STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345447	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Ridge Health and Rehabilitation	**25 Reynolds Mountain Boulevard , Asheville, North Carolina, 28804**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 03/30/26 through 04/09/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #22C4D1-H1.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/30/26 through 04/03/26. The following intakes were investigated: 2966290, 2963816, 2803948, 2786643, 2736195, 2657645, 2641580, 2602861, 2568427, 803054, 803038 and 803036. Intake# 2803948 resulted in immediate jeopardy. The survey team returned to the facility on 04/09/26 to validate the credible allegation. Therefore, the exit date was changed to 04/09/26. 9 of the 34 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.40 at tag F742 at a scope and severity (J) The tag F742 constituted Substandard Quality of Care. Immediate Jeopardy began on 02/06/26 and was removed on 04/06/26. An extended survey was conducted.	F0000		
F0742 SS = SQC-J	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain	F0742	Resident #101 was discharged for emergency services on 2/6/2026. On 2/6/2026 current residents with current or historical psychiatric and/or post-traumatic stress diagnoses, suicidal ideation, or self-harm behaviors were reviewed by Director of Nursing, Assistant Director of Nursing and Social Services to ensure that care plans were up to date and included any person-centered interventions needed to identify and prevent similar episodes. In addition, the review ensured all Resident with current or historical psychiatric diagnoses were receiving psychiatric	05/05/2026

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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F0742 SS = SQC-J	Continued from page 1 the highest practicable mental and psychosocial well-being; This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with staff, power of attorney (POA), Nurse Practitioners, Psychiatrist and Medical Director, the facility failed to ensure Resident #101, who was admitted on 1/26/26 following a stay at an inpatient psychiatric facility beginning on 1/9/26 for a severe episode of recurrent major depressive disorder with suicidal behavior with attempted self-injury, received the necessary treatment that was person-centered and individualized to meet her needs. The resident's psychiatric diagnoses included major depressive disorder, post-traumatic stress disorder (PTSD), bipolar disorder, and delusional disorders. The inpatient psychiatric facility's discharge summary included an order for antipsychotic medication (olanzapine) every night at bedtime. This order was inaccurately transcribed as a PRN (as needed) order and was administered once during the resident's stay at the facility. The Psychiatrist from the inpatient psychiatric facility indicated that olanzapine did not work as a PRN medication when utilized for depression or psychosis and if it was stopped on a person with bipolar disorder, their psychotic and mood symptoms would eventually come back. A care plan with individualized approaches that addressed the resident's prior suicide attempts and suicidal ideation was not developed in order to protect the resident from further suicidal behaviors. Multiple staff who worked with the resident were not aware of her history of suicide attempts, and a statement made by the resident that she would be better off dead than staying at the facility were not communicated to all staff or documented. On 2/6/26, Resident #101 was found by staff lying in bed with a safety razor in hand and blood on hands, wrists and abdomen with multiple shallow lacerations to bilateral wrists, bilateral antecubital (inner crook of the elbow) areas and right neck. Resident #101's eyes were half open and half closed and she was unresponsive to staff except for painful stimuli. She had labored breathing and bounding pulse. Resident #101 was transferred to the emergency department for evaluation. No lacerations required closure. Resident #101 was treated for urinary tract infection and was psychiatrically cleared and ready for placement in a non-psychiatric facility on 2/10/26. This deficient practice was for 1 of 1 resident reviewed for behavioral health services. Immediate jeopardy began on 2/6/26 when Resident #101, who had been admitted to the facility following	F0742	Continued from page 1 services routinely. The Director of Nursing/designee are performing an ongoing review of the psychiatric diagnosis(es) for Residents as well as the psychoactive medication order summaries for those Residents identified to be at risk. The order summaries will be compared to the most recent history and physical or psychiatric assessment to ensure the medications orders are transcribed into the records accurately. The nursing and direct care staff were educated on 4/28/2026 through 5/1/2026 regarding the need to identify other Residents who may be at risk as well as any updated interventions for the Residents who were considered to be at risk. The education included the importance of correct medication transcription and the need for monitoring all Residents for behavioral changes as well as monitoring rooms for hazards. The staff education regarding the identification of Residents at risk and accurate medication transcription for new staff will be provided during orientation. The Director of Nursing/Designee also will perform Quality Improvement Monitoring for to ensure Residents at risk are identified and medication transcriptions are correct five (5) X per week for four (4) weeks; three (3) time a week for four (4) weeks and then one (1) X week for four (4) weeks. Any interventions will be documented, reviewed, and corrected. Any interventions will be reviewed with the QAPI team for necessary revisions. The Director of Nursing/Designee introduced the plan during the monthly QAPI Committee meeting on 04/29/2026. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report the findings to the Quality Assurance Performance Improvement Committee during the regularly scheduled QAPI meetings. Alleged Date of Compliance: 05/05/2026	05/05/2026

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F0742 SS = SQC-J	Continued from page 2 a stay at an inpatient psychiatric unit precipitated by the self-harming behavior of superficial lacerations to her wrists, was not provided with the necessary behavioral health care to prevent the resident from obtaining a safety razor and making shallow lacerations to her bilateral wrists, bilateral antecubital areas, and right neck. The immediate jeopardy was removed on 4/6/26 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity (D – no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education was in place and monitoring systems that were put into place were effective. The findings included: A review of the History & Physical for Resident #101 dated 1/9/26 which was in Resident #101's medical record indicated the resident was a 65-year old female who was admitted to the inpatient psychiatric facility on 1/9/26 for inpatient psychiatric care. She initially presented to the Emergency Department (ED) from a skilled nursing facility with suicidal ideation and self-harming behaviors. She was evaluated by an ED medical provider and cleared clinically for psychiatric assessment, meeting criteria for inpatient admission. She had a history of bipolar disorder, hypertension, hyponatremia (abnormally low sodium levels in the blood), frequent falls and visual loss/blindness. The patient did have a history of 2 prior suicide attempts, one at age 29 and one in 2008. In 2008, she was discharged from a mental health and substance use treatment center on lamotrigine (prescription medication used to treat epilepsy and manage bipolar disorder) and quetiapine (prescription atypical antipsychotic medication) for presumed bipolar disorder. Patient reported no history of manic episodes. She reported some history of racing thoughts which she attributed to anxiety/PTSD (post-traumatic stress disorder), but no elevated mood or decreased need for sleep. Patient had spent most of her life not engaged in psychiatric treatment. She reported that she was doing okay until September when she fell in her trailer and broke her hip. While she was hospitalized for that in October, she began to lose her vision. She was scheduled for cataract surgery in December, but her surgery had to be canceled because she was hospitalized for severe hyponatremia. Her sleep and appetite had been poor. She has had intermittent passive suicidal ideation with active suicidal ideation for 2 days prior to admission. She said that currently she was "not depressed or suicidal, just tired and exhausted." Her	F0742		05/05/2026

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F0742 SS = SQC-J	Continued from page 3 weight had dropped from a baseline of 127 to 88 pounds. She felt isolated and lonely as her vision loss prevented her from connecting with people in the way she was used to. Her treatment plan included safety precautions, behavioral observation, group therapies and Occupational Therapy consult. Discussed medication options for depression, sleep and appetite in patient with questionable history of bipolar disorder. After talking with patient and her Healthcare Power of Attorney (HCPOA), the bipolar disorder seemed unlikely, and all were in agreement with a trial of mirtazapine (prescription tetracyclic antidepressant). Further review of Resident #101's History & Physical in her medical record indicated the following additional documentation from the inpatient psychiatric facility: On 1/10/26: Mirtazapine was discontinued due to patient reported inability to tolerate it by having chest discomfort and psychosis was becoming more prominent. On 1/11/26: Olanzapine 2.5 milligrams (mg) at bedtime was started for psychosis, mood stabilization, sleep and appetite stimulation. (Olanzapine is an atypical antipsychotic medication used to treat schizophrenia, bipolar disorder and sometimes depression; it works by balancing neurotransmitters in the brain to reduce hallucinations, delusions and severe mood swings.) On 1/12/26: She tolerated first dose of olanzapine. It was unclear if she was confused or paranoid and would be watched to clarify. On 1/13/26: She was still showing signs of paranoia and her olanzapine was increased to 5 mg at night. On 1/14/26: She was tolerating olanzapine, but still showing significant signs of psychosis. On 1/15/26: She continued to appear to have a psychotic depression. She refused medications last night. If she continued to refuse, may need to consider nonemergency forced medication protocol. Strongly encourage patient to be out of bed. On 1/16/26: Patient was taking olanzapine again and still with significant paranoia. On 1/17/26: She was taking medications, still very depressed, but less overt delusions. Strongly encouraged patient to be out of room/bed.	F0742		05/05/2026

