheek with an open palm slap. The staff reported they were unable to separate the residents quickly enough to avoid the occurrence. Nurse #10 took Resident #86 to the dining room while the nursing supervisor took Resident #93 with her. Resident #86 stated when he was in his bathroom and coming into his room, he found Resident #93 on his side of the room looking through his belongings (not roommates). Resident #86 reported he asked Resident #93 what he was doing. Resident #93 walked up to Resident #86 and hit Resident #86 on the side of the head making him fall. The DON interviewed both residents and heard similar stories of the initial unwitnessed incident in Resident #86's room and the witnessed altercation at the nursing station. The report further stated upon completion of the facility investigation through resident interviews, skin assessments and psych provider evaluations, the facility substantiated the resident-to-resident altercation. Residents #86 and Resident #93 would remain separate and with 1:1 staff supervision until cleared by psychology and the medical director. As of 10/19/25 both residents remained on one-on-one with no behaviors noted since the altercation.</p> <p>Interview with NA #11 on 2/27/26 at 8:54AM revealed from what she could recall, she was sitting at the nursing station when Resident #93 was observed walking down the hall towards the nursing station laughing but could not recall the date during 2nd shift. She stated she saw Resident #86 sitting in his doorway, seated in his wheelchair. She did not see Resident #93 coming out of Resident #86's room but he was coming from the direction of Resident #86 room. She recalled asking Resident #93 what he had done because she could tell something had happened. NA #11 indicated she thought Resident #93 verbalized Resident #86 had hit him. She indicated she saw Resident #86 approaching the nursing station fussing in broken English. NA #11 revealed when Resident #86 got to the nursing station in his wheelchair, he stood up and hit Resident #93 in the face.</p>	F0600		

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F0600 SS = D	<p>Continued from page 6</p> <p>Interview with Nurse #10 on 2/7/26 at 9:20AM revealed she was the nurse assigned to 500 hall when the altercation occurred with Resident #86 and Resident #93. She recalled Resident #93 already being at the nursing station when Resident #86 came down the hall to the nursing station in his wheelchair. Resident #86 appeared very upset. When Resident #86 got to the nursing station he stood up and shook his finger at Nurse #10 and was saying something she could not make out. She stated when she stood up to talk to Resident #86, Resident #86 smacked Resident #93. Nurse #10 couldn't remember what side of the face Resident #93 was hit. The residents were separated and Resident #86 was moved from the 500 hall with 1:1 supervision.</p> <p>a. Resident #14 was admitted to the facility on 1/3/22 with a diagnosis that included hypertension, schizoaffective disorder, major depressive disorder and bipolar disease.</p> <p>Resident #14's quarterly MDS assessment dated 9/2/25 revealed he was cognitively intact, had no behaviors directed towards others and required substantial to maximum assistance with activities of daily living (ADL).</p> <p>Review of care plan dated 7/8/25 and revised 12/13/25 revealed Resident #14 exhibited or was at risk for distressed/fluctuating mood symptoms of being agitated/restless/anxious related to schizoaffective disorder, personality disorder, post-traumatic stress disorder (PTSD) and history of hallucinations. The goal stated Resident #14 would express anxieties/fears to staff, including psych providers, regarding his changes in mood (anxiety/depression, etc.). The interventions included redirect and reassure Resident #14, observe for signs and symptoms of worsening anxiety/fear/anger or agitation. The interventions further included to observe for worsening signs and symptoms of existing psychiatric disorder (e.g., mania, hypomania, frequent mood changes, etc.).</p> <p>Interview with NA #10 on 2/27/26 at 9:10AM revealed she recalled an argument that occurred with Resident #86 and Resident #14 who shared a room. Although she could not recall the date NA #10 could recall she was working 1st shift (7:00 am to 3:00 pm). The argument was over the volume of the televisions, and the residents were going back and forth for control. She indicated she recalled the argument taking place while she was passing dinner trays. She indicated Resident #14 had requested Resident #86 turn down his television and Resident #86 yelled back that it was his television. NA #10 indicated she had tried to intervene, but she was</p>	F0600		

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F0600 SS = D	<p>Continued from page 7 passing dinner trays. She stated she told Resident #14 and Resident #86 they both needed to turn down their televisions. She recalled Resident #86 peering over to Resident #14's side of the room (behind curtain) stating it was his television. NA #10 revealed she notified the nurse (could not recall name) that Resident #86 and Resident #14 could not agree on the volume of the televisions and to see if she could assist. NA #10 stated she did not know what the nurse told Resident #86 and Resident #14, but when the nurse came out of the room she verbalized everything was fine. NA #10 indicated her shift was over before the incident occurred.</p> <p>Interview with Nurse #12 on 2/27/26 at 12:30PM revealed she recalled being assigned to the 300 hall on the date of the incident involving Resident #14 and Resident #86. She indicated she worked first shift (7:00 AM to 3:00 PM) and the incident occurred on 2nd shift (3:00 PM to 11:00 PM). She recalled being approached by an NA (could not recall name) notifying her that Resident #14 and Resident #86 were arguing about the television. She indicated by the time she arrived at Resident #14 and Resident #86's shared room, the resident were no longer arguing about the television.</p> <p>The Initial Allegation Report dated 12/2/25 stated an allegation of resident-to-resident abuse between Resident #86 and Resident #14. The stated Resident #86 and Resident #14 were separated and placed on 1:1 supervision for monitoring and safety. The details of physical or mental injury/harm revealed Resident #14 had an abrasion to his forehead which was cleaned by nursing staff and Resident #86 had an injury to his finger.</p> <p>The Investigation Report dated 12/9/25 revealed the facility became aware of the incident on 12/2/25 at 9:00AM in room #309. The report indicated the incident resulted in physical harm. Resident #14 had an abrasion to his forehead that was cleansed by nursing staff. Resident #86 had a scratch on his finger that was cleansed by nursing staff.</p> <p>Review of a late-entry nursing note dated 12/3/25 stated Resident #86 was expected to transfer rooms. He required a private room due to an altercation on 12/2/25. Resident #86 was moved immediately following the altercation.</p> <p>Interview with Nurse #5 on 2/27/26 at 10:53AM revealed she recalled an incident in which Resident #86 hit Resident #14 on 12/2/25. She stated she recalled being by the medication cart when Resident #86 came out of</p>	F0600		

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F0600 SS = D	<p>Continued from page 8</p> <p>his room and was waving his arms as if he wanted help. When she got to the shared room of Resident #86 and Resident #14, she observed the room to be in disarray and Resident #14 had blood on his forehead. Resident #14 verbalized Resident #86 hit him with his "reaching device" (device used to aid in reaching items) on his head. She indicated Resident #14 continued to verbalize there was an issue with the volume of the television. Nurse #5 believed Resident #86's universal television remote was controlling Resident #14's television. Following her observation, she brought Resident #86 out of the room, and he was immediately placed on 1:1 supervision. Nurse #5 requested assistance from another nurse (name unknown) for assistance and to assess Resident #14's injuries. Nurse #5 indicated prior to her shift, she was notified during shift change Resident #14 and Resident #86 had an issue with the television volume, but she was told the issue was resolved. The altercation with Resident #86 and Resident #14 was not observed by staff.</p> <p>Interview with the Director of Nursing on 2/27/26 at 10:41PM revealed following the 12/2/25 incident with Resident #86 and Resident #14 interventions were put into place and included 1:1 was initiated for Resident #86 continuously, education was provided to staff regarding abuse with the inclusion of roommate compatibility, a private room was provided for Resident #86 and psych evaluation.</p> <p>Interview with the Administrator on 2/27/26 at 11:49AM revealed his date of employment was 11/3/25. He stated Resident #86 and Resident #14 were involved in an argument over preference of the television volume on 12/2/25 in their shared room. He stated it was identified the resident's television remotes were synched with one another, so they were inadvertently controlling each other's television volumes. Following the incident Resident #86 was placed on 1:1 supervision and he was placed in a private room. A plan of correction was put into place where the facility identified a timeline of the events. Monitoring was put into place, education regarding abuse and roommate compatibility was included.</p> <p>b. Resident #54 was admitted to the facility on 5/6/24 with a diagnosis that included vascular dementia with mood disturbance, insomnia due to other mental disorder and anxiety disorder.</p> <p>Quarterly MDS assessment dated 10/3/25 indicated Resident #54 was severely cognitively impaired, was independent with mobility and had no physical behaviors directed towards others during the lookback period.</p>	F0600		

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F0600 SS = D	<p>Continued from page 9</p> <p>Review of Resident #54 care plan dated 4/2/25 revealed he exhibited or had the potential to exhibit physical behaviors related to his cognitive loss/dementia. Resident #54 would go into other rooms and not leave when asked. Resident #54 showed little knowledge of personal space. He paced, wandered and yelled at others expressing frustration, agitation and restlessness. The goal stated Resident #54 would be kept safe in his living environment. The interventions included, remove him from the environment if needed, gently guide Resident #54 from the environment while speaking in a calm, reassuring voice and divert Resident #54 by giving alternatives objects or activities.</p> <p>Review of the facilities Initial Allegation Report dated 12/24/25 stated the facility became aware of an alleged incident of resident-to-resident abuse between Resident #54 and Resident #86 on 12/24/25 at 7:10PM. The residents were separated and each placed on 1:1 supervision for monitoring and safety. Law enforcement was contacted regarding the incident.</p> <p>The Investigation Report dated 12/31/25 revealed an attached investigation summary that included protect both residents, (Resident #54 and Resident #86) were immediately separated by the facility staff and placed on 1:1 supervision. Resident #54 was moved to a different hall on 12/25/25. On 12/24/25 NA #6 was providing 1:1 supervision to Resident #86 while they were by the nursing station. According to NA #8, Resident #54, who was ambulatory, was standing at the nursing station conversing with other staff. Resident #54 began to speak to Resident #86. In a matter of seconds, Resident #54 leaned in closer to Resident #86, still speaking but not making sense. At that time per NA #8, Resident #86 reached out and struck Resident #54 openhanded across the face. Both residents were interviewed by the DON, and the residents were immediately separated and taken back to their rooms and placed on 1:1 supervision. Based on the accounts of events from the residents and the witness statements taken from staff it had been determined during the investigation that the resident-to-resident abuse was substantiated by the facility.</p> <p>An interview was conducted with Nurse #11 on 2/26/26 at 6:13PM. Nurse #11 indicated she was agency staff and vaguely remembered the incident that occurred with Resident #86 and Resident #54. She recalled Resident #86 utilized a wheelchair for ambulation and Resident #54 was able to walk independently. Nurse #11 did not</p>	F0600		