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F0742 SS = SQC-J	Continued from page 4 On 1/18/26: She was depressed, but no evidence of delusions on this date. If she continued to improve, would start referral process back to SNF (skilled nursing facility). On 1/20/26: Patient reported that she was trying to spend more time outside of her room again. She did not express any delusional content and denied suicidal ideation, homicidal ideation and auditory verbal hallucinations. She did express some ambivalence about living, but acknowledged that her outlook may brighten after cataract surgery. She was in agreement with returning to SNF. On 1/21/26: No behavioral problems were reported. She had been cooperative with care. She tried to be very attentive to her hygiene and grooming as much as she could with her visual impairment. She denied suicidal ideation, homicidal ideation and auditory verbal hallucinations. She remains in agreement with plan for discharge to SNF rehabilitation. A review of the Discharge Summary from the inpatient psychiatric facility dated 1/26/26 for Resident #101 which was in her medical record at the facility indicated the following information: The reason for hospitalization was Resident #101, who had a history of PTSD, depression and bipolar disorder, presented with suicidal ideation and a superficial wrist abrasion from her nursing facility in the setting of visual loss and increasing weakness/falls. Resident #101's discharge diagnoses included severe episode of recurrent major depressive disorder without psychotic features, bilateral visual loss and suicidal behavior with attempted self-injury. The list of medications included olanzapine 5 mg disintegrating oral tablet every night at bedtime for mood symptoms for 7 days. The discharge summary was marked with a handwritten note that it was verified by Nurse Practitioner #1 on 1/26/26. A phone interview with the Psychiatrist from the inpatient psychiatric facility on 4/8/26 at 10:52 AM revealed Resident #101 was admitted to inpatient psychiatry on 1/9/26 for depression after she presented with superficial lacerations to her wrists. The Psychiatrist stated that Resident #101 was admitted to inpatient psychiatry at that time because she had made suicidal statements and suicidal gestures as evidenced by the lacerations on her wrists. He shared that they tried mirtazapine which she did not tolerate and she was still having psychotic thoughts even with this medication. The Psychiatrist stated at that time she was voicing thoughts about being afraid of getting arrested. The	F0742		05/05/2026

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F0742 SS = SQC-J	Continued from page 5 Psychiatrist stated he decided to discontinue mirtazapine and started Resident #101 on olanzapine which she complained of side effects as well, but they were mostly psychotic thoughts. Resident #101 eventually stayed with a low-dose olanzapine and PRN (as needed) trazodone (antidepressant that can be used for insomnia) for sleep when she was discharged to the facility. The Psychiatrist stated that at the time of discharge to the nursing facility, Resident #101 had perked up, was getting out of bed, engaging in group therapies and was consistently denying any suicidal thoughts. Resident #101 was admitted to the facility on 1/26/26 with diagnoses that included major depressive disorder, PTSD, bipolar disorder, delusional disorders and cataract. A review of Resident #101's medical record indicated a physician's order dated 1/26/26 for olanzapine disintegrating oral tablet (dissolves quickly in the mouth without water) 5 mg every 24 hours as needed (PRN) for mood for 14 days. This order was entered by Nurse #4. This PRN order for olanzapine did not align with the order noted on the inpatient psychiatric facility's discharge summary for scheduled olanzapine every night at bedtime. Resident #101 also had the following psychotropic medication orders: 1/26/26 – melatonin (a natural hormone that regulates your sleep-wake cycle) 3 mg every 24 hours PRN for sleep for 7 days 1/26/26 – trazodone hydrochloride 50 mg –every 24 hours PRN for sleep for 14 days During a phone interview with the Psychiatrist from the inpatient psychiatric facility on 4/8/26 at 10:52 AM, he verified that when Resident #101 was discharged to the facility she had an order for olanzapine 5 mg to be given at bedtime and not PRN. He explained that olanzapine did not work as a PRN medication for psychosis or any mood disorders. He stated that if olanzapine was stopped abruptly, there was a risk of losing the medication from the blood pretty quickly and it would stop being effective. He further explained that the half-life of olanzapine (which was the time when 50% of the active substance would be gone from the body) was after 21 hours so it would take about 3 to 4 days for the medication to be completely out of the system. He stated however that the effects would take a week or so for the medication to stop acting as a mood stabilizer. He explained that the half-life of the	F0742		05/05/2026

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F0742 SS = SQC-J	Continued from page 6 medication did not correlate with its effectiveness. The Psychiatrist further stated that olanzapine could be given PRN for anxiety or as a calming agent because of its sedating side effects, but it did not work as PRN for depression or psychosis. He also stated that if olanzapine was abruptly stopped on a person with bipolar disorder, the psychotic and mood symptoms would eventually come back. He shared that people with mood disorders had a cyclical response to antipsychotic medications and it depended on the nature of their psychosis and how fast they could cycle through it. People who had been stable long would take a longer time for their symptoms to come back if their antipsychotic medication was stopped. He stated that in Resident #101's case, she had not been stable long with olanzapine so it would take less time for her mood symptoms to come back. The Psychiatrist also stated that he was not seeing Resident #101 when her olanzapine was stopped at the facility but her experiencing recurrence of psychotic symptoms such as paranoia was likely due to stopping her olanzapine and changing it to PRN instead of scheduled. He further stated that since Resident #101 was not actively suicidal at the time of discharge to the facility, he would not necessarily recommend suicide precautions, and he was not aware of the protocols they followed at the nursing home. He said that at the psychiatric hospital, they checked for suicidality daily and they had protocols in place for residents who had active suicidal thoughts which included precautions to avoid access to razors or other sharp objects. A physician's order dated 1/26/26 for Resident #101 indicated Psychiatry as needed. An interview with Nurse #4 on 4/2/26 at 9:16 AM revealed she was the nurse who admitted Resident #101 to the facility on 1/26/26. Nurse #4 stated that she had just realized that she entered the order for olanzapine incorrectly after reviewing Resident #101's discharge instructions. Nurse #4 stated that she should have entered it to be given at bedtime routinely instead of PRN, and it was possible that she had looked at another medication order and got it confused with that. Nurse #4 stated that she knew Resident #101 came from a psychiatric hospital for attempting suicide by cutting her wrists from reading her discharge summary from the hospital. Nurse #4 stated that there were no suicide precautions implemented when Resident #101 was admitted. An interview with Nurse Practitioner (NP) #1 on 4/2/26 at 9:42 AM revealed she did not officially see Resident #101 on 1/26/26, but she had verified her	F0742		05/05/2026

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F0742 SS = SQC-J	Continued from page 7 discharge summary and medication list with a nurse on 1/26/26 prior to the resident's admission when the nurse read out all of Resident #101's medications to her over the phone. NP #1 stated Resident #101's olanzapine was supposed to be given every night at bedtime, but she extended it from 7 days which was originally in the discharge summary to 14 days. NP #1 stated that she wanted to make sure that Resident #101 did not run out of the antipsychotic medication before psychiatry could come and evaluate her. NP #1 stated if Resident #101 ran out of her olanzapine, she doubted if it would have changed anything because it was a low dose. NP #1 stated that she was not aware of Resident #101's olanzapine being transcribed as PRN instead of scheduled. She shared that the facility had recently changed their system of double-checking the admission orders and she did not know if that system was in place when Resident #101 was admitted to the facility. NP #1 stated that Resident #101 had a lot of mental health issues such as bipolar disorder, a prior suicide attempt, depression with psychotic features and suicidal ideation. A review of a progress note dated 1/27/26 in Resident #101's medical record by NP #2 indicated Resident #101 reported today that she was not having suicidal ideation/homicidal ideation. Discussed with her that behavioral health provider would be seeing her as well and helping with managing her olanzapine. Resident #101 reported that this medication made her "brain feel like a ping pong ball." Patient Health Questionnaire-9 (PHQ-9): The resident refused, "I don't want to answer those questions." (PHQ-9 is a 9-question, self-administered tool used by clinicians to screen for, diagnose and measure the severity of depression.) Continue olanzapine 5 mg by mouth at bedtime for 14 days. NP #2 indicated that behavioral health services were to follow Resident #101. No delusions were reported today. A phone interview with NP #2 on 4/2/26 at 3:27 PM revealed that because of Resident #101's history of prior suicide attempts, she asked her during her visit on 1/27/26 if she had any suicidal or homicidal ideations and Resident #101 answered no. NP #2 stated she could not give any more details about her visit except what were already indicated in her 1/27/26 note. NP #2 stated that she agreed with the olanzapine order from the inpatient psychiatric facility's discharge summary, and that she was not aware that it had been ordered as PRN in Resident #101's medical record. NP #2 further stated that this was an issue she had with the facility and that she had found errors with admission orders and	F0742		05/05/2026

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F0742 SS = SQC-J	Continued from page 8 medications multiple times before. NP #2 stated that she would have changed Resident #101's olanzapine if she had noticed that it was entered as PRN instead of scheduled. Resident #101's care plan initiated on 1/27/26 indicated Resident #101 was on antipsychotic therapy related to mood. The goal read: the resident will be/remain free of antipsychotic drug related complications. The interventions included: administer antipsychotic medications as ordered by physician, monitor behavioral symptoms and side effects, complete AIMS (Abnormal Involuntary Movement Scale) quarterly, dose reduction attempts per evaluation if clinically indicated and evaluate medication use and resident's response quarterly. Resident #101's care plan initiated on 1/28/26 indicated Resident #101 used antidepressant medication related to depression (history of suicidal ideation). The goal read: the resident will show decreased episodes of signs/symptoms of depression (suicidal ideation) through the review date. The interventions included: 15-minute checks times (x) 72 hours as needed, administer antidepressant medications as ordered by physician, monitor/document side effects and effectiveness every shift, educate the resident/resident representative about risks, benefits and the side effects and/or toxic symptoms, monitor/document/report as needed adverse reactions to antidepressant therapy and psychiatric consult as needed. There were no specific interventions related to suicide precautions. A review of an Initial History and Physical dated 1/28/26 by the Medical Director indicated Resident #101 had been initiated in physical therapy and occupational therapy. She reported that she was anxious to do all the therapy and wanted to improve her functional independence. She slept well overnight, denied any increased mood symptoms or suicidal ideation, and her appetite was stable. Resident #101 refused the PHQ-9 stating, "I don't want to answer those questions." Her psychiatric diagnoses included mood disorder with anxiety. No increased nervousness or depression were noted. She continued on olanzapine and trazodone which were recently initiated in the hospital when she had suicidal ideation. Will have behavioral health services continue to evaluate and treat. A review of a Pharmacy Consultation Report issued on 1/28/26 for Resident #101 indicated Resident #101 was recently admitted to the facility. The medication review process revealed the following	F0742		05/05/2026

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F0742 SS = SQC-J	Continued from page 9 discrepancies on the admission orders: hospital discharge summary listed olanzapine as routine but it was PRN x 14 days in the electronic medical record. A review of an Order Summary Report for Resident #101 dated 1/29/26 indicated an order for olanzapine disintegrating oral tablet 5 mg every 24 hours PRN for mood for 14 days. This order was started on 1/26/26 with an end date of 2/9/26. The report was signed by NP #2 on 1/29/26. Further phone interview with NP #2 on 4/2/26 at 3:27 PM revealed she signed off on the order summary report two days after she had already seen Resident #101, and she did not review the medication orders in Resident #101's medical record or check them against the inpatient psychiatric facility's discharge summary medication list. NP #2 stated that the order summary report was just a list of all current orders which she normally signed off on and reviewed after she had already visited the resident. A review of a Psychiatric Periodic Evaluation dated 1/29/26 by the Psychiatric-Mental Health Nurse Practitioner indicated Resident #101 was seen today at the request of staff. She was seen in her bed and had just completed therapy. She appeared to be calm and reported that she was feeling "okay." She reported that she had been sleeping okay and her appetite was good. When asked about any suicidal or homicidal ideation, she stated, "I have never had that." When asked why she was admitted to an inpatient psychiatric facility, she stated that she was just having a bad day. Discussed having any suicidal or homicidal thoughts currently and Resident #101 stated that she would never want to hurt anybody else. She denied any suicidal ideation. She stated that she felt safe at the facility. Resident #101 voiced several protective factors which she said prevented her from hurting herself. She reported that she was compliant with her medications. There were no acute changes in mood or mentation reported by staff. Resident #101's olanzapine 5 mg daily PRN for mood was to continue for mood lability (rapid, intense, and uncontrollable shifts in mood) or agitation. The Psychiatric-Mental Health Nurse Practitioner indicated she would reevaluate on next visit. A phone interview with the Psychiatric-Mental Health Nurse Practitioner (PMHNP) on 4/2/26 at 10:13 AM revealed she was familiar with Resident #101 and had seen her in September 2025 at a different long term care/nursing facility. The PMHNP stated that	F0742		05/05/2026

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F0742 SS = SQC-J	Continued from page 10 she knew Resident #101 had come from a psychiatric hospital after a suicide attempt from the other facility. She stated that she did not review the discharge summary from the psychiatric hospital, and she did not know that the olanzapine was ordered to be given at bedtime routinely. She added that she assumed it had been ordered as PRN from the psychiatric hospital. The PMHNP stated that during her visit on 1/29/26 with Resident #101, the resident had no hallucinations or delusions and had voiced no suicidal ideation. She shared that the psychiatric hospital had discharged Resident #101 because they had deemed her safe to be at the facility. She stated that she did not think the facility should have implemented any suicide precautions for Resident #101, and that one on one supervision was not a possibility at the facility. She further shared that her plan was to continue olanzapine PRN and evaluate on the next visit if she needed to order it routinely if they ended giving a dose to Resident #101. A review of the Trauma Informed Care Assessment dated 1/28/26 and completed by the Social Services Director for Resident #101 indicated on the PTSD Screen that Resident #101 had not experienced any of the events listed on the assessment. The events listed on the assessment were: a serious accident or fire, a physical or sexual assault or abuse, an earthquake or flood, a war, seeing someone be killed or seriously injured and having a loved one die through homicide or suicide. A review of PHQ – 2 to 9 assessment (a tool used to screen for depression) dated 1/28/26 and completed by the Social Services Director indicated Resident #101 reported feeling down, depressed or hopeless 7-11 days, feeling tired or having little energy 2-6 days and having poor appetite or overeating 7-11 days. Resident #101 answered “no” to the question about whether she had thoughts that you would be better off dead, or hurting yourself in some way. Resident #101 had a score of 5 which indicated mild depression. An interview with the Social Services Director on 4/9/26 at 11:28 AM revealed the trauma informed care assessment was part of the clinical assessments which were usually done on admission. The Social Services Director stated he or the admitting nurse usually completed this assessment. He shared that when he completed Resident #101’s trauma informed care assessment, he asked the questions in the assessment and Resident #101 answered “no” to all the events listed. The Social Services Director stated at the time of the	F0742		05/05/2026

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F0742 SS = SQC-J	Continued from page 11 assessment, he knew Resident #101 came into the facility with a diagnosis of PTSD, but he did not ask Resident #101 why she had this diagnosis. The Social Services Director stated that he did not know where the diagnosis of PTSD came from. He explained that residents who came in with a diagnosis of PTSD were always referred to psychiatry for further evaluation and treatment. The Social Services Director also shared that when he completed the PHQ-2 to 9 evaluation, Resident #101 specifically said “no” to the question about being suicidal. He further stated that Resident #101 told him that she was feeling down because she was in a nursing home, she was “blind,” and that she was supposed to have cataract surgery, but it got canceled due to her spending a lot of time in the hospital. The Social Services Director stated that he gave a referral to nursing to see if they could get an appointment with a local eye care center, but Resident #101 was not at the facility long enough for them to be able to follow up on it. A review of Resident #101’s Medication Administration Records (MAR) for 1/26/26 through 1/30/26 indicated PRN olanzapine 5 mg was administered one time on 1/30/26 at 11:03 PM by Nurse #2. There was no documentation in Resident #101’s medical record that indicated the reason for the administration of PRN olanzapine on 1/30/26 at 11:03 PM by Nurse #2. Attempts were made to interview Nurse #2, but they were unsuccessful. The admission Minimum Data Set (MDS) assessment dated 2/1/26 indicated Resident #101 was cognitively intact and had severely impaired vision. The MDS further indicated that Resident #101 reported feeling down, depressed or hopeless and had poor appetite or overeating 7 to 11 days over the last two weeks. Resident #101 also reported feeling tired or having little energy 2 to 6 days. Thoughts that you would be better off dead or thoughts of harming yourself was coded as never to 1 day. No behaviors or rejection of care were noted. Resident #101 did not have range of motion impairment to either upper or lower extremities and she used a manual wheelchair. She required supervision or touching assistance with oral hygiene, upper body dressing and personal hygiene. She required partial/moderate assistance with shower/bathing self, lower body dressing and putting on/taking off footwear. She required supervision or touching assistance with rolling left and right, sit to lying and lying to sitting on side of	F0742		05/05/2026