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F0600 SS = D	<p>Continued from page 10 recall Resident #86 having a 1:1 but did have a NA (name unknown) beside him while Resident #86 was at the nursing station. She recalled Resident #54 approach Resident #86, and Resident #86 was saying, "leave me alone". Resident #54 reached out to Resident #86, and Resident #86 stood up from this wheelchair and hit Resident #54. From the nursing station she noticed Resident #54 leaning down toward Resident #86 before he was hit. Nurse #11 stated she could not tell if Resident #86 was hit with an open hand or his fist. Nurse #11 revealed she was not the assigned nurse for the residents but witnessed the incident because it occurred in front of the nursing station.</p> <p>Interview with NA #12 on 2/26/26 at 6:35PM revealed she recalled providing Resident #86 1:1 supervision on 12/24/25. She recalled Resident #54 coming off the 200 hallway towards the nursing station. NA #12 stated Resident #54 was about 5 steps from Resident #86 who was seated in his wheelchair within arm's reach of her. She stated she didn't think anything would happen when Resident #54 approached close to Resident #86 as she assumed Resident #54 was just coming over to speak. NA #12 indicated she could not remember what Resident #54 was saying but he leaned close to Resident #86 and Resident #86 hit him in the face with an open hand. Resident #54 was not directly in Resident #86 face, but he was very close. She stated Resident #86 hit Resident #54 so quickly she did not have time to prevent the altercation. NA #12 indicated she becomes aware she's assigned 1:1 when she arrives to shift and reviews the assignment sheet. She stated she had not received any instructions regarding Resident #86's triggers or what to avoid.</p> <p>An interview and observation was conducted with NA #9 in Resident #86's room on 2/27/26 at 8:10AM. NA #9 revealed she was assigned the task of 1:1 supervision for Resident #86. She further stated she was as needed (PRN) staff but worked with Resident #86 often. She further revealed she was usually assigned to conduct 1:1 with the resident weekly, completing 16-hour shift with Resident #86. NA #9 revealed the facility had not told her why she was providing Resident #86 with 1:1 supervision. She had overheard a nurse (name not known) verbalizing there was an incident but not the details of the incident. NA #9 further revealed she was only instructed to tell a nurse if Resident #86 was upset and to get them if she needed assistance. Resident #86 was described as very social and he occasionally becomes upset but was easily calmed. NA #9 stated she was not aware of triggers that led to previous resident-to-resident altercations.</p>	F0600		

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F0600 SS = D	<p>Continued from page 11</p> <p>An interview was conducted with the DON on 2/27/26 at 10:41PM. The DON stated interventions were put into place following 12/24/25 the incident with Resident #86 and Resident #54. The interventions included continued 1:1 supervision with Resident #86, re-education on abuse, resident rooms were reassigned and psych evaluation were completed. The DON stated she was unaware if NAs assigned to provide Resident #86 with 1:1 supervision staff were educated about potential triggers.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 2/27/26 at 10:53AM revealed staff were told when providing 1:1 supervision, they were to stay with the assigned resident at all times. Staff further ensure residents on 1:1 were not being aggressive with other residents. When staff were assigned 1:1 supervision, staff were told triggers. The ADON indicated Resident #86 triggers were if anyone was messing with his personal items or got into his personal space. The ADON could not recall any formal in-service being conducted regarding Resident #86's triggers to resident-to-resident aggression.</p> <p>Interview with the Administrator on 2/27/26 at 11:49AM revealed on 12/24/25 Resident #86 hit Resident #54 in the face while Resident #86 was receiving 1:1 supervision and the incident took place at the nursing station. He described Resident #54 as very friendly and hard of hearing. He revealed he believed Resident #54 leaned in to hear what Resident #86 was saying when Resident #86 was startled and hit Resident #54. He stated both Residents were residing on the same hall and as an intervention, Resident #54 was assigned to another hall. He further revealed staff received education on de-escalation and dementia training. He stated he would expect NAs to be told about what may trigger a resident to display aggressive behaviors prior to providing 1:1 supervision. He further stated he would have to get with the nurse educator to identify if triggers were discussed. He indicated 1:1 supervision failed on 12/24/25 because the movements of Resident #86 were "swift" and happened in a matter of seconds. The NA assigned to provide 1:1 was present and within arm's reach of the Resident #86 when the incident occurred. To his understanding Resident #54, Resident #86 and staff were talking at the nursing station and Resident #54 leaned in close to Resident #86.</p>	F0600		
F0641 SS = D	<p>Accuracy of Assessments</p> <p>CFR(s): 483.20(g)(h)(i)(j)</p>	F0641	<p>F 641 Accuracy of Assessments</p> <p>1. Resident #05, Minimum Data Set (MDS) was modified on</p>	04/08/2026

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F0641 SS = D	<p>Continued from page 12</p> <p>§483.20(g) Accuracy of Assessments.</p> <p>The assessment must accurately reflect the resident's status.</p> <p>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>§483.20(i) Certification.</p> <p>§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.</p> <p>§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>§483.20(j) Penalty for Falsification.</p> <p>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-</p> <p>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or</p> <p>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.</p> <p>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review, the facility failed to complete an accurate Minimum Data Set (MDS) assessment in the area of skin conditions for 1 of 11 residents who MDS assessments were reviewed (Resident #5).</p> <p>The findings included:</p> <p>Resident #5 was admitted to the facility on 10/08/2025 with diagnoses of left patella fracture, atrial fibrillation (A-fib), congestive heart failure (CHF), hypothyroidism, and Alzheimer's disease.</p>	F0641	<p>Continued from page 12</p> <p>4/01/26 to reflect pressure injury/ open area over bony prominence of the spine.</p> <p>2. All residents with pressure injury/open areas over bony prominences have the potential to be affected. A whole house lookback audit of current residents with pressure injury/open areas over bony prominences was completed by Nurse Leadership designee on 4/01/26 for identification of residents with pressure injury/open areas over bony prominences and MDS coding of residents identified with pressure injury/open areas over bony prominences</p> <p>3. Education was provided to the Director of Nursing by Regional Clinical Nurse on 3/30/26 regarding accuracy of MDS section M. Education was initiated on 3/31/26 by Director of Nursing for MDS staff ensuring accuracy with completion of MDS.</p> <p>4. The MDS Coordinator or designee will complete an audit of all residents for pressure injury/ open area over bony prominences and Minimum Data Set (MDS) coding accuracy of assessment for residents with pressure injury/open areas over bony prominences weekly x 4 weeks, then bi-weekly x2 weeks, then monthly x 1 month. Results of these audits will be brought before the Quality Assurance Performance Improvement committee (QAPI) for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance. Director of Nursing will be responsible for implementation of the plan</p> <p>5. Date of compliance 4/08/26</p>	

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F0641 SS = D	<p>Continued from page 13</p> <p>An admission progress note written on 10/08/25 at 2:46 PM by Nurse #8 stated Resident #5 had arrived at the facility via ambulance on a stretcher. She noted that Resident #5 had a dark spot to her coccyx, an open area to her spine, and redness to her left knee.</p> <p>A review of Resident #5's care plan dated 10/09/25 revealed she was found to be at risk for skin breakdown. The goal dated 10/9/25 stated Resident #5 would not show any signs of skin breakdown for 90 days. The interventions also dated 10/9/25 included to pat (do not rub) skin when drying, observe skin for signs and symptoms of skin breakdown including redness, cracking, blistering, decreased sensation, and skin that does not blanch easily, provide preventative skin care (lotions, barrier creams as ordered), apply barrier cream with each cleansing, observe skin conditions daily with activities of daily living (ADL) care and to report abnormalities and the resident's skin was to be checked weekly by a licensed nurse. There were no care plans or interventions included for Resident #5 for or directly speaking to the open area noted to her spine or the dark spot on her coccyx observed on admission.</p> <p>Resident #5's admission Minimum Data Set (MDS) dated 10/15/25 revealed she was severely cognitively impaired and required extensive assistance with activities of daily living, bed mobility, and transfers. The MDS noted that she was at risk for developing pressure ulcers/injuries but stated she did not have a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing or device. That MDS stated Resident #5 had no pressure ulcers or skin issues. Under 'Other ulcers, wounds, and skin problems' the MDS indicated none were present. The MDS did not indicate that Resident #5 was to have a pressure relieving device in her chair or have her participate in a reposition/turning program or be part of a nutrition and hydration program for skin.</p>	F0641		
F0686 SS = G	<p>Treatment/Svcs to Prevent/Heal Pressure Ulcer</p> <p>CFR(s): 483.25(b)(1)(i)(ii)</p> <p>§483.25(b) Skin Integrity</p> <p>§483.25(b)(1) Pressure ulcers.</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that-</p>	F0686	<p>F686 Pressure ulcer</p> <p>Resident #5's knee immobilizer was discontinued on 11/20/25. Resident #5's wound was healed as of 3/2/2026.</p> <p>Current residents with splints or braces have the potential to be affected. An audit on all current</p>	04/08/2026

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F0686 SS = G	<p>Continued from page 14</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, record review and interviews with staff, Wound Care Nurse Practitioner (NP), Orthopedic Specialist Nurse Practitioner (Orthopedic Specialist NP), and Physician, the facility failed to follow physician orders for a knee immobilizer for Resident #5 as specified in the hospital discharge summary. Despite documented skin assessments, a facility-acquired pressure ulcer was discovered on 11/11/25 under the knee immobilizer on the back of the resident's left lower leg after a nurse aide observed drainage on the resident's bed sheets. When the pressure ulcer was assessed on 11/13/25 it was described as an unstageable pressure ulcer/injury (obscured full-thickness skin and tissue loss) with a length of 3.45 centimeters (cm), width 2.84 and no depth. It was documented that the wound was 40% granulation tissue (pink-red moist tissue that fills an open wound, when it starts to heal) and 60% slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft and stringy). The Orthopedic Specialist NP stated she was contacted by the facility on 11/13/25 and notified the resident had a new wound and wanted to know if they could remove the immobilizer and she gave a verbal order to remove the immobilizer. During the same phone conversation, the Orthopedic Specialist NP requested to see Resident #5 that same day and was told this was not possible due to transportation issues and an appointment was scheduled for 11/17/25. Interviews revealed through the process of elimination the knee immobilizer was not removed until 11/20/25 and potentially continued to put pressure on the pressure ulcer. Resident #5 was first seen by the Wound Care NP on 11/25/25 who noted the wound was a medical device related pressure ulcer and noted it to be stage 4 (a wound that is severe and extends through the skin and underlying tissues, exposing muscle, tendon and/or bone). On the same date the Wound Care NP debrided (the medical removal of dead, damaged or infected tissue to promote healing) a moderate amount of non-viable slough/necrotic tissue</p>	F0686	<p>Continued from page 14</p> <p>residents with orders for splints and braces was conducted on 3/31/2026 by Assistant Director of Nursing (ADON) to ensure all residents had orders to monitor and check skin integrity underneath any device.</p> <p>3. Education was initiated on 3/31/26 by Nurse Practice Educator for all licensed nurses and certified nursing assistants to include (Full-time, Part-time, PRN and Agency licensed nurses) skin monitoring for any resident that has a device requiring skin checks, pressure ulcer prevention, and risks for pressure ulcer development, releasing and checking skin underneath and around braces. Any licensed nurse (Full-time, Part-time, PRN, and Agency) that cannot be reached within the initial reeducation time frame of 24 hours will not take an assignment until they have received this reeducation by the Director of Nursing/ designee. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation period by the Director of Nursing/designee.</p> <p>4. The Director of Nursing, Assistant Director of Nursing, and Nurse Manager/designee will audit 4 residents with splints/braces/immobilizers 5 times per week for 4 weeks, 3 times per week x 4 weeks and weekly x 4 weeks. The Director of Nursing will report the findings of the audits to the monthly Quality Assurance and Performance Improvement (QAPI) Meeting to ensure compliance x 3 months. The QAPI committee is responsible for ongoing compliance.</p> <p>5. Date of Compliance: 4/08/26</p>	

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F0686 SS = G	<p>Continued from page 15 with forceps and scalpel. Treatments continued as ordered and the Wound Care NP debrided the pressure sore three additional times before the pressure ulcer was healed on 3/3/26. The deficient practice occurred for 1 of 1 resident with a pressure sore (Resident #5).</p> <p>A review of Resident #5's discharge summary from the local hospital dated 10/8/25 at 11:43AM, revealed she was admitted on 10/6/25 for a fractured patella (kneecap) after sustaining a fall while residing at a different facility. The discharge instructions stated 'Knee immobilizer in place when bearing weight. Knee immobilizer should be in place with your leg in extension any time you are trying to bear weight on your left leg. You may bear weight on that leg as long as the immobilizer is in place. When you are not bearing weight, the immobilizer may be removed for periods of time for comfort.' Also included in the discharge summary were orders to continue Eliquis 2.5 mg (milligrams) tablet, one tablet by mouth 2 times per day and Remeron 15 mg tablet, one tablet by mouth nightly.</p> <p>Resident #5 was admitted to the facility on 10/08/2025 with diagnoses of left patella fracture, atrial fibrillation (A-fib), congestive heart failure (CHF), moderate protein-calorie malnutrition (1/13/26), hypothyroidism, and Alzheimer's disease.</p> <p>A review of Resident #5's Physician's order dated 10/8/25 at 1:21PM stated, Left knee immobilizer in place at all times. May remove for bathing and skin checks every day and night shift for left knee fracture. Review of the resident's Electronic Medical Record (EMR) revealed this order was entered into by Nurse #4 (House Supervisor).</p> <p>A Physician Order dated 10/08/25 for Resident #5 stated Eliquis (blood thinner) tablet 2.5 mg to be given by mouth twice daily for A-fib.</p> <p>Review of Physican's orders for Resident #5 revealed an order dated 10/8/25 for Remeron 15 mg to be given at bedtime for depression.</p> <p>An interview was conducted with House Supervisor (Nurse #4) on 3/12/26 at 1:10PM. Nurse #4 stated that she and House Supervisor (Nurse #8) both do admissions and said that typically one will do the assessment documentation</p>	F0686		

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F0686 SS = G	<p>Continued from page 16 and the other will do the orders. She said that she had transcribed the order for the knee immobilizer for Resident #5 and explained she got this information from the discharge summary that came from the hospital. She explained the process of transcribing orders to a resident's EMR involved getting the discharge summary from the hospital and then taking those discharge orders off and entering them into the EMR. Nurse #4 stated usually the orders were double checked by the other House Supervisor, Nurse #8. Nurse #4 said that newly admitted residents are then discussed during a morning meeting the day after they are admitted to the facility but could not recall for certain what was discussed the morning after Resident #5 was admitted. She said they did not complete any orders in the EMR until the resident was in the room at the facility. Nurse #4 said the orders did not go to the physician immediately to be verified but if they had questions they would call the physician. She stated she did not recall calling the physician to clarify the order for the knee immobilizer for Resident #5. Nurse #4 was looking at the EMR and said she copied the order for the immobilizer from the discharge summary from the hospital, but when she read and compared the order on the hospital discharge summary with the order she had entered into the resident's EMR, they did not match. After Nurse #4 realized, they did not match, she said she did not recall where the information that she transcribed could have come from. Nurse #4 stated she would go back and look to see if she could find this documentation, but she was not able to produce this order.</p> <p>During an interview conducted on 3/12/26 at 1:30PM, Nurse #8 stated that when there was an admission to the facility she usually read through the discharge summary before she entered any orders into the resident's EMR. She said that she or Nurse #4 (both were working as House Supervisors on the day the resident was admitted) would have transcribed the orders and the other would have double checked them once they were transcribed into the EMR. She could not recall for certain who transcribed the orders for Resident #5, but once made aware that Nurse #4 had, she said that she would have double checked the orders. Nurse #8 reviewed Resident #5's EMR and compared the discharge summary orders with the order that was transcribed into the resident's EMR and stated she was not sure where the transcribed order for the knee immobilizer came from, as it did not match what the hospital discharge summary instruction, but that those orders 'had to come from somewhere.' Nurse #8 was not able to provide documentation of the order that stated the knee immobilizer was to be in place at</p>	F0686		

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F0686 SS = G	<p>Continued from page 17 all times.</p> <p>An interview was conducted on 3/13/2026 at 9:18AM with Physical Therapy Assistant (PTA) #2 who stated when it comes to the use of an immobilizer and someone had broken a bone, they have to be very conservative especially if they have mental limitations, to be sure they do not bear weight, and as a reminder. When reviewing Resident #5's discharge summary dated 10/8/25 PTA #2 said the knee immobilizer would have needed to be on when bearing weight. He said in his professional opinion, this meant the resident could take it off, when she was not bearing weight. When asked should the immobilizer have been on the resident all the time, he replied 'probably not'. He said that he felt it was sufficient for staff to check the immobilizer for appropriate fitting and skin underneath the immobilizer twice daily and that if they were allowed to be removed, they should be removed.</p> <p>An admission progress note written on 10/08/25 at 2:46PM by Nurse #8 stated Resident #5 had arrived at the facility via ambulance on a stretcher. She noted that Resident #5 had a dark spot to her coccyx, an open area to her spine, and redness to her left knee. She also noted that Resident #5 had range of motion impairment and was unable to move left lower extremity.</p> <p>A review of Resident #5's Treatment Administration Record (TAR) for October 2025 revealed the order for the knee immobilizer which read, "Left knee immobilizer in place at all times. May remove for bathing and skin checks every day and night shift for left knee fracture". The start date for this was 10/8/25 and end date was 11/20/25. There were two spaces for the nurses to initial labeled "Day" and "Night" and it did not have specific times. All boxes were initialed by a nurse for the day spaces with the exception of 10/20/25 and 10/23/25. All night spaces were initialed by a nurse with the exception of 10/30/25.</p> <p>A review of Resident #5's care plan dated 10/09/25 revealed she was found to be at risk for skin breakdown. The goal dated 10/9/25 stated Resident #5 would not show any signs of skin breakdown for 90 days. The interventions also dated 10/9/25 included to pat (do not rub) skin when drying, observe skin for signs and symptoms of skin breakdown including redness, cracking, blistering, decreased sensation, and skin that does not blanch easily, provide preventative skin</p>	F0686		

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F0686 SS = G	<p>Continued from page 18 care (lotions, barrier creams as ordered), apply barrier cream with each cleansing, observe skin conditions daily with activities of daily living (ADL) care and to report abnormalities and the resident's skin was to be checked weekly by a licensed nurse. There were no care plans or interventions included for Resident #5 for the use of a knee immobilizer or directly speaking to the open area noted to her spine, or the dark spot on her coccyx observed on admission.</p> <p>Resident #5 was also care planned for exhibiting or being at risk for dehydration as evidenced by medications (diuretics, laxatives), dated 10/9/25. The goal also dated 10/9/25 stated the resident would not exhibit any signs or symptoms of dehydration for 90 days. The interventions dated 10/9/25 included to administer medications as ordered and monitor effectiveness and signs and symptoms of side effects. Staff were to asses contributive/causative factors, monitor for signs and symptoms of dehydration, monitor labs as ordered, and monitor weight per protocol and report as indicated.</p> <p>Resident #5 also had a care plan for nutritional risk dated 10/9/25. It stated she was at increased risk for weight fluctuations due to fluid shifts secondary to diagnosis of CHF and use of diuretic medication. It also stated she was on Remeron to stimulate appetite and that her intake of meals were 25-75%, with the average being 56%. It was noted the resident reported being hungry as a bear and added large protein portions. The goals dated 10/9/25 included that the resident would consume more than 50% of at least 3 meals every day and would maintain a stabilized weight without significant changes. Interventions dated 10/9/25 included to honor food preferences within meal plan, encourage resident to chew and swallow each bite, offer/encourage fluids of choice, instruct resident and family that anorexia (not eating), weight loss, and/or dehydration may be unavoidable due to advancing disease process, weigh as ordered and alert dietician and physician to any significant loss or gain, monitor changes in nutritional status (changes in intake, ability to feed self, unplanned weight loss/gain, abnormal labs) and report to food and nutrition/physician as indicated, monitor intake at all meals, offer alternate choices as needed, alert dietician and physician to any decline in intake, provide regular liberalized diet, offer snacks, provide supplements as ordered/tolerated, supervise/assist as needed with meals, and place call light in reach. There were no new interventions for nutritional risk, added</p>	F0686		

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F0686 SS = G	<p>Continued from page 19 after 10/9/25.</p> <p>A review of physician orders for Resident #5 revealed an order dated 10/10/25 for spironolactone (diuretic) 12.5mg to be given by mouth daily.</p> <p>Continued review of physician orders revealed an order dated 10/10/25 for Voltaren Gel (topical pain reliever) 1% to be administered to her left knee 3 times per day.</p> <p>Resident #5's admission Minimum Data Set (MDS) dated 10/15/25 revealed she was severely cognitively impaired and required extensive assistance with ADL, bed mobility, and transfers. The MDS noted that she was at risk for developing pressure ulcers/injuries but stated she did not have a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing or device. That MDS stated Resident #5 had no pressure ulcers or skin issues. Under 'Other ulcers, wounds, and skin problems' the MDS indicated none were present. The MDS did not indicate that Resident #5 was to have a pressure relieving device in her chair or have her participate in a reposition/turning program or be part of a nutrition and hydration program for skin. The MDS did not indicate that the resident had a dark spot to her coccyx or open area to her spine as noted in the admission note. It also indicated she did not have malnutrition or risk for malnutrition.</p> <p>Review of an Advanced Skin Check dated 10/16/25 at 7:12PM written by Nurse #6 included skin was warm and dry, skin color within normal limits and turgor was normal. It was documented that the Resident did not have an external device.</p> <p>A Braden Scale for Predicting Pressure Ulcer Risk Evaluation was documented on 10/16/25 at 7:13PM by Nurse #6 and revealed "Braden Evaluation: Sensory Perception: Slightly limited. Moisture: Occasionally moist. Activity: Chairfast. Resident is Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. Nutrition: Adequate. Friction and shear: Potential problem."</p> <p>Review of an Advanced Skin Check that was written on 10/25/2025 at 9:49AM by Nurse #16 stated skin was warm</p>	F0686		

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F0686 SS = G	<p>Continued from page 20 and dry, skin color within normal limits and turgor was normal. It was documented that the Resident did not have an external device.</p> <p>A review of the Orthopedic Specialist Nurse Practitioner's (Orthopedic NP) note dated 10/30/25 revealed that Resident #5 was seen for a follow up visit for her left patella fracture. The recommendations included for resident to be weight bearing as tolerated to left lower extremity with the knee immobilizer, continue knee immobilizer when sitting and lying, and physical therapy may take off knee immobilizer to work range of motion, limit flexion (bend) to 60 degrees, and a new referral was given for therapy. The resident was to return for follow up in 3 weeks.</p> <p>A review of Resident #5's Treatment Administration Record (TAR) for November 2025 revealed the order for the knee immobilizer which read, "Left knee immobilizer in place at all times. May remove for bathing and skin checks every day and night shift for left knee fracture". The start date for this was 10/8/25 and end date was 11/20/25. There were two spaces for the nurses to initial labeled "Day" and "Night" and it did not have specific times. All the blocks were initialed by a nurse from 11/1/25 through 11/19/25 and only the day box was initialed on 11/20/25.</p> <p>On 11/1/25 at 3:33PM, Nurse #6 Documented an Advanced Skin check which stated skin was warm and dry, skin color within normal limits and turgor was normal. "Resident has an external device. External device(s) description: brace on Left leg External device removed and site inspected: Yes. Observe for any discoloration on the device / cast that may indicate drainage under the device / cast: Yes. Observe for any new edema, skin changes, or odor that may indicate skin / wound infection: Yes."</p> <p>An interview conducted with Nurse Aide (NA) #8 on 3/12/26 at 2:53PM revealed that she provided a bed bath to Resident #5 on 11/7/25 but was not very familiar with the resident as that was the only time she worked with her in 2025. She stated that she never completely opened the brace because she was not familiar with Resident #5 so she would have been a little bit scared to. NA #8 indicated she did not see any skin issues at the time she gave Resident #5 her bed bath, but she did not observe the back of resident's left leg, because</p>	F0686		