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F0742 SS = SQC-J	Continued from page 12 bed. She required partial/moderate assistance with sit to stand, chair/bed to chair transfer and walking 10 feet. The primary medical condition listed was major depressive disorder, single episode, severe with psychotic features. Other active diagnoses included bipolar disorder, psychotic disorder, PTSD and cognitive communication deficit. The MDS also indicated that Resident #101 received antipsychotic and antidepressant medications. On 2/3/26, the Director of Nursing (DON) signed the Pharmacy Consultation Report issued on 1/28/26 related to the discrepancy with the olanzapine being listed in the hospital discharge summary as scheduled but being entered as PRN for 14 days in the facility record. There was a handwritten note that read olanzapine changed to PRN by provider. An interview with the DON on 4/3/26 at 11:46 AM revealed she received the pharmacy recommendation on 2/3/26 which was issued to the facility on 1/28/26 about the olanzapine order. She stated she checked in Resident #101's electronic medical record on 2/3/26 and saw that it was ordered as PRN, so she assumed that it had been changed by the Psychiatric NP. The DON stated that she did not clarify with a provider about the olanzapine order. The DON stated that she misunderstood what the pharmacist was asking about in the recommendation. She stated that she thought the pharmacist was clarifying about having a stop date for the PRN olanzapine which was already in the orders for 14 days. The DON stated that her signature on 2/3/26 meant that she had reviewed the pharmacy recommendation and had addressed it on that date. The DON stated that she did not think about clarifying the olanzapine order with a provider, but she should have. She also stated that they were not doing any double checks on orders for new admissions, so they missed the discrepancy between what was ordered in the electronic medical record and the inpatient psychiatric facility's discharge summary order for olanzapine. An interview was conducted with Nurse #4 on 4/2/26 at 9:16 AM. Nurse #4 stated that Resident #101 often came out to the hallway and screamed or yelled for random things. Nurse #4 shared that Resident #101 could not see at all, so she was always yelling, "Where are you?" Review of the progress notes in Resident #101's medical record indicated daily documentation from 1/27/26 through 2/5/26 of Resident #101's mood being pleasant and no unwanted behaviors were witnessed.	F0742		05/05/2026

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F0742 SS = SQC-J	Continued from page 13 A phone interview with Nurse #6 on 3/31/26 at 3:28 PM revealed she took care of Resident #101 on the night shift, and she was always sleeping at night. Nurse #6 stated that on the morning of 2/6/26 around 6:00 AM, Resident #101 kept on going to other residents' rooms. Nurse #6 stated that one of the nurse aides went to get her out of the resident's room. Nurse #6 stated that she was not aware of any past suicide attempts, and she was not told about any suicide precautions for Resident #101. A phone interview with NA #6 on 4/3/26 at 7:21 AM revealed she usually worked with Resident #101 on the night shift. NA #6 stated that on the night of 2/5/26, Resident #101 was agitated, kept on getting out of bed and apologizing, but she did not specify what she was apologizing for. NA #6 stated that this was the only night she saw Resident #101 being agitated like that. Resident #101 normally just stayed in her bed and rang her call light if she needed to use the bathroom. NA #6 further stated that she did not remember Resident #101 yelling or hollering on the morning of 2/6/26. NA #6 stated that she had worked with Resident #101 and she had never made any statements about wanting to die or kill herself. NA #6 further reported that she was not aware of Resident #101's previous history of attempting suicide, and that she was not told about any kind of suicide precautions for Resident #101. Resident #101's MAR from admission on 1/26/26 through 2/6/26 revealed no monitoring and/or documenting of behaviors. A review of Resident #101's MAR for 1/31/26 through 2/6/26 indicated PRN olanzapine 5 mg was not administered. A review of a Change in Condition form for Resident #101 dated 2/6/26 at 8:47 AM and completed by Nurse #5 indicated the resident was found lying in bed with a safety razor in hand and copious amount of blood on hands, wrists and abdomen. Multiple shallow lacerations noted to bilateral wrists, bilateral antecubital areas and right neck. Resident #101 only responded to painful stimuli. Her respiratory rate was 30 per minute (normal 12 to 20 breaths per minute) and her oxygen saturation (measures the percentage of oxygen-saturated hemoglobin compared to total hemoglobin in the blood indicating how effectively red blood cells deliver oxygen throughout the body) was 88% (normal 95%-100%) on room air. She had labored or rapid breathing and shortness of breath. Resident #101 had altered level of consciousness and was unresponsive.	F0742		05/05/2026

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F0742 SS = SQC-J	Continued from page 14 Interventions included to call 911 for emergency medical transport. A phone interview with Nurse Aide (NA) #5 on 3/31/26 at 2:54 PM revealed on 2/6/26 when she was about to bring Resident #101's breakfast tray, she noticed that Resident #101's door was closed. NA #5 stated it was unusual for Resident #101's door to be closed because she normally kept it open and that she thought a staff member must have closed her door. NA #5 stated that she knocked and did not hear any answer. She stated that she opened the door and called Resident #101's name, but she did not respond. NA #5 went closer and she noticed that Resident #101 was shaking and her eyes were half open and half closed and her breathing wasn't normal. Resident #101 was shallow breathing, and she checked her pulse on the left side of her neck which was rapid. NA #5 stated that she noticed a cut on Resident #101's neck and then she pulled her cover and found a large amount of blood on her gown where she had cut her wrists. NA #5 stated that before this incident, she did not know that Resident #101 had a history of cutting herself, and that they were not told that she was on a suicide watch. NA #5 stated she did not know where or how Resident #101 obtained a razor and she never noticed one in Resident #101's basket. NA #5 explained that Resident #101 had a basket in her room where she kept personal items such as toothpaste, toothbrush and hair brush. She further reported that two nights before the incident, the night shift nurse aide (she could not remember which NA) had reported to her during shift change that Resident #101 had been up and all over the building, going in and out of other residents' rooms. NA #5 also stated that on 2/5/26, Resident #101 had asked her if she could go home with her. Resident #101 said to her that she did not feel safe at the facility, and she was making statements that maybe she would be better off dead than staying at the facility. NA #5 stated that she reported this to the Rehabilitation Director because his office was next door and he was available. NA #5 told the Rehabilitation Director that Resident #101 had concerns about not feeling safe at the facility. An interview with the Rehabilitation Director on 3/31/26 at 4:07 PM revealed on 2/5/26, he talked to Resident #101 for about an hour because NA #5 reported to him that Resident #101 voiced concerns about not feeling safe at the facility. Resident #101 was very anxious about everything. Resident #101 could not see very well so she was paranoid, thinking that people were walking into her room and not saying anything to her. The Rehabilitation	F0742		05/05/2026

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F0742 SS = SQC-J	Continued from page 15 Director stated that he never saw anything concerning during his talk with Resident #101. He stated that he thought because of her lack of vision, she was afraid of people taking advantage of her, and Resident #101 reported that the staff would whisper and leave without talking to her. Resident #101 was calm and collected when he talked to her and said nothing about wanting to harm herself or wishing she would die. The Rehabilitation Director further stated that he had heard from Resident #101 that she wanted her facial hair removed, so nursing might have tried to help her with that. He stated that he did not know about Resident #101's prior suicide attempt and that there were no suicide precautions in place for her. An interview with Nurse #5 on 3/31/26 at 3:55 PM revealed she was getting ready to start her morning medication pass on 2/6/26 when NA #5 alerted her to come to Resident #101's room. Nurse #5 stated that Resident #101 was not responding even when she called her name a few times. Nurse #5 explained that Resident #101 had her hands crossed and were resting on top of her abdomen with a safety razor still in her hand. She stated that there was a big bloody spot on Resident #101's gown which measured approximately 4-5 centimeters. Nurse #5 stated that she hollered for the Treatment Nurse who was out in the hallway. They put pressure on her wounds. Resident #101 had cut both wrists and antecubital areas. Nurse #5 stated that the lacerations were shallow, but it looked like she made a lot of attempts to cut herself. Nurse #5 stated that she did not check Resident #101's blood pressure because she did not want to exacerbate the blood loss from her wounds, and she could not recall what her (the resident's) pulse rate was, but she remembered her pulse being rapid. Nurse #5 added that Resident #101 also had a shallow cut on her neck which looked like a nick and had dried blood. The Treatment Nurse came in with some dressings which they applied to both wrists for pressure. She had NA #5 call 911 and EMS (emergency medical services) was at the facility within 10 minutes. Nurse #5 stated that she did not know how Resident #101 obtained the razor, whether she got it during a shower or if somebody thought she could shave herself and gave her one or if she wandered around and took it from somewhere inside the facility. Nurse #5 stated that NP #2 told her that Resident #101 had attempted suicide at her last facility, but she was not on any suicide precautions. A follow-up interview with Nurse #5 on 4/2/26 at 12:10 PM revealed Resident #101 had one small cut on her neck, 3 to 4 attempts from a 3-blade razor on	F0742		05/05/2026