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F0686 SS = G	<p>Continued from page 21 she only opened the brace 'a little bit'.</p> <p>A telephone interview was conducted on 3/12/26 at 4:06PM with Nurse #14 who revealed that she had worked the night shift (7:00PM to 7:00AM) with Resident #5 on 11/7/25 and initialed the TAR for the immobilizer. Nurse #14 recalled that the resident had a brace on and that she had to apply the pain cream to that knee. She said that she believed she would have fully removed the brace, so she did not get any cream on the brace. Nurse #14 stated it was too hard to recall the details because it was 4 months ago and she always does what the instructions say to do. She said that she never saw any indication of a wound or skin issue, but she could not remember if she looked at the back of the resident's left leg. Nurse #14 indicated she also worked on 11/17/25, 11/18/25, and 11/19/25, but could not recall from memory if the immobilizer was still on. She stated that if she signed for it saying it was in place, then it was.</p> <p>A review of an Advanced Skilled Evaluation dated 11/8/25 at 3:19PM revealed that Nurse #3 documented Resident #5's as "1" which the key stated meant Resident #5's skin was "warm and dry; skin color and turgor (skin elasticity) were normal.</p> <p>An interview was obtained on 3/12/25 at 2:38PM with NA #13 who provided the bed bath to Resident #5 on 11/8/25 during the 7:00AM to 3:00PM shift. NA #13 stated she fully removed the immobilizer from the resident's leg and rolled her over to bathe her back and back of legs as well and did not see any skin issues.</p> <p>A review of the physician's orders revealed an order for physical therapy dated 11/8/25 at 9:00AM which stated Physical Therapy Recertification Orders: patient to be seen 3-5 times a week for 4 weeks (for generalized weakness). Skilled services to include: Therapeutic Exercise, and Therapeutic Activity, gait training, neuro re-ed (therapeutic exercises that are designed to re-develop normal, controlled movement patterns), manual and wheelchair management. Individual, group, and concurrent treatment sessions as appropriate.</p> <p>A review of Skilled Evaluation dated 11/09/25 at 6:29PM completed by Nurse #7 indicated a "1" which the key stated meant Resident #5's skin was "warm and dry; skin</p>	F0686		

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F0686 SS = G	<p>Continued from page 22 color and turgor (skin elasticity) were normal.</p> <p>During a telephone interview conducted on 3/10/26 at 2:46PM with Nurse #7 revealed that she did not recall that Resident #5 had a brace. She said it had been too long ago to remember that, but that she followed whatever the instructions told her to do. She went on to explain that if the TAR said to remove the brace to do a skin check, she removed the brace to do the skin check. Nurse #7 could not recall the details of Resident #5's immobilizer. Once reminded what the order on the TAR stated, and she had initialed it on 11/9/25 (7:00AM to 7:00PM shift), Nurse #7 stated that based on the wording of the order, she did not feel that she would necessarily have had to remove the brace fully to mark the TAR as completed, but could not recall what she did for certain.</p> <p>A telephone interview with Nurse #9, conducted on 3/10/25 at 5:31PM revealed that she worked with Resident #5 on 11/8/25 and 11/9/2025 and recalled that she had initialed the TAR for the knee immobilizer for those dates indicating it was on at all times and could be removed for hygiene and skin checks. She stated she typically only worked 4-hour shifts, and she never had to remove the immobilizer. She said when she would remove Resident #5's patch or apply cream to the left knee this never required her to fully remove the brace. Nurse #9 stated she was able to see Resident #5's skin 'fine' without removing the brace fully.</p> <p>A "skin check" written on 11/08/25 at 3:48PM by Nurse #3 indicated Resident #5's skin was warm & dry; skin color and elasticity were normal. Nurse #3 further noted that the resident had a splint, and that the splint was removed and inspected. The Nurse documented that she did not observe any discoloration on the device that could have indicated drainage under the device and that she did not observe any new edema, skin changes, or odor that may have indicated skin or wound infection.</p> <p>An interview was completed with Nurse #3 on 2/27/26 at 1:00PM and she stated that she had worked with Resident on 11/8/25 and 11/10/25 from 7:00AM to 3:00PM but did not see any skin issues at all under the immobilizer. Nurse #3 indicated she would have noted skin issues if she had and she could not recall if she fully removed the immobilizer or not.</p>	F0686		

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F0686 SS = G	<p>Continued from page 23</p> <p>During a follow up telephone interview with Nurse #3 conducted on 3/12/26 at 9:45AM, she revealed that she had worked on 11/8/25 and 11/10/25 from 7:00AM to 3:00PM and she did notice some redness and indentations from the brace those days but would just reposition Resident #5 in the bed and she felt this would correct the issue. Nurse #3 stated the indentations were usually present to the lower leg or back of the resident's thigh, but she did not see any wounds. She also said that she would usually just open the brace but did not have to fully remove the brace. Nurse #3 explained she completed her skin checks by herself (without the assistance of a 2nd staff member) and felt like she could see the back of Resident #5's leg 'pretty well'. She stated she never documented or reported the redness or indentations because she felt like they were not a big deal and that she never noticed any skin that was non-blanchable (redness or discoloration that does not fade when pressure is applied, indicating potential tissue damage or compromised blood flow).</p> <p>During an interview on 3/12/26 at 2:10PM, NA #14 revealed that she worked on 11/9/25 from 7:00AM to 3:00PM with Resident #5 but did not recall any details other than who the resident was and that she was 'always smiling'. She did provide a bed bath to Resident #5 but said she did not recall if she had a knee immobilizer on or not.</p> <p>A telephone interview was conducted on 3/11/26 at 9:45AM with Nurse #15 who had worked on 11/10/25 3:00PM to 11:00PM with Resident #5 and had signed the TAR that evening for the immobilizer. She stated she was familiar with Resident #5 but does not work with her much. Nurse #15 indicated she did not recall anything that happened in November. Nurse #15 could not say if the immobilizer was on or not or if she had to remove it or not. Nurse #15 explained they had to remove braces to check skin, but she did not recall if she ever had to do it personally. She said that typically if she had someone with a brace on, she would remove the brace and check the skin, but she would only go by what the order said. Once reminded of how the order for Resident #5's immobilizer was written on the TAR, Nurse #5 said she did not feel she would have had to remove it fully because it sounds like it was just off for baths. Nurse #15 further stated she never saw a wound and had no reason to take the brace off.</p>	F0686		

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F0686 SS = G	<p>Continued from page 24</p> <p>An interview was conducted on 3/12/26 at 2:40PM with NA #19 who revealed she had worked on 3/10/25 and provided a bed bath to Resident #5. NA #19 stated she rarely worked with Resident #5 but did recall who she was. She indicated she took immobilizer off for the bath and she washed Resident #5's body front and back. NA #19 further stated she did not find any skin issues with the resident and would have told the nurse if she had. She recalled the resident was able to speak but mostly limited to yes and no answers.</p> <p>A review of Resident #5's physician orders revealed an order for a chest x-ray on 11/10/25 at 9:23AM.</p> <p>Review of Skilled Nurse Note written by Nurse #3 dated 11/10/25 at 5:34PM, noted that Resident was without fever, had normal oxygen saturation, and had clear lung sounds on both sides. She wrote that she had no new onset or worsening of weakness and had no difficulty breathing. She went on to write that Resident #5 had no cough or shortness of breath noted. Under skin, she wrote skin warm & dry, skin color within normal limits and turgor was normal.</p> <p>A telephone interview with NA #7 on 03/5/26 at 11:10AM revealed she was the NA who provided Resident #5 with the bed bath on 11/11/25. She stated this would have been shortly before the lunch trays were passed, which she approximated to be between noon and 1:00PM. NA #7 recalled this was when she noticed a circle of yellow drainage about the size of a penny on the Resident's fitted bed sheet and she wondered where the drainage was coming from. NA #7 indicated she opened Resident #5's leg immobilizer up immediately to look at her leg. NA #7 said she lifted the resident's leg to be able to see the back of her leg and identified the wound. She said the wound was open, did not look good, and looked like it had been there a while. NA #7 further revealed it was dark colored and roughly the size of a half-dollar with no blood or odor noted. NA #7 thought the brace was too tight and had left indentions all over Resident #5's leg (front and back). NA #7 described the indentations on Resident #5's leg as if someone would have tight fitting socks on all day that resulted in creases all over. NA #7 also said where the immobilizer ended on the resident's left lower leg was exactly where the wound was located. She stated Resident #5 had not suffered any injury prior to this wound being found that she was aware. NA #7 further stated the resident did not give any indication of pain and she reported the wound to the Nurse #6 who</p>	F0686		

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F0686 SS = G	<p>Continued from page 25 immediately came and looked at the wound.</p> <p>A Review of Change in Condition note dated 11/11/25 at 12:25PM revealed Nurse #6 noted Resident #5 had a respiratory infection and a new pressure ulcer. The note did not describe the respiratory symptoms or any information regarding the wound. The note did state primary care provider feedback: recommendations: to do continued wound care on patient and to do antibiotics for treatment of pneumonia. Below this is states "New intervention orders: wound care".</p> <p>A Physician order dated 11/11/25 at 12:30PM instructed to cleanse Resident #5's left lower leg with would cleanser and apply calcium alginate (a wound additive to promote healing) and foam. This dressing was to be changed daily on day shift and as needed.</p> <p>A review of Resident #5's physician orders revealed an order with a start date of 11/11/25 at 2:00PM and end date of 11/13/25, for an antibiotic (ceftriaxone sodium) 1 gram to be administered via injection one time daily.</p> <p>Physician order with start date of 11/12/25 at 7:00AM and end date of 11/18/25 stated to monitor resident for signs and symptoms of pneumonia every day and night shift.</p> <p>A review of Resident #5's physician orders revealed an order for Cefdinir Oral Capsule (antibiotic used to treat bacterial infections) 300 mg to be given by mouth, twice daily for 5 days, with a start date of 11/13/25 at 9:00AM through 11/18/25.</p> <p>A review of Skilled Evaluation documented on 11/11/25 at 5:52PM by Nurse #6 stated Resident #5 had a new skin issue which was located on her left front lateral lower leg. The issue type was described as pressure ulcer/ injury and stated the wound was acquired in-house. Nurse #6 indicated measurements were not documented as a part of the assessment and the reason was the Wound Care Nurse would assess and measure.</p> <p>A telephone interview was conducted with Nurse #6 and the Director of Nursing (DON) on 3/5/25 at 10:00AM. Nurse #6 stated she had first observed the pressure</p>	F0686		

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F0686 SS = G	<p>Continued from page 26</p> <p>ulcer on Resident #5's left leg on 11/11/25 at approximately 8:30AM when NA #7 retrieved her to look at a wound she had found. Nurse #6 said when she entered Resident #5's room, the knee immobilizer was off, and she observed a wound located to the back lower portion of the left leg. She said she documented that the wound was located to the front of the leg because she "easily got confused with directions" (meaning front/ back/left right). The DON explained that she was aware that it was documented in the wrong location on the leg and explained that the documentation self-populated the wound location after that original nurse entered the wrong location, and if they changed it anytime afterward, it would look like a whole new wound, so they just left it. Nurse #6 described the wound bed as being yellow and red in color and had no drainage present. Nurse #6 then stated she thought the edges looked to have slight bleeding present, but not to the point of dripping blood. She did not see any drainage on the sheets or on the immobilizer and did not notice an odor to the wound. Nurse #6 indicated she did not measure the wound. She went on to say that they have an order to apply pain gel to Resident's left knee 3 times a day (at 9:00AM, 1:00PM, and 5:00PM) and they can look at the Resident's skin at those times. Nurse #6 said she had not applied the pain gel to Resident #5's knee yet that day, prior to the wound being found. She said the Resident did not show any signs or symptoms of pain. After observing the wound, she contacted the Nursing Supervisor and the Physician. Nurse #6 recalled that neither the Nursing Supervisor nor Physician assessed the wound that day. The DON indicated that the Nursing Supervisor did not always come to look at wounds when reported to her. The DON said that Nurse #6 notified her of the wound on 11/11/25 and she did not recall making an observation of the wound herself on 11/11/25.</p> <p>During an additional telephone interview conducted on 3/12/26 at 11:53AM with Nurse #6, the order on the TAR was reviewed which stated, "Left knee immobilizer in place at all times. May remove for bathing and skin checks every day and night shift for left knee fracture", was reviewed. Nurse #6 stated that this meant that she was going in and taking a look at it to make sure the knee immobilizer was in place at all times. She said it also 'meant that if the aides needed to take it off to give her a bath, we could do that'. Nurse #6 indicated she did not remove the brace when she applied the pain patch or cream and would only see a little bit of the skin during those times. When asked if Nurse #6 ever fully removed Resident #5's knee immobilizer, she stated only a couple times, so the</p>	F0686		

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F0686 SS = G	<p>Continued from page 27</p> <p>aides could give her a bath. Nurse #6 stated that she did not provide wound care the day the wound was first observed. She only covered the wound with a "dry dressing" because she expected the wound care nurse to do the initial wound care treatment and assessment. A clarification of the time that she was first notified about the pressure ulcer from NA #7 was obtained from Nurse #6 during this interview. She said upon reviewing the 'change in condition' note written at 12:25PM and the physician order written at 12:30PM on 11/11/25, she concluded that she must have been notified by NA #7 about the wound no earlier than 11:35AM.</p> <p>A review of the TAR for November 2025 showed an order for a dressing change dated 11/11/25, which stated to cleanse left lower leg with wound cleaner and apply calcium alginate and foam. Change daily and as needed. The order was not initialed by a nurse as completed on 11/11/25.</p> <p>Further review of the TAR showed an additional order for a dressing change dated 11/12/25, which also stated to cleanse left lower leg with wound cleaner and apply calcium alginate and foam. Change daily and as needed. This order was initialed by staff daily on 11/12/29 through 11/19/25.</p> <p>Review of Skilled Evaluation dated 11/12/25 at 2:36PM revealed that Nurse #1 noted that Resident #5's cardiovascular assessment indicated skin was warm and pink with brisk capillary refill and no edema present. In the skin portion of the assessment, there was a '1' documented which the key stated meant Resident #5's skin was "warm and dry; skin color and turgor (skin elasticity) were normal. She went on to note that she had a 'skin issue' described as 'pressure ulcer/injury' which was acquired in-house which had 'not been evaluated'.</p> <p>A telephone interview was obtained from Nurse #1 on 03/05/26 at 10:50AM which revealed she had worked with Resident #5 on 11/12/25 from 7:00AM to 3:00PM, the day after the wound was found. She saw the wound and said it looked open and raw with red and yellow tissue present. Nurse #1 revealed there was not a lot of drainage noted, but the drainage present was 'yellowy-red' colored. She stated Resident #5 still had the immobilizer on and it was 'pushing into the wound' and noted it was a heavily padded brace. She initialed the TAR for that day as well and provided the wound</p>	F0686		

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F0686 SS = G	<p>Continued from page 28 care as ordered. Nurse #1 stated she had not noted any skin issues before learning that Resident #5 had a wound when she worked on 11/12/25.</p> <p>During an additional interview with Nurse #1 on 3/13/26 at 11:47AM, she said that when she applied the pain gel to Resident #5, she opened the straps of immobilizer but did not remove it completely. She said when the fasteners were opened, the immobilizer did not lay open loosely on the bed like fabric but was stiff. Nurse #1 indicated the immobilizer could become misaligned or could have slid down from Resident #5 wiggling around in the bed and she would make slight adjustments when necessary.</p> <p>During an interview with Nurse #16 on 3/13/26 at 1:35PM, she revealed that she had worked on 11/12/25 from 3:00PM to 11:00PM and signed the TAR which stated the immobilizer was on at all times and may remove for hygiene and skin checks but said that it was so long ago she could not really recall it.</p> <p>On 03/12/26 at 3:25PM NA #15 was interviewed and stated she did not work much with Resident #5 but did not recall seeing any skin issues on her except for possible a little redness to her bottom, and said if she had noticed she would have noticed anything, she would have had the nurse look. NA #15 stated she had the nurse help her take the brace off when she gave the resident a bath on 11/12/25 during the day shift. She said she always bathed both front and back of the residents.</p> <p>An interview on 3/13/26 at 9:59AM with NA #11 revealed that she worked with Resident #5 on 11/12/25 and 11/18/25 and explained that she would open knee immobilizer and roll her with the brace on but never fully take the immobilizer off. She said that she did not ever recall seeing any skin issues but would get the nurse and have her look at the resident's skin, if she had.</p> <p>A review of the physician's orders for Resident #5 revealed an order for Protein Liquid 30ml by mouth twice daily, for the indication of 'supplement', that had a start date of 11/12/25 and end date of 12/3/25.</p> <p>Review of a nutrition note dated 11/12/25 at 9:53PM by</p>	F0686		

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F0686 SS = G	<p>Continued from page 29</p> <p>Dietary Staff, indicated that Resident #5 had significant weight change of 7.35% loss in one month's time. Her meal intakes ranged from 25-100%, with the average being 58%, and indicated this was consistent since admission to the facility. The note stated Resident had been receiving large protein portions and Remeron (a medication to help with appetite). The note stated that the weight loss was likely caused by fluid shifts over true weight loss because her intake was consistent since admission, but pointed out that she had a new wound, so dietary was going to provide Protein Liquid of 30 milliliters (2 tablespoons) twice per day, to 'better meet the protein needs and for risk of malnutrition'.</p> <p>A review of the physician's orders for Resident #5 revealed an order for Protein Liquid 30ml by mouth twice daily, for the indication of 'supplement', that had a start date of 11/12/25 and end date of 12/3/25.</p> <p>An Advanced Skin Issue Note written by the DON, dated 11/13/25 at 6:54AM, revealed she had evaluated Resident #5's wound. The wound was described as located in front left lateral lower leg and was listed as a pressure ulcer / injury but noted to be 'unstageable' which she stated was a wound that one does not know how deep it is going to be because there is dead tissue covering it, but noted it to be unstageable in her note "due to non-removable device / dressing". The DON documented it was a new wound which was acquired in-house. The measurements included length 3.45 centimeters (cm) width 2.84cm, depth 0cm, and area of 6.41cm². There was not any undermining (skin edges separated from the underlying tissue, creating a pocket beneath the visible wound surface that can delay healing) or tunneling (passageway under the skin) noted. Granulation was listed as 40% of the wound and slough made up 60%. It was also noted to have light serosanguineous (pale, red, and watery) drainage. There was no odor after cleansing and tissue around the wound was reddened. There was no edema or swelling noted and once cleaned, she noted that she dressed the wound 'per the physician's order'. Under the additional care portion of the note, it said Resident #5 was to have pressure reducing devices for bed and chair and for Resident #5 to change / shift positions frequently.</p> <p>During an interview with the DON on 3/12/26 at 1:40PM she confirmed she was the wound care nurse for the facility and revealed that after completing the wound assessment for Resident #5 on 11/13/25, Medical Records</p>	F0686		

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F0686 SS = G	<p>Continued from page 30 called the Orthopedic Specialist's office to alert them of the new pressure ulcer and to request an appointment for her to be seen. The DON did not know why she did not assess Resident #5's wound on 11/11/25, when it was found.</p> <p>An interview with Medical Records on 3/13/26 at 11:20AM revealed that she had called the Orthopedic Specialist's office on 11/13/25 to ask if the immobilizer could be removed and to set up an appointment for Resident #5. She could not say who specifically she spoke to, stating it was whoever was at the desk. Medical Records indicated they did not give her the order to remove the brace, but she was focused mostly on the appointment for her to be seen to address the wound. Medical Records stated the Orthopedic Specialist office had requested to see the resident that same day (11/13/25) but due to transportation issues at the facility, she told them they were unable to have her seen that day and an appointment was scheduled for 11/17/25.</p> <p>A telephone interview was conducted on 3/12/26 at 5:30PM and revealed that Nurse #16 had worked with Resident #5 on 11/13 /25 and 11/15/25 during the 3:00PM to 11:00PM shift, but she did not recall much from working with her during that time. She stated that based on the information on the TAR, she was initially stating the immobilizer was in place at all times, apart from checking the skin. Nurse #16 stated she believed she was able to complete the skin check by herself and did not need a second person to hold the resident's leg. She said she completed skin checks on those days, but Nurse #16 could not recall if the resident had a dressing on her leg or not. Nurse #16 further stated she was able to visualize the back of the leg adequately while supporting the leg alone but could not recall for certain if she removed the brace entirely or just opened it up partially.</p> <p>A monthly nutrition note dated 11/14/25 by Dietary Staff stated Resident #5 had a new unstageable pressure injury to the left lower leg due to a non-removable device/dressing. Average oral intake was 57%. The resident was supported with large protein portions and Protein Liquid twice a day (consuming 100%). It was noted the base regular diet provided approximately 88 grams protein, the Protein Liquid provided 30grams protein, and the house supplement provided 6 grams of protein. Encourage intake of protein at meals. The note indicated the current intake was likely meeting the</p>	F0686		