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F0742 SS = SQC-J	Continued from page 16 both antecubital areas and her wrists were almost completely skinned. Nurse #5 stated that was what she meant by skinned was that it looked like Resident #101 had taken the top of the skin off from both wrists. An interview with the Treatment Nurse on 4/2/26 at 8:09 AM revealed she was working on the morning of 2/6/26 when Resident #101 had cut both wrists. The Treatment Nurse stated that when she got in the room, she noted that Resident #101 had a bloody spot on top of her gown which was about 4 to 5 centimeters. Resident #101 had cut both wrists, both antecubital areas and she had a spot on the right side of her neck with dried blood. Resident #101 was pale in color, had bounding pulse (strong, forceful or throbbing sensation felt in the arteries) from her carotid artery and looked like she was in shock. The Treatment Nurse stated that Resident #101 wasn't talking at first, they had to do a sternal rub on her, and it took one minute to get her to wake up. She remembered Resident #101 asking them why they were holding pressure on her wrists and they told her they were trying to stop the bleeding. Resident #101 stated, "Why? I don't want to live." They continued to hold pressure and got the bleeding to stop. EMS took over when they arrived at the facility and transported her to the hospital. The Treatment Nurse further stated that a few nights before the incident, Resident #101 was up and down the hall, wandering down the hall in her wheelchair, yelling and trying to go in other residents' rooms. The Treatment Nurse shared that she was aware of Resident #101's prior suicide attempt because NP #2 told her that Resident #101 had attempted suicide at her last facility and she had also read Resident #101's discharge summary. She stated that there were no suicide precautions in place for Resident #101. A review of the hospital records dated 2/6/26 through 2/17/26 indicated Resident #101 was seen at the Emergency Department on 2/6/26 for superficial abrasions and lacerations to the bilateral wrists and flexor creases of the elbow, slight superficial laceration of the right side of the neck, nothing requiring suturing, no deep lacerations, and neurovascularly intact distally (no nerve damage or circulation problem beyond the injury specifically hands/fingers). On 2/9/26, Resident #101 was diagnosed with urinary tract infection (UTI) and was more confused with some fluctuations of her orientation. She denied suicidal thoughts. She denied any depression and could not explain why she cut herself. She was started on antibiotics for UTI and on 2/10/26 and Resident #101 was	F0742		05/05/2026

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F0742 SS = SQC-J	Continued from page 17 psychiatrically cleared and ready for placement in a non-psychiatric facility. She was discharged home on 2/17/26. An interview with MDS Coordinator #1 on 4/2/26 at 8:47 AM revealed she did not think the superficial wrist abrasion in Resident #101's discharge summary from the inpatient psychiatric facility were self-induced. MDS Coordinator #1 stated that she did not notice suicidal behavior with attempted self-injury on the discharge summary and if she did, she would have possibly included in her care plan to monitor for symptoms of suicidal ideation and to identify if Resident #101 had a plan to harm herself. MDS Coordinator #1 stated that she did not know that Resident #101 had attempted to "slit her wrists" before at another facility. MDS Coordinator #1 stated that she thought Resident #101 had been in the psychiatric hospital for suicidal ideations but no actual self-harm. She further stated that Social Services usually did the behavior and trauma assessments and was was also responsible for the care plans on those areas. A phone interview with Resident #101's POA on 3/31/26 at 1:06 PM revealed a nurse called her on 2/6/26 and notified her about Resident #101 being sent to the hospital. The POA stated that the nurse told her that Resident #101 had been given a razor and had cut herself. Resident #101's POA stated that this was Resident #101's third record suicide attempt, and she did the same thing at the previous facility she was in. She stated that she was not aware that Resident #101 had a diagnosis of PTSD, and she did not know where and why she was diagnosed with this condition. A phone interview with the Assistant Director of Nursing (ADON) on 3/31/26 at 1:55 PM revealed staff notified her on 2/6/26 after they found Resident #101 with cuts on the right side of her neck and both arms. The ADON stated that they found a regular safety razor in her hand, but no one knew how she obtained the razor. The ADON stated that Nurse #6 had reported to her (the ADON) that Resident #101 had been wandering around the building the night before. The ADON also stated that Resident #101 had told the nursing staff that she was going to die after she had cut her wrists. The ADON stated that she did not know Resident #101 had made a suicide attempt at a previous facility, and the nursing staff was not aware that Resident #101 was not supposed to have a razor in her room. The ADON stated that Resident #101 should not have had a razor in her room because she had made a previous attempt to cut her wrist at a previous	F0742		05/05/2026

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F0742 SS = SQC-J	Continued from page 18 facility. The ADON stated she thought Resident #101 was at the facility for failure to thrive, and that Resident #101 was not on any suicide watch. A phone interview with the Medical Director on 4/1/26 at 12:10 PM revealed Resident #101 was appropriate to be at the facility, and they could not refuse to admit her. The Medical Director stated that if Resident #101 was saying that she had no suicidal ideation, she would not be admitted to a psychiatric facility. She stated that she remembered speaking to staff about what had happened to Resident #101 when she cut her wrists and in her experience, if a resident said that they were going to kill themselves, they were going to do that. The Medical Director stated that they could not have prevented Resident #101 from harming herself. She further stated that she did not think Resident #101 should have been on suicide precautions, and that it would not have been appropriate to have somebody sitting with Resident #101 twenty-four hours a day because that would be an invasion of her privacy. An interview was conducted with Nurse Practitioner (NP) #1 on 4/2/26 at 9:42 AM. NP #1 stated that she walked in Resident #101's room one time because her call light was on, and she helped her to the bathroom. NP #1 stated at that time, she did not see anything concerning for Resident #101 to require suicide precautions. NP #1 further stated that she did not think Resident #101 was at the facility long enough for them to evaluate her for potential suicide intent. An interview with the DON on 4/1/26 at 2:26 PM revealed she came into the facility shortly after the incident involving Resident #101 and they had already taken her to the hospital. The DON stated that she was aware of her (the resident's) history of suicide attempts, but Resident #101 was not on any suicide precautions. The DON stated there was no formal education for staff about Resident #101's history, but she assumed the nurses and nurse aides passed on this information in their report. The DON stated that she found out that Resident #101 had a previous suicide attempt prior to coming to the facility after Resident #101 had already been admitted. The DON stated that Resident #101 had already been accepted for admission before they even found out about her history of psychiatric disorders. The DON shared that they had psychiatry see her and she denied any suicidal ideation at the hospital. The DON stated that she investigated how Resident #101 got the razor, but every staff member she talked to denied having given it to the resident. She reported that she had not heard from staff about	F0742		05/05/2026

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F0742 SS = SQC-J	Continued from page 19 statements that Resident #101 wanted to die or kill herself, but staff were supposed to report this to the nurse and if the resident said this to a nurse, the nurse should have reported it to her (the DON). The DON further reported that all she knew was that Resident #101 had denied any suicidal ideation. The DON stated at the time of Resident #101's admission, she thought the Nurse Practitioner was reconciling the medications with the discharge summaries to make sure the orders were entered correctly because NP #2 signed off on the order summary reports. She added that she did not know that NP #2 was not doing any checks. An interview with the Administrator on 4/2/26 at 12:13 PM revealed the problem with Resident #101's discharge summary from the inpatient psychiatric facility was that it only indicated that she had an abrasion. The Administrator said that the discharge summary did not say that Resident #101 used a sharp object to cause the abrasion on her wrist, and that it would have been helpful had the hospital let them know that Resident #101 had used a sharp object. The Administrator stated that they obtained the discharge summary after Resident #101 was already in the facility. The Administrator stated that Resident #101 had a care plan for 15-minute checks as needed but she was never placed on 15-minute checks because as far as she knew, the resident had always denied any suicidal ideation. The Administrator stated she won't deny that she often heard from residents about being better off dead than staying at the facility and when this was reported to the Rehabilitation Manager on 2/5/26, it was possible that he might have thought it was a situational comment because they often hear from residents that they did not want to be here. The Administrator stated that Resident #101 was probably given a razor by a nursing staff member after she requested to shave her facial hair. She shared that she investigated the incident but was not able to pinpoint who gave Resident #101 a razor. The Administrator further stated that it was unfortunate that the incident involving Resident #101 happened, but she did not know what else they could have done, and she maintained that they did everything they could to keep Resident #101 safe. She also stated that she was not aware that Resident #101's olanzapine was not given as ordered, and that it should have been transcribed accurately when she was admitted to the facility. The Administrator was notified of immediate jeopardy on 4/2/26 at 12:26 PM. The facility provided the following credible allegation	F0742		05/05/2026