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F0686 SS = G	<p>Continued from page 31 resident's needs. House Supplement was recently added and there were no new recommendations. Continue with Plan of Care and the Registered Dietitian to follow monthly, quarterly, or as needed.</p> <p>A review of the Orthopedic Specialist NP's progress note dated 11/17/25 at 8:45AM revealed Resident #5 was seen for a follow up visit for her left patella fracture, and an order was written to "D/C (discontinue) knee immobilizer", and weight bearing as tolerated to left lower extremity. The NP noted that she last saw Resident #5 on 10/30/25 and at that visit she continued the knee immobilizer and had written a prescription for her knee immobilizer to be removed for Physical Therapy (PT) and with hygiene. The Orthopedic Specialist NP noted that she had received a phone call from the resident's facility on 11/13/25 because the facility noticed a wound on the Resident #5's leg and facility staff were "curious if her brace could be removed". The Orthopedic Specialist documented that she gave the facility a verbal order to remove the brace. Measurements of wound were documented as 3cm wide, 4cm long, and 0.5cm deep. There was no drainage noted and the wound was described as soft to touch, with no bone exposed.</p> <p>During a telephone interview with the Orthopedic Specialist NP on 3/10/26 at 8:32AM, she stated that she saw Resident #5 in her office on 10/30/25 and Resident #5 did not have any skin concerns at that time. She said that she was supposed to have another follow up visit with the resident mid-November, but that the facility called her office on 11/13/25 (before the next follow up visit) and reported that the resident had a new wound and wanted to know if they could remove the immobilizer. She said that she gave a verbal order to remove the immobilizer and read aloud from her note, that she spoke directly to House Supervisor (Nurse #8). The Orthopedic Specialist NP said that she would have liked to have been notified immediately on 11/11/25 when the wound was first found and that she would have discontinued the brace immediately that day. She said that she felt that continuing to leave the brace on for the additional days, did make the wound worse as the immobilizer was the source of pressure on her skin in the first place, and did not believe it was not supported properly. She said that providing support to limbs in an immobilizer or brace, is basic nursing knowledge and that they should have supported Resident #5's leg, so it did not have the pressure from the brace. The Orthopedic Specialist NP stated she felt the resident's pressure ulcer was "100% avoidable". She</p>	F0686		

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F0686 SS = G	<p>Continued from page 32 also stated that the wound should have been caught long before it got to the degree of wound at the time it was found. The Orthopedic Specialist NP explained if facility staff did not completely remove the immobilizer from the resident's leg and have a 2nd person hold the leg up for them so they could fully visualize the back of the resident's leg, that this would have been an insufficient skin assessment. She said that she sent documentation back to the facility after her appointment on 11/17/25 which stated to discontinue the immobilizer and to avoid pressure to the posterior left lower leg. She read back on her note from 11/17/25 and stated that she because she mentioned in her note that the resident "rests with knee in 85 degrees of flexion", that told her Resident #5 was not in the knee immobilizer at the time of assessment.</p> <p>An interview on 3/13/26 at 1:09PM with NA #12 revealed that she transported Resident #5 to her appointment to see the Orthopedic Specialist NP on 11/17/25 but could recall if she had a brace on or not. She said that she was certain when she returned to the facility that she gave the paperwork to the House Supervisor because that was who she always gave it to, but she could not recall which nursing supervisor it was.</p> <p>An interview with Nurse #8 was conducted on 3/13/26 at 12:09PM. Nurse #8 indicated that she realized there were two active orders for Resident #5's knee immobilizer and did not know why one order for the knee immobilizer was removed on 11/17/25 or the other on 11/20/25. Nurse #8 stated she did not recall receiving a verbal order from the Orthopedic Specialist NP to remove the brace on 11/13/25.</p> <p>During an interview with Nurse #1 on 3/13/26 at 11:48AM, she said that although she worked with Resident #5 on the day she went to her appointment at the Orthopedic Specialist NP's office (11/17/25), she did not recall seeing the paperwork that came back with the resident from the appointment. She said that if she did get the paperwork, she would have given it to the house supervisor. Nurse #1 also clarified that her initial on the TAR for the immobilizer meant to her that she was going in and looking at her skin and seeing how it looked. Nurse #1 stated she would have laid the brace open and examined the skin underneath. Nurse #1 indicated she never had to fully remove the immobilizer and explained she would have left it under her leg so there was as little manipulation as possible. She said she would have had to elevate</p>	F0686		

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F0686 SS = G	<p>Continued from page 33 Resident #5's leg to be able to see the back of her leg and she felt this was sufficient.</p> <p>Review of Resident #5's physician orders revealed there were two separate orders for the knee immobilizer active for the resident at one time. One order specified to 'Continue knee immobilizer when sitting and lying, Physical Therapy may take off knee immobilizer to work on knee and range of motion, limit flexion to 60 degrees, weight bearing as tolerated and left lower extremity in knee immobilizer'. This order did not have a start date entered, but showed it was discontinued on 11/17/25. The second knee immobilizer order was the original order dated 10/8/25 that specified for the left knee immobilizer in place at all times. May remove for bathing and skin checks every day and night shift which was discontinued on 11/20/25.</p> <p>During an interview on 3/13/26 at 11:06AM House Supervisor (Nurse #4) stated that she discontinued the order for the immobilizer from the TAR which stated, 'Continue knee immobilizer when sitting and lying, Physical Therapy may take off knee immobilizer to work on knee and range of motion, limit flexion to 60 degrees, weight bearing as tolerate and left lower extremity in knee immobilizer' because she would assume she received appointment papers to do so, but did not recall for sure seeing them. She said if she took the order off, then that would be the reason. She stated she was not aware that there was a second immobilizer order and was not sure why it was removed from the TAR on the 11/20/25.</p> <p>During an interview on 3/13/26 at 12:41PM the Assistant Director of Nursing (ADON/Nurse #5) stated she discontinued the remaining immobilizer order because she got the order from the paperwork that would have come back from Resident #5's appointment with the Orthopedic Specialist on 11/17/25. She said she did 'look behinds' to be sure that nothing gets missed as far as orders. Nurse #5 indicated this required her to review paperwork that residents received from appointments. The interview further revealed she got the paperwork from Resident #5's Orthopedic Specialist appointment on 11/17/25 emailed to her on the 11/19/25, but sometimes she received a lot of orders to review and may not get to them all on that same day. Nurse #5 stated this was why she did not remove the knee immobilizer from the TAR until 11/20/25. She said that the expectation was that these orders were transcribed immediately when a resident returned from their</p>	F0686		

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F0686 SS = G	<p>Continued from page 34 appointments and usually it was one of the House Supervisors that did this, but they can be missed. This was why they have the process to do the 'look behind', which was how this was caught. Nurse #5 revealed she did not physically go down the hallway and take the immobilizer off of Resident #5 and she believed she told the floor nurse to do this but could not recall who this was.</p> <p>An interview conducted on 3/13/26 at 11:20AM with Medical Records revealed that when residents returned from medical appointments with paperwork, the paperwork goes to nursing supervisor first and was reviewed and then it goes to Medical Records for scanning. She explained after it goes to the nursing supervisor, it would be placed into her (Medical Records) mailbox for review for when the follow-up appointment would be or if she needed to schedule an appointment. Medical Records indicated she was not a nurse, so she does not transcribe any new orders. Medical Records stated she shared the appointment paperwork back to the supervisors via email for a double check, but if she was busy the process of emailing may take a few days. Medical Records confirmed she did scan Resident #5's paperwork into her file on her computer on 11/17/25 but it did not get emailed out to Nurse #4, Nurse #5, and Nurse #8 until 11/19/25 for the double check.</p> <p>During a telephone interview conducted on 3/12/26 at 4:28PM, NA #9 stated that she was familiar with Resident #5 when she would have provided her bed bath on both 11/16/25 and 11/20/25. NA #9 stated she bathed Resident #5 and then put the brace back on her leg (over her pants). She recalled the nurse coming into the room to do the dressing change while she (NA #9) was completing the bath and then helped her put the pants and brace back on the resident. NA #9 further stated she did not recall any skin issues prior to this and would tell her nurse if she had ever noted a wound prior.</p> <p>A telephone interview was conducted with Nurse #14 on 3/13/25 at 2:31PM. Nurse #14 was familiar with Resident #5, and said that when she worked on 11/18/25, she removed the brace only enough to be able to see the skin and would not have fully removed it without making a note in her chart saying she removed it. She stated when she worked on 11/20/25, she did not discontinue the brace or realize there was an order to do so. Nurse #14 indicated she would have remembered if she received that order or if she physically discontinued the brace.</p>	F0686		

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F0686 SS = G	<p>Continued from page 35</p> <p>During an interview on 3/12/26 at 4:06PM with Nurse # 14, she revealed that she had worked the night shift (7:00PM to 7:00AM) with Resident #5 on 11/17/25, 11/18/25, and 11/19/25 and she initialed the TAR for the immobilizer. Nurse #14 stated that if she signed the TAR stating the brace was on at all times, then it was. Nurse #14 could not recall further details because it was four months ago. The highlighted does not make sense.</p> <p>An interview was conducted on 3/12/26 at 2:30PM with NA #6. She said she worked on 11/17/25, 11/18/25, and 11/19/25 and thought the brace was still on Resident #5 but could not recall for certain as that was a long time ago.</p> <p>An interview was conducted on 3/12/26 at 2:30PM with NA #6. She said she worked on 11/17/25, 11/18/25, and 11/19/25 and thought the brace was still on Resident #5 but could not recall for certain as that was a long time ago. NA #6 stated anytime she worked with Resident #5 she always took the brace all the way off to bathe her and would wash her front and back fully.</p> <p>Review of 'Skin Issue' documentation dated 11/18/25 (no time stamp), written by DON indicated the pressure ulcer to be described as 'Stable: previously deteriorating wound, characteristics plateaued'. The measurements of the wound were length 3.34cm, width 2.77cm, depth 0cm, and area 6.17cm.</p> <p>On 3/13/26 at 3:22PM the DON stated she was not certain who eventually removed Resident #5's immobilizer from her leg because nobody could remember doing it, but through process of elimination, it had to be Nurse #6. The DON indicated that she, the ADON, neither of the House Supervisors who worked that day, or Nurse #17 had removed it, so it had to be Nurse #6. The DON said that Nurse #6 initialed the TAR for the immobilizer on 11/20/25 indicating it was still on and then the next shift nurse did not, so it had to be discontinued on Nurse #6's shift (before 7PM).</p> <p>During a telephone interview with Nurse #6 on 3/13/26 at 1:43PM, she stated that she did not recall removing the immobilizer off of Resident #5's leg on 11/20/25, but that it was too long ago to say for sure.</p>	F0686		

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F0686 SS = G	<p>Continued from page 36</p> <p>A 'Skin Issue' documentation dated 11/24/25 (no time stamp), revealed the DON indicated the pressure ulcer was 'Improving: overall wound characteristics improved'. The measurements of the wound were length 3.45cm, width 2.69cm, depth 0cm, and area 6.46cm.</p> <p>A progress note written on 11/25/25 by the Wound Care NP (NP) revealed that she was asked to assess Resident #5's pressure ulcer to her left lower leg during rounds. She noted that Resident #5's wound had improved since it was first identified but did not specify in what way it had improved. She indicated the measurements of the wound before debridement included 3.4cm, 2.7cm, and .3cm, (note did not differentiate length, width, depth) and after debridement the measurements were 3.4cm, 2.7cm, and .5cm (did not differentiate length, width, depth). The NP documented the wound was a medical device related pressure ulcer and noted it to be stage 4. She described the wound bed tissue to be made up of 80% slough; 10% tendon (flexible fibrous tissue attaching muscle to bone); 10% granulation; 0% eschar (hardened, dry, black or brown tissue which is scab-like); 0% non-granular tissue (tissue that indicates lack of healing response); 0% purple/maroon; and 0 % bone. The NP noted there was a small amount of serous drainage and that Resident #5 reported mild pain. Associated risk factors included limited mobility, advanced age, and frailty. Resident #5's functional status was noted to be non-ambulatory and nutritional status was marked as adequate. The NP indicated continue offloading with the use of a pillow under Resident #5's calf. The wound was treated with sharp wound debridement and cleansed with wound cleanser. The NP noted a moderate amount of non-viable slough/necrotic tissue was removed with forceps and scalpel. A small amount of bleeding was controlled with pressure, and the wound was then redressed according to the treatment orders.</p> <p>A telephone interview was obtained with the Wound Care NP on 02/27/2026 at 12:21PM, with the Wound Care NP revealed she had not seen the resident's immobilizer because it was discontinued by orthopedic team after the development of the pressure ulcer. She stated if she remembered correctly, when she observed the wound for the first time on 11/25/25, the wound tissue was pretty necrotic (dead), and the wound had some purple tissue around the edges. The Wound Care NP stated when she fully opened the wound bed up the tendon was visible, and she could stage the pressure ulcer as a stage 4. The Wound Care NP indicated she believed the</p>	F0686		

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F0686 SS = G	<p>Continued from page 37</p> <p>immobilizer likely caused the pressure ulcer which was located laterally and posteriorly on the Resident's left leg. She stated resident's wound would be unavoidable if the immobilizer could not be removed. The Wound Care NP stated if skin was observed every 12 hours, there would have been indication of deep tissue injury (purple coloration of the skin) which would continue to get worse over time. The Wound Care NP indicated Resident #5 had contributing factors for wound development, which included age, poor nutrition, the brace, and rotation of her left leg. The Wound Care NP explained that the wound could not have developed that amount of slough and wound debris in only 12 hours. The Wound Care NP said necrosis (tissue death) which was present in her wound would take at least a week to develop. The NP further stated the pressure ulcer was not likely caused by an acute injury like a laceration or puncture because there was no clean edging to the wound and there was no loose flappy tissue that she would have expected to see in an acute traumatic injury of the skin.</p> <p>A progress note dated 12/9/25 written by the Wound Care NP stated that Resident #5 had wound care on that date which involved sharp debridement of the wound. The note the medical grade honey (an enzymatic additive for wound treatment) has supported the autolytic debridement (is a process of wound management that uses the body's own defense mechanisms to remove non-viable tissue) of this wound. It was noted Resident #5 now had some loose slough tissue that could be removed. The wound was described as having no undermining or tunneling and was made up of 75% granulation tissue, 5% slough, 0% eschar, 0% non-granular tissue, 0% purple/maroon, 10% tendon, and 0% bone. There was a moderate amount of drainage, no odor and no pain. The recommendation was to continue offloading with the use of a pillow under the calf or use of offloading boot. Measurements prior to debridement were 3.6cm, 1.8cm, and .4cm (did not differentiate width, length, depth) and post debridement measurements were 3.6cm, 1.8cm, and 1 cm (did not differentiate width, length, depth).</p> <p>A progress note dated 12/16/25 written by the Wound Care NP stated that Resident #5 had wound care on that date which involved sharp debridement of the wound. The note stated the medical honey was on backorder at this time. There was some new purple areas on the distal aspect of the wound, likely pressure related. She wears an offloading boot while in bed. It did not appear to be hitting the wheelchair leg while up, but the staff will monitor for this. The wound was described as no</p>	F0686		

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F0686 SS = G	<p>Continued from page 38</p> <p>undermining or tunneling and was made up of 70% granulation tissue, 10% slough, 0% eschar, 0% non-granular tissue, 0% purple/maroon, 20% tendon, and 0% bone. There was a moderate amount of drainage, no odor and no pain. The plan was to continue offloading with the use of a pillow under the calf or use of offloading boot. Measurements prior to debridement were 3.8cm, 1.7cm, and 1cm (did not differentiate width, length, depth) and post debridement measurements were unchanged.</p> <p>A care plan interventions for Resident #5 was added on 12/21/25 that stated to obtain dietitian consult as needed/ordered, obtain skilled PT/OT evaluation to improve functional mobility, provide wound treatment as ordered, weekly wound assessment to include measurements and description of wound status, and observe for verbal and nonverbal signs of pain related to wound or wound treatment and medication as ordered.</p> <p>A new goal of 'healing wound', was added to Resident #5's care plan on 12/31/25 that stated the resident's wound / skin impairment will heal as evidence by decrease in size, absence of erythema (redness) and drainage and /or presence of granulation (new tissue growth) for 90 days. A care plan intervention of heel suspension device donned on left foot was added on 1/7/26 for Resident #5.</p> <p>A progress note dated 1/12/26 written by the Wound Care NP stated that Resident #5 had wound care on that date which involved sharp debridement of the wound. The note stated much of the tendon was covered with granulation tissue and had filled in. There was still some tendon exposed on the proximal edge. The wound was described as no undermining or tunneling and was made up of 75% granulation tissue, 5% slough, 0% eschar, 0% non-granular tissue, 0% purple/maroon, 10% tendon, and 0% bone. There was a moderate amount of drainage, no odor and no pain. The plan was to continue offloading with the use of a pillow under the calf or use of offloading boot. Measurements prior to debridement were 1.95cm, .89cm, and .4cm (did not differentiate width, length, depth) and post debridement measurements were unchanged.</p> <p>A review of 'Skin Issue' documentation dated 2/9/26 (no time stamp), written by the DON revealed the pressure ulcer was 'Improving: overall wound characteristics improved'. The measurements of the wound were length</p>	F0686		

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F0686 SS = G	<p>Continued from page 39 1.25cm, width 0.42cm, depth 0.2cm, and area 0.38cm.</p> <p>A care plan intervention for Resident #5 was added on 2/22/26 for a pressure reducing mattress.</p> <p>During an interview on 2/24/26 at 3:45PM, the DON revealed she was also the main wound care nurse for the facility and does the majority of the wound care during the weekdays.</p> <p>During a follow up interview with the Wound Care NP on 3/13/26 at 9:09AM, she revealed that when she debrided the wound for the second time on 12/9/25 she thought the wound was 'still evolving' and that it took a couple of attempts to get all of the necrotic tissue off. She stated she relied on the enzymatic process (dressing changes that use enzyme focused debridement) as well, to help facilitate with debridement of Resident #5's wound. She acknowledged that she also debrided the wound a third and fourth time (on 12/16/25 and on 1/12/26) to continue to remove slough tissue.</p> <p>A review of the Wound Care NP's progress note dated 3/3/26 at 9:45PM revealed that the wound was healed. The directions stated to apply silicone bordered foam to intact scar, change dressing weekly for 1-2 weeks, and to continue offloading with the use of a pillow under the calf or use of offloading boot.</p> <p>An interview was conducted on 02/25/2026 at 4:08PM with the Director of Rehabilitation and PTA #1. They both recalled working with Resident #5 and stated she had a left leg immobilizer but that neither of them recalled working with her immobilizer, they said because it was discontinued shortly after starting PT and that another PTA usually worked with Resident #5 (PTA #2). PTA #1 said she focused more on the upper body, and the Director was a speech therapist. PTA #1 did recall when other staff worked with the resident, at times the immobilizer had to be adjusted because it would work its way down the leg with therapy activities. She explained that with the thigh being larger than the lower leg, gravity would tend to make the immobilizer slide down some. PTA #1 recalled when Resident #5 first arrived at the facility, the immobilizer was always on. They were made aware of the wound to left lower leg by nursing department after it had developed. They said they did not ever see her skin under the immobilizer as this would require them to remove her pants.</p>	F0686		

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F0686 SS = G	<p>Continued from page 40</p> <p>On 02/26/2026 at 10:42 AM an interview and observation was conducted with PTA #2. PTA #2 was familiar with Resident #5, and he indicated it was typical for him to work with someone with an immobilizer on. PTA #2 stated it was common for this type of immobilizer to slide down the leg with therapy, and he observed this when he worked with Resident #5. He said he would typically feel the 4 points on the immobilizer to check for appropriate tightness. At no point did Resident #5 indicate pain or did he see any indication of a developing wound. PTA #2 explained that he saw no exudate (drainage) on the resident's clothing and no wound on visible skin. He said he did not fully check Resident #5 skin because he would have had to remove her pants. PTA #2 could not recall what type of immobilizer the resident had but it was the type that did not bend. He said it was a 'cheaper' model and believed it had 2 hard bars that ran on each lateral side of the immobilizer. If worn properly, PTA #2 did not think the immobilizer would have caused a wound where it was located. Upon observation with PTA #2, of Resident #5's room, revealed no immobilizer present. PTA #2 stated he thought the family took it home.</p> <p>A telephone interview was conducted on 03/06/36 at 4:20PM with a Representative of the immobilizer provider and revealed the immobilizer had 3 aluminum 'stays' which were support rods sewn into the immobilizer. She explained there was one contoured aluminum rod that ran along the length of the back of the leg and then 2 straight rods, that each ran along the left and right side. She stated there was no guidance provided for checking skin integrity under the immobilizer, as that would be up to the prescriber to determine. The Representative indicated if not worn correctly, the immobilizer could possibly cause injury. She explained the pamphlet stated contraindications for the immobilizer included 'Patients with poor peripheral circulation, diabetes, or decrease in skin sensitivity should not use a knee immobilizer.' The pamphlet also included that the knee immobilizer should fit generally 2 inches above the ankle bone and 2 inches below the groin. Any longer could result in abnormal wear and skin pressure.</p> <p>An observation and interview was obtained on 3/13/26 at 1:10PM of Resident #5's pressure wound to her lower left leg. The DON removed a boarder foam dressing from the wound and it was noted to have 2 pin-point areas of red blood on the surface, otherwise it was dry with</p>	F0686		

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F0686 SS = G	<p>Continued from page 41 some flakey skin on it. The wound itself looked dry and healed without any active bleeding or drainage visible. There remained some slight depth and scarring to the healed wound bed. The DON stated that she thought the spots on the dressing were just 'scabby bits' and not blood and stated that they were only using a dressing now to protect the area, but that it had been healed since 3/3/26.</p> <p>During an interview with the DON on 02/27/26 at 1:20 PM she revealed she believed the staff were making observation of Resident #5's skin integrity and that nothing could have been done to prevent the wound from occurring.</p> <p>An interview was conducted with the Physician on 02/26/2026 at 2:31PM. The Physician stated he was familiar with Resident #5 and that her wound had developed quickly. He indicated the orthopedic office had 'pretty strict orders not to remove that brace' and initially he did not recall that there was an order to check Resident #5's skin twice a day. The Physician stated he would expect if the skin was observed twice a day, the staff should have seen the wound. The Physician said that he thought the immobilizer had a securement that went around the leg at 4 separate points and he was thinking that the bottom securement was the one that caused the wound. He said that he could not remember the type of immobilizer Resident #5 had, but if the immobilizer was positioned on Resident #5 incorrectly, this could have caused the wound in the location it was at. The Physician stated he thought it would have had to have been causing pressure for a day or 2 before it would 'get like that' (meaning a stage 4 pressure ulcer). He said he had not seen a wound like Resident #5's occur with only 12 hours uninterrupted pressure. The Physician indicated he had seen Resident #5 before the wound occurred and he never saw any indication of a wound. The Physician further stated, "but then again, I never took the brace off, so I wouldn't have." He said initially that he felt the Resident's wound was unavoidable but then went on to say that the more he thought about it, he wondered if something traumatic occurred and that could be why it got so bad so quickly. The Physician indicated he wondered about this because he had never seen a pressure ulcer look that bad in only 12 hours and that he could expect that it would have been more like 48 hours to look like that. That was why he thought possibly "it was something else that could have caused it like the hard part of the brace cutting into her when staff moved the leg brace or something." The</p>	F0686		