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F0742 SS = SQC-J	Continued from page 20 of immediate jeopardy removal: *Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and The Nurse assigned to the skilled unit on 2/6/2026 identified Resident #101 as having suffered a serious adverse outcome related to the failure to provide appropriate treatment and services for mental and psychosocial well-being. Resident #101 was provided immediate first aid by the attending Nurse. The Nurse then assigned a nursing assistant to provide continuous supervision and proceeded to contact 911 for an ambulance. The Nurse contacted the Director of Nursing who in turn notified the Executive Director. Resident #101 was then transferred to the emergency department via Emergency Medical Services (EMS). On 2/6/2026 current residents with current or historical psychiatric diagnoses, suicidal ideation, or self-harm behaviors were reviewed by Director of Nursing, Assistant Director of Nursing and Social Services to ensure that care plans were up to date and included any person-centered interventions needed to identify and prevent similar episodes. In addition, the review ensured all Resident with current or historical psychiatric diagnoses were receiving psychiatric services routinely. During the time period noted for the IJ removal (2/6-2/9/2026), a transcription error had not been identified by the facility. The Medical Director/Designee verifies the orders active on the MAR on or about the 1st of every month. The Director of Nursing and Assistant Director of Nursing reviewed the psychoactive medication order summaries for the Residents identified to be at risk on 4/5/2026. The order summaries were compared to the most recent history and physical or psyche assessment to ensure the medications orders were transcribed into electronic medication record accurately. The nursing and direct care staff were educated on 2/6-2/09/26 regarding the need to identify other Residents who may be at risk as well as any updated interventions for the Residents who were considered to be at risk. The education included the need for monitoring all Residents for behavioral changes as well as monitoring rooms for hazards. On 2/6/2026, the Executive Director instructed the interdisciplinary team (IDT) to monitor Resident behaviors and observe Resident rooms for hazards during the mock survey rounds completed weekly. The mock survey rounds are reviewed during the morning stand up meeting, On 2/9/26, the Director of Nursing and Assistant Director of Nursing reviewed	F0742		05/05/2026

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F0742 SS = SQC-J	Continued from page 21 the medication regime for the Residents with the potential to be affected to ensure the medication orders were correct. *Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. On 2/6/2026 the Director of Nursing and Assistant Director of Nursing provided education to the nurses and direct care staff regarding the sharps policy to include giving disposable razors to Residents without supervision, regardless of mental status. The education included a review of the protocol for residents stating or alluding to the fact that they want to harm themselves. Staff were instructed to immediately notify the nurse on the hall. The nurse on hall will alert Director of Nursing and/or Assistant Director of Nursing who will provide guidance for immediate intervention and place an emergent referral with the psych services provider for assessment. New Residents with a psychiatric diagnosis or who are receiving psychotropic medications are referred to Psychiatric services for follow-up upon admission. In addition, should a Resident develop new or exacerbated behavioral changes, psych services are contacted for a consult. Also, on 4/4 thru 4/5/2026 the Director of Nursing and Assistant Director of Nursing provided education to the nursing staff regarding accurate medication transcription. The electronic administration record includes a behavior monitoring chart requirement when a Resident is receiving psychotropic medications. This requires the nurse to document behaviors as part of the electronic medical record. On 2/9/2026 the Director of Nursing and Assistant Director of Nursing implemented a new process related to a 2-nurse medication reconciliation along with post order entry cross check with the provider to ensure that discharge summary orders were transcribed correctly. This will be completed on all new admissions and readmissions effective 2/9/2026. On 2/9/2026 licensed nurses were educated on this process by the Director of Nursing and Assistant Director of Nursing. The Assistant Director of Nursing reviewed the current nurse roster to ensure all nurses received the education. Newly hired licensed staff after 2/9/2026 will be provided with this education during the nursing section of the new hire orientation process. The Executive Director has assigned the DON/Nursing Admin designee to be responsible for the clinical portion of new hire	F0742		05/05/2026

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F0742 SS = SQC-J	Continued from page 22 orientation. Effective 02/09/2026 the facility Interdisciplinary team will review all new admissions and readmissions during the morning clinical meeting to ensure that the baseline care plan completed by the admitting nurse includes care planning for residents with suicide risk. The IDT review includes validation of carry over to the nursing assistant Kardex located on the electronic medical record documentation tablet for nursing assistants. The Kardex information is also in a printed version located at the nursing stations. The Director of Nursing/Nursing Admin designee have ensured that the staff nurses were made aware of their responsibility to implement the admission baseline care plan since CMS added this parameter to the charting requirements. The baseline care plan responsibility is also a part of the new hire training for nurses which is completed by the Director of Nursing/Nursing Admin designee. After the baseline care plan is developed, the IDT takes on the responsibility for care plan and Kardex updates as well as the responsibility to inform the nurses and nursing assistants. Ancillary staff to include, but not limited to activities, therapy, housekeeping/laundry as well as other staff members who interact on a regular basis with the Residents are asked to report behavior and other mood changes or comments of a hopeless nature to the nurse for follow up. While there are numerous staff who are not on a “need to know basis” regarding the care plan, these staff members often have daily interactions with Residents and can recognize inconsistencies in mood and behavior. Each ancillary department manager is a member of the IDT and is responsible for alerting their staff to Resident care plan updates as indicated, as well as the importance of reporting behavioral changes noted and/or references made regarding self-harm or hopelessness. The IDT consists of the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Managers, Social Services Director, Minimum Data Set (MDS) Nurses, as well as all ancillary department managers. Immediate Jeopardy Removal Date: 04/06/2026 A credible allegation validation of mental health services was conducted in the facility on 4/9/26. Record review included the facility reviewed all current residents with current or historical psychiatric diagnoses, suicidal ideation or self-harm behaviors to ensure their care plans were up to date and included person-centered interventions and were receiving psychiatric services routinely. The residents’ psychoactive medication order summaries	F0742		05/05/2026

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F0742 SS = SQC-J	Continued from page 23 were also reviewed and compared to the most recent history and physical or psychiatric assessment to ensure the medication orders were transcribed accurately. The in-service training records indicated that all staff including nursing, housekeeping/laundry, activities and therapy staff had been educated on monitoring all residents for behavioral changes as well as monitoring rooms for hazards, and immediately notify the nurse on the hall about any resident stating or alluding to the fact that they want to harm themselves. Nurses were educated about alerting the Director of Nursing and/or Assistant Director of Nursing of any reports of residents having suicidal ideation for immediate intervention and an emergent referral with the psychiatric services provider for assessment. Nurses were also educated on accurate medication transcription including 2-nures medication reconciliation along with post order entry cross check with the provider and setting up behavior monitoring for residents receiving psychotropic medications. Interviews with nurses revealed they also received education on care planning for residents with suicide risk and informing the nurse aides of person-centered interventions through Kardex updates. Interviews with staff that included administrative, dietary, housekeeping, therapy and nursing all revealed that they had received the education on reporting behavior and other mood changes or comments of a hopeless nature to the nurse for follow up. The facility's IJ removal date of 4/6/26 was validated.	F0742		05/05/2026
F0565 SS = E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written	F0565	The Executive Director met with Resident #90 (Resident Council President), on 4/27/2026. The Resident Council President was asked for permission for the Executive Director and/or Director of Nursing/Designee to attend Resident Council each month to follow-up on the previous month's concerns. Permission was granted. Current and past grievances were determined, and updates provided to the Resident Council. An ADHOC Resident Council was held on 4/27/2026. The Residents in attendance were asked for their permission for the Executive Director and/or Director of Nursing/designee to attend Resident Council each month to follow up on the previous month's concerns. Residents # 5, #90 (President), #33, #43, #62, #68, #79, #87 and #80 were in attendance. All Residents in attendance gave permission. The Resident Council was informed of the new grievance plan moving forward to ensure	05/05/2026

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F0565 SS = E	Continued from page 24 requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on record review and resident and staff interviews, the facility failed to resolve and communicate the facility's efforts to address concerns voiced by residents during Resident Council meetings for 11 of 12 months reviewed (April 2025, May 2025, June 2025, July 2025, August 2025, September 2025, October 2025, November 2025, January 2026, February 2026 and March 2026). The findings included: A review of the grievance logs from April 2025 to March 2026 showed that no grievances were filed on behalf of the Resident Council from April 2025 to December 2025. Further review of the log revealed grievances filed on behalf of Resident Council in January 2026, February 2026, and March 2026 had no documentation of complaints/grievances, plans to resolve the complaints/grievances or actions taken to resolve the complaints/grievances. The Resident Council minutes dated 4/16/25 and recorded by the Activity Director showed grievances related to housekeeping, dietary, and nursing services. Housekeeping concerns included bathrooms that were not consistently cleaned, delayed trash removal, and slow laundry services. Dietary grievances included missing tray items such as utensils, condiments, and napkins; incorrect or	F0565	Continued from page 24 their grievances were heard and acted on as soon as possible. Updates to previous concerns were discussed and any new grievances documented. The Executive Director has assumed the role of Grievance Coordinator and will be receiving, logging, assigning, and tracking the grievances from Resident Council as well as all other grievances presented. The Executive Director provided education on 4/28/2026 to the Interdisciplinary Team regarding the policy changes; nursing staff members were educated on 04/29/2026 through 05/01/2026 regarding the facility grievance policy changes. Ancillary staff were also educated regarding the new grievance process. The education included the requirement to complete the grievance form, submit the form to the Executive Director who will then log the grievance and delegate resolution to the appropriate department. The Executive Director will track the grievances and ensure a timely response. Education regarding the grievance process for new staff will be provided during orientation. The Executive Director will be monitoring the grievance log weekly for twelve (12) weeks to ensure the affected department provides a timely solution whenever possible. The staff education regarding grievance and the need for a timely response for new staff will be provided during orientation. Any interventions will be documented and reviewed with the QAPI team for necessary revisions. The Executive Director introduced the plan during the Monthly QAPI Committee meeting on 04/29/2026. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Executive Director will report the findings to the Quality Assurance Performance Improvement Committee during the regularly scheduled QAPI meetings. Alleged Date of Compliance: 05/05/2026	05/05/2026

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F0565 SS = E	Continued from page 25 incomplete meals; and unavailable alternatives. Nursing concerns included delayed response to emergency call lights and nursing assistants being hesitant to assist across halls. Residents #5, #15, #79 and #90. Resident #90 was the Resident Council President. The Resident Council minutes dated 5/13/25 and recorded by the Activity Director showed ongoing housekeeping concerns with inconsistent room cleaning and delays in receiving basic supplies like toilet paper and paper towels. Dietary grievances included missing tray items such as utensils, condiments, and napkins, and incorrect or incomplete meals. Nursing concerns included lack of communication regarding medication changes. The minutes did not show the facility's response to grievances voiced during the previous Resident Council meeting. Residents #5, #15, #62, #79 and #90 attended this meeting. The Resident Council minutes dated 6/10/25 and recorded by the Activity Director showed ongoing dietary grievances, with residents reporting meals as cold, bland, inconsistently prepared, and lacking variety. Housekeeping concerns included incomplete room cleaning, ongoing delays in laundry services, and residents needing to repeatedly request cleaning. The minutes did not show the facility's response to grievances voiced during the previous Resident Council meeting. Residents #5, #15, #33, #79 and #90 attended this meeting. The Resident Council minutes dated 7/15/25 and recorded by the Activity Director showed continued dietary concerns, including poor food quality, inconsistent preparation, and unresolved complaints. Nursing concerns included nursing assistants' reluctance to assist with resident needs and unprofessional attitudes. Housekeeping concerns included ongoing laundry delays and a lack of a consistent room cleaning schedule. The minutes did not show the facility's response to grievances voiced during the previous Resident Council meeting regarding inconsistently prepared meals and delays in receiving items back from the laundry. The Resident Council minutes dated 8/12/25 and recorded by the Activity Director showed ongoing concerns in both nursing and housekeeping services. In nursing, residents reported that some nurse aides were unwilling to remove soiled briefs from trash cans, and negative attitudes from certain staff members. In housekeeping, concerns were noted regarding bathrooms not being consistently stocked with toilet paper. Residents also expressed	F0565		05/05/2026

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F0565 SS = E	Continued from page 26 a desire for quicker follow-up on concerns in general. The minutes did not show the facility's response to grievances voiced during the previous Resident Council meeting. Residents #5, #15, #33, #79 and #90 attended this meeting. The Resident Council minutes dated 9/09/25 and recorded by the Activity Director showed concerns with staff disposing of used briefs in resident trash cans and did not show the facility's response to grievances voiced during the previous Resident Council meeting. Residents #5, #15, #79 and #90 attended this meeting. The Resident Council minutes dated 10/14/25 and recorded by the Activity Director showed ongoing nursing grievances, including nurse aides leaving soiled briefs in resident trash cans, medication accuracy, and poor staff attitudes. The Old Business section of the minutes revealed last month's concerns were reviewed and updates were provided by department heads. There was no documentation showing the updates, and the minutes indicated there were no staff members or visitors invited by the Resident Council present. Residents #15, #79 and #90 attended this meeting. The Resident Council minutes dated 11/11/25 and recorded by the Activity Director showed under Old Business that nursing had addressed the issues of nurse aides throwing briefs on the floor instead of properly disposing of them, medication accuracy and negative staff attitudes and medication timeliness. There were concerns regarding shower schedules not being followed and showers being missed. There was no documentation showing the facility's response to the nursing grievances. Residents #15, #79 and #90 attended this meeting. The Resident Council minutes dated 1/13/26 and recorded by the Activity Director showed ongoing concerns with staff attitudes, soiled briefs left in resident trash cans, and medication accuracy. There were also concerns regarding missing personal belongings, inconsistent showers and call lights not being answered in a timely manner. The minutes indicated there was no Old Business, as the December 2025 meeting was conducted by corporate staff and no minutes were recorded. There was no documented follow-up from the grievances voiced at the November 2025 meeting. Residents #5, #15, #79 and #90 attended this meeting. The Resident Council minutes dated 2/12/26 and recorded by the Activity Director showed under Old Business that all concerns had been documented	F0565		05/05/2026

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F0565 SS = E	Continued from page 27 and forwarded to the appropriate departments for review and resolution. The concerns included missing personal belongings, inconsistent showers, staff attitudes, medication accuracy, dirty briefs being left in trash cans and call lights not being answered in a timely manner. There was a new concern with staff being on their phones during work hours. There was no documentation showing the facility's response to the Old Business concerns. Residents #5, #15, #68, #79 and #90 attended this meeting. The Resident Council minutes dated 3/10/26 and recorded by the Activity Director showed dietary concerns related to inconsistent portion sizes and nursing concerns regarding excessive noise from night shift staff. The status update for Old Business read "Resolved," with no further documentation provided. Residents #5, #15, #33, #68, #79, #87, #89 and #90 attended this meeting. A Resident Council meeting was conducted on 4/01/26 at 2:01 PM with Residents #5, #15, #33, #43, #62, #68, #79, #80, #87, #89 and #90 (Resident Council President) in attendance. Residents #15, #42, #79, #87 and #90 agreed the Resident Council was never provided with information regarding what was being done to address their concerns during the Resident Council meetings, nor were they provided any written communication. Residents #5, #15, # 42, #80, #87 and #90 agreed during a discussion of unresolved grievances they felt like they were being ignored and their voices didn't matter. The group indicated they raised the same concerns in each meeting and found it frustrating that there was no follow-up or resolution. An interview on 4/02/2026 9:57 AM with the Activity Director revealed she organized the Resident Council meetings and took the minutes each month. She indicated the meetings would include reviewing resident rights, the previous month's business, upcoming events and current concerns. The Activity Director revealed she provided updates and resolutions regarding concerns from the previous month during the meeting under Old Business. She noted when grievances were voiced, they were documented in the meeting notes and communicated verbally to the appropriate department heads and to the Social Service Manager. The Activity Director indicated the Social Service Manager also received a copy of the Resident Council minutes each month and would verbally inform her when issues had been resolved, which she then shared at the next Resident Council meeting. She revealed no written documentation of investigations or outcomes had	F0565		05/05/2026

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F0565 SS = E	Continued from page 28 ever been provided to her, and in December 2025 the grievance process changed so that information was documented on formal grievance forms. The Activity Director indicated the Social Service Manager completed the grievance forms based on the Resident Council notes she provided. Although the Activity Director reported she no longer received updates regarding the outcomes of grievances, she noted most concerns were addressed and resolved over time. When did she stop getting updates regarding the outcomes of grievances? On 4/02/2026 at 10:34 AM an interview with the Social Services Manager revealed he was the Grievance Official for the facility. He stated that upon reviewing the Resident Council minutes, he would complete a formal grievance form and forward it to the appropriate department head for follow-up. The Social Service Manager explained that the process had been updated in December 2025 to include attaching Resident Council meeting minutes to grievance forms so department heads would have additional context for concerns raised. He acknowledged he had not been recording Resident Council grievances on the grievance logs but had started to do so in January 2026. The Social Service Manager reported he tracked grievance resolution by reviewing the following month's Resident Council meeting minutes and indicated that department heads attended meetings to explain their investigations, outcomes, and how issues had been resolved. However, he was unable to explain how follow-up was being conducted as the Resident Council minutes reflected no other staff had attended meetings except for the August 2025 meeting. The Social Service Manager indicated he did not receive any written notification of grievances being resolved, he reported that he considered fourteen days sufficient time to investigate and resolve an issue so that is what he recorded as a resolution date on the grievance logs. An interview on 4/03/2026 at 1:31 PM with the Administrator revealed that in December 2025 their corporate office directed the use of formal grievance forms and inclusion of Resident Council meeting minutes for follow-up and tracking. She confirmed the Social Services Manager served as the grievance official and was responsible for receiving and routing concerns to the appropriate department heads and following up with investigations. The Administrator indicated that food service concerns were part of an ongoing process and would not be resolved immediately, as improvements required time and coordination within the Dietary Department. She reported that the Dietary Department was	F0565		05/05/2026