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F0686 SS = G	Continued from page 42 Physician confirmed Resident #5 was on a blood thinner and that there would likely be bleeding present if an acute injury had happened, unless the brace was on tight, which would limit the bleeding. He stated that staff would likely see blood present on the brace or bed, but staff also should have seen drainage from a pressure ulcer too. The Physician viewed a picture of the Resident's wound taken by the DON on 11/13/26 and stated there would not be the amount of slough tissue present initially with an acute injury but stated over time this could develop. He clarified 'over time' to mean a day or two. The Physician said that staff were expected to follow the Physician orders, but that if they did not follow the orders, he couldn't help that. A follow-up interview occurred on 02/26/2026 at 4:49 PM with the Physician and revealed he thought Resident #5's pressure ulcer could have developed when staff got the resident up to a Geri-Chair, which could have caused a deep bruise and opened up a few days later. He stated staff would not necessarily have been able to see a deep bruise because sometimes it took a couple days.	F0686		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of 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	F0761	F 761 Medication Storage 1. Oral medications were removed from the bedside of resident #7 by nurse #2 on 2/24/2026. Resident #7 stated he was not taking them. The medications were accounted for by Nurse #2 and disposed of since they had been left unattended. 2. An audit was completed on current resident rooms in the facility on 3/29/26 by the Nursing Supervisor to ensure no medications are being stored at the bedside. Any medications found at the bedside were removed immediately and the assigned nurse was provided education/coaching. 3. Education was initiated on 3/31/26 by Nurse Practice Educator for all licensed nurses to include (Full-time, Part-time, PRN and Agency) on following the Policy and Procedure for Medication Administration Policy, medication storage, refusals and following physician orders for medications left at bedside. Any licensed nurse (Full-time, Part-time, PRN, and Agency) that cannot be reached within the initial reeducation time frame of 24 hours will not take an assignment until they have received this reeducation by the Director of Nursing/ designee. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation period by the Director of	04/08/2026

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F0761 SS = D	<p>Continued from page 43 systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, record review and resident, staff and Physician interviews, the facility failed to secure medications stored at the bedside for 1 of 1 resident reviewed for medication storage (Resident #7).</p> <p>The findings included:</p> <p>Resident #7 was admitted to the facility on 6/25/25.</p> <p>A review of Resident #7's physician's orders dated 6/25/2025 revealed an order that stated, Resident may not administer his own meds.</p> <p>A review of Physician's order dated 6/25/25 for Resident #7 revealed that staff were to monitor swallowing during medication pass and to document if resident coughed, complained of pain, or demonstrated difficulty when swallowing meds.</p> <p>An observation and interview were conducted on 2/24/26 at 2:50PM with Resident #7 in his room. It was observed that he had a medication cup containing 7 pills sitting on his bedside table. Observation of the hallway outside of resident's room revealed the nurse for this hallway (Nurse #2) was no longer passing medications on the hallway. Resident #7 said he would take his medications in the cup, "when they let me out of this place."</p> <p>An interview was then conducted on 2/24/26 at 2:55PM, in Resident #7's room with Nurse #2 (nurse assigned to the 100 hallway). She stated the medication cup contained different medications and named them. Nurse #2 indicated they were Resident #7's lunch "meds" (medications) which she gave him at approximately 1:30PM. Nurse #2 stated, 'He usually takes them.' Nurse #2 then asked Resident #7 if he would take the medication and resident refused stating, "I will take them when I get up outta here" and he did not take the medication. Nurse took the med cup with her out of the resident's room and walked back to the staff breakroom.</p> <p>In a continued interview and observation on 2/24/26 at 2:58pm, outside of Resident's room, Nurse #2 explained she would typically administer Resident #7's medications to him, by just handing them to him to take and he would take them. She went on to say that in this case, he told her he would take them so she trusted that he would do that. Nurse #2 stated this was a lapse</p>	F0761	<p>Continued from page 43 Nursing/designee.</p> <p>4. Director of Nursing, Assistant Director of Nursing, and Nurse Manager/designee will audit 5 random nurse medication passes three times per week x 4 weeks to monitor for nurse staying with resident during administration and medications not left at bedside, then 3 random nurse medication passes two times weekly x 4 weeks, then 5 random nurse medication passes weekly x 4 weeks. The Director of Nursing will report the findings of the audits to the monthly Quality Assurance and Performance Improvement (QAPI) Meeting to ensure compliance x 3 months. The QAPI committee is responsible for ongoing compliance.</p> <p>5. Date of Compliance: 4/08/26</p>	

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F0761 SS = D	<p>Continued from page 44 in her judgement and she should not have left them in there because he didn't take them. She said she was aware that he was not supposed to have his medications left at bedside as well as the order to monitor swallowing during medication pass and document if Resident #7 coughed, complained of pain, or demonstrated difficulty when swallowing medications.</p> <p>An interview was conducted on 2/26/2026 at 2:45PM with the Physician. He stated that he couldn't really speak to Resident #7 having his own meds at his bedside. The Physician did not recall initially that Resident #7 had an order that stated he was not permitted to administer his own medications, but stated, "Then he probably shouldn't." He indicated he did not feel like the pills in the cup would hurt Resident #7 to have them on his bedside table, but that he did know he was resistive to care at times. He said he did expect all physicians' orders to be followed by staff, but he can't always control what the staff did.</p> <p>An interview with the Director of Nursing (DON), conducted on 2/27/2026 at 1:14PM revealed that there was only one resident in the facility during the time of survey who had an order to administer their own medications. All other residents had orders that they may not self-administer medications. The DON stated that Nurse #2 should have stayed and watched Resident #7 take his medications and should not have left them at the bedside.</p> <p>Interview with the Administrator on 2/27/2026 at 1:23PM revealed that he was not aware that medications were left at the bedside of Resident #7. The Administrator stated he was not familiar with the resident, and he did not feel he could speak about the situation.</p>	F0761		
F0812 SS = E	<p>Food Procurement,Store/Prepare/Serve-Sanitary</p> <p>CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements.</p> <p>The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p>	F0812	<p>F812</p> <p>On 2/23/26, the dietary aide removed the scoop from the container of flour and hung it on the hook on the exterior of the container. On 2/23/26, the District Manager cleaned the underside of the steam table hood ensuring there was no orange, brown residue. On 2/25/26, the Dietary Manager removed the 20 wet plastic plate bases, rewashed them and ensured they were air dried before placing them back on the tray line.</p> <p>On 4/1/26), the District Manager, conducted an audit of the kitchen to ensure all serving scoops were properly stored on the exterior of containers, to ensure the bottom of the steam table hood was clean and maintained</p>	04/08/2026

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F0812 SS = E	<p>Continued from page 45</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation and staff interviews, the facility failed to store a scoop in a manner that prevented it from becoming contaminated by direct contact with flour, maintaining a clean steam table hood, and ensuring plastic plate bases were dried before being stacked for 2 of 2 kitchen observations. This deficient practice had the potential to affect food served to residents.</p> <p>The findings included:</p> <p>1. The initial tour of the kitchen was on 2/23/26 at 10:17 AM with the Dietary Manager. A large bin of flour was observed by the prep table with the scoop stored in the container of flour.</p> <p>The Dietary Manager was interviewed on 2/23/26 at 10:17 AM. The Dietary Manager asked a kitchen aide to remove the scoop from the flour. The Dietary Manager explained the hook to hang the scoop was inside the container and when the lid to the container slid to the closed position, it often knocked the scoop back into the flour.</p> <p>2. At 10:19 AM on 2/23/26, a continuation of the tour revealed the underside of the steam table hood contained orange, brown residue and felt slick to touch.</p> <p>The Dietary Manager was interviewed on 2/23/26 at 10:20 AM. The Dietary Manager confirmed the buildup, stating the steam table was cleaned between each meal but did not think the underneath of the hood had been cleaned "for a while."</p> <p>3. During a follow-up kitchen tour on 2/25/26 at 11:45 AM 20 out of 30 plastic plate bases were stacked wet on the tray line ready for use.</p>	F0812	<p>Continued from page 45</p> <p>in good repair and that all plastic plate bases were not stored wet and were properly air dried while on the tray line. No identified issues as a result of the audit.</p> <p>3. On 4/1/26, the District manager educated all current Dietary staff on proper storage of serving scoops, routine cleaning on the steam table hood between each meal and the process for air drying plastic plate basis prior to being placed on the tray line.</p> <p>4. The Administrator / Designee will conduct on-going audits of the kitchen area to ensure proper storage of serving scoops, to ensure the underside of the steam table hood is clean and to ensure plastic plate bases are properly air dried prior to being placed on the tray line 5 times per week for 4 weeks, 3 times per week x 4 weeks and weekly x 4 weeks. The Administrator will report the findings of the audits to the monthly Quality Assurance and Performance Improvement (QAPI) Meeting to ensure compliance x 3 months. The QAPI committee is responsible for ongoing compliance.</p> <p>5. Date of Compliance: 4/8/26</p>	

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F0812 SS = E	Continued from page 46 The Dietary Manager was interviewed on 2/25/26 at 11:50 AM. The Dietary Manager stated she had checked other dishware for dryness but had not checked the plastic plate bases. The Dietary Manager then removed the plastic plate bases, rewashed them, and ensured they were air dried, placing them back on the tray line. The Administrator was interviewed on 2/27/26 at 10:22 AM. The Administrator stated he did not know why the hood to the steam table was not clean or why the scoop was left in the flour, and he would want the kitchen staff to keep the kitchen clean and not leave the scoops in the bins. The Administrator also stated he would want all dishware clean and dry before placing it on the tray line.	F0812		
F0814 SS = D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interviews, the facility failed to keep the area around the trash compactor free from accumulated trash and debris for 1 of 1 trash compactor observed. This failure had the potential to attract pests and rodents. The findings included: An observation of the dumpster area occurred on 2/23/26 at 10:23 am with the Dietary Manager (DM). The observation revealed the facility had one trash compactor located in a fenced area behind the kitchen entrance. Directly in front of the trash compactor was a cement platform with a grassy area to the left side and back of the trash compactor. On the left side of the trash compactor in the grassy area there were four plastic bottles, six disposable cups, four disposable gloves, and seven straws. The DM was interviewed on 2/23/26 at 10:24 am. The DM explained the cement platform was cleaned weekly by a member of the kitchen staff but the trash and debris on the left side and back of the trash compactor did not get picked up. The DM stated she was not sure why the area was not attended to and commented that all departments in the facility used the same trash compactor. During an interview with the Administrator on 2/27/26 at 10:22am, the Administrator stated he did not know	F0814	F814 On 2/27/26, the Dietary Account Manager cleaned the trash and debris that was accumulated around the trash compactor in the facility parking lot. On 2/27/2026, the Maintenance Assistant conducted rounds of the entire exterior of the center to ensure no trash and debris was accumulated to ensure pests and rodents were not attracted. On (4/1/2026) education was completed by District Manager to all current staff, to ensure that when trash and debris is disposed of in the trash compactor that no trash or debris is present on the ground around the trash compactor. The Administrator or Dietary Manager will conduct ongoing audits of the trash compactor area 5 times per week for 4 weeks, 3 times per week x 4 weeks and weekly x 4 weeks to ensure no trash or debris is present around the trash compactor area. The Administrator will report the findings of the audits to the monthly Quality Assurance and Performance Improvement (QAPI) Meeting to ensure compliance x 3 months. The QAPI committee is responsible for ongoing compliance. Date of Compliance: 4/8/26	04/08/2026

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F0814 SS = D	Continued from page 47 why the trash compactor area had not been cleaned and explained he would want the area cleaned of any debris.	F0814		