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F0565 SS = E	Continued from page 29 responsible for following up on concerns and ensuring corrective actions and monitoring were completed, and the Nursing Department was responsible for following up on the nursing concerns raised. The Administrator revealed the grievance process was still being refined, with a focus on clarifying responsibilities, improving consistency, and ensuring Resident Council concerns were addressed, tracked, and resolved promptly.	F0565		05/05/2026
F0755 SS = E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with staff and Pharmacist, the facility failed to implement a system to consistently and accurately reconcile controlled medications obtained from home for 1 of	F0755	Resident # 8 is no longer a respite care Resident. He was admitted for long-term care on 2/7/2026, and his medications are now supplied by the pharmacy in single dose packaging. The Director of Nursing completed a review of the current Residents medications on 4/27/2026, and no other non-compliant medications were identified. The narcotic count sheets for all Residents have been reviewed to ensure compliance with nursing signatures. Beginning 4/26/2026, the facility will no longer accept medications in bulk for respite care Residents. The medications will be required to be placed into single dose packaging, and the facility will only accept the number of medications needed for the duration of the respite stay. The Director of Nursing/designee reviewed and will continue to review narcotic countdown sheets for accuracy and completion. The Director of Nursing provided education to the nurses from 4/28/26 through 5/01/2026 regarding the new respite care admission plan regarding medications, as well as the requirement for accuracy counts and two nurse signatures on the narcotic countdown sheets. The staff education regarding the respite care medication protocol and the proper procedure for narcotic sheet countdown for new staff will be provided during orientation. The Director of Nursing/designee will perform Quality Improvement Monitoring for Residents admitted for respite care to ensure the medications are packaged properly and in sufficient amount for the respite stay weekly for twelve (12) weeks. In addition, the Director of Nursing/designee will review the Resident narcotic countdown sheets five (5) X/week for 4 weeks; three (3) X/week for four (4) weeks; then weekly for four (4) weeks. Any interventions will be documented and reviewed with the QAPI team for necessary revisions. The Director of Nursing introduced the plan during the monthly QAPI Committee meeting on 4/29/2026.	05/05/2026

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F0755 SS = E	Continued from page 30 1 resident reviewed for medication management (Resident #8). As a result, a total of 31 tablets of Lorazepam (a controlled medication) were unaccounted for. The facility also failed to keep accurate records of controlled medications for 1 of 2 medication cart narcotic records reviewed. The findings included: 1.Resident #8 was admitted to the facility 1/9/26 for a respite stay with diagnoses that included anxiety disorder. Resident #8 had the following physician's orders for Lorazepam: 1/9/26 - Lorazepam oral tablet (benzodiazepine) one (1) milligram (mg) – give one tablet by mouth every 8 hours as needed for anxiety. This order was changed on 1/12/26 to Lorazepam oral tablet one (1) mg – give one tablet by mouth every 8 hours as needed for anxiety for 14 days. The admission Minimum Data Set (MDS) assessment dated 1/16/26 indicated Resident #8 was moderately cognitive impaired and received antianxiety medications. The Medication Administration Record (MAR) for January 2026 for Resident #8 indicated he received Lorazepam one (1) mg as needed for anxiety on 1/10/26, 1/11/26, 1/12/26, 1/15/26, 1/16/26, 1/18/26, 1/19/26 and 1/22/26. Medication Aide (MA) #1 signed that she administered Lorazepam to Resident #8 on 1/10/26 at 12:00 PM and 1/11/26. Nurse #11 signed that she administered Lorazepam to Resident #8 on 1/10/26 at 8:55 PM. Nurse #12 signed that she administered Lorazepam to Resident #8 on 1/18/26. A review of the sign-out sheet for Resident #8's Lorazepam one (1) mg tablets indicated it was initially received on 1/9/26 with 152 pills inside the bottle as counted by MA #1 and the Director of Nursing. The dose recorded on the MAR for 1/19/26 was not documented on the sign-out sheet and there were two doses documented on the sign-out sheet for 1/11/26 at 9:00 PM and 1/13/26 that were not recorded on the MAR. The ending count on the sign-out sheet was 142 pills after the last Lorazepam tablet was signed out on 1/22/26. On 1/25/26, a discharge with return anticipated MDS assessment indicated Resident #8 was discharged to the hospital.	F0755	Continued from page 30 The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report the final findings to the Quality Assurance Performance Improvement Committee during the regularly scheduled QAPI meetings. Alleged Date of Compliance: 05/05/2026	05/05/2026

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F0755 SS = E	Continued from page 31 A phone interview with Nurse #7 on 4/1/26 at 12:52 PM revealed she had counted the controlled medications with the night shift nurse on the morning of 2/2/26 when she discovered that Resident #8 had 31 missing Lorazepam tablets. Nurse #7 stated that Resident #8 was at the hospital at that time, but he had a bottle of Lorazepam tablets in the narcotic drawer of the medication cart. Nurse #7 further stated that the bottle of Lorazepam tablets came from home because Resident #8 initially came to the facility for a respite stay. She shared that there was a sign-out sheet for Resident #8's Lorazepam but there was a discrepancy in the count, and 31 Lorazepam tablets were unaccounted for. Nurse #7 stated that she reported this immediately to the Director of Nursing. An interview with Medication Aide (MA) #1 on 4/1/26 at 10:29 AM revealed she remembered getting questioned about Resident #8's missing Lorazepam tablets. MA #1 stated she had given Resident #8 two tablets out of his bottle of Lorazepam tablets, and she signed them out on the sign-out sheet. MA #1 stated that when Resident #8 was first admitted to the facility, the nurses and medication aides were counting his controlled medications. MA #1 stated that when Resident #8 went to the hospital, his bottle of Lorazepam tablets was kept in the narcotic drawer of the medication cart, but they had not been consistently counting them at each shift change. MA #1 stated that they should have been counting all the controlled medications in the medication cart regardless of whether they came from the pharmacy or from home. A phone interview with Nurse #11 on 4/8/26 at 4:49 PM revealed she had given Resident #8 a dose of Lorazepam on 1/10/26 at 8:55 PM which she obtained from his bottle of Lorazepam tablets. Nurse #11 stated that she did not count the Lorazepam pills in the bottle while Resident #8 was in the hospital because it was taped shut with two signatures on the bottle. Nurse #11 stated she could not remember whose signatures they were. She further stated that since Resident #8 was in the hospital, they did not have a reason to count the Lorazepam pills especially a big bottle with over a hundred pills. Nurse #11 also stated that she did not know how it was realized that the Lorazepam count was off and she was not certain when the pills went missing. A phone interview with Nurse #12 on 4/8/26 at 5:01 PM revealed she had given Resident #8 a Lorazepam tablet on 1/8/26 and she had signed it out on the sign-out sheet. Nurse #12 stated that she couldn't	F0755		05/05/2026

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F0755 SS = E	Continued from page 32 speak for everyone, but she always counted Resident #8's Lorazepam pills when she had that medication cart. Nurse #12 stated that she had gone on vacation and after she came back, she heard about Resident #8's missing Lorazepam pills. During an interview with the Director of Nursing (DON) on 4/1/26 at 2:37 PM, the DON reported that Nurse #7 informed her on 2/2/26 of missing Lorazepam tablets for Resident #8. The DON stated she removed the medication bottle, verified its contents, and noted that although it contained over 100 tablets, 31 tablets were unaccounted for. The DON stated that she started an investigation and interviewed all the nurses and medication aides who had worked on that medication cart. The DON stated she checked with each one when it was counted last, but she was unable to narrow down to a specific staff member when the pills went missing. The DON stated that she found out that not everyone had been counting the Lorazepam tablets belonging to Resident #8 because he was in the hospital and it was a big bottle of pills. She also stated that she asked the pharmacy to replace the missing pills and bill the facility for them. The DON stated that there were only 10 doses signed out on the sign-out sheet. A phone interview with the Pharmacist on 4/1/26 at 3:58 PM revealed they had filled 31 Lorazepam tablets for Resident #8 on 2/6/26 per request from the DON not to use insurance and to charge them to the facility. The Pharmacist stated that they always sent a sign-out sheet with each controlled substance they dispensed, and the nurses were supposed to be counting the controlled medications at each shift change. The Pharmacist clarified that if the medication came from home, the facility should have had enough blank sign-out sheets they could use to sign out those controlled medications. An interview with the Administrator on 4/3/26 at 1:40 PM revealed Resident #8's missing Lorazepam tablets were due to not all staff counting the tablets in the bottle because there were a lot of pills in the bottle. The Administrator stated they found out about this after the DON interviewed all the nurses and medication aides who worked on the medication cart where Resident #8's Lorazepam pills were stored. The Administrator stated that they needed to put some tighter controls on how medications from home were handled to keep this from happening again. The Administrator stated Resident #8's Lorazepam bottle was labeled to have 90 tablets in it, but when they admitted Resident #8 to the facility, the bottle contained more than 90 tablets. The	F0755		05/05/2026

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F0755 SS = E	Continued from page 33 Administrator stated that they should not have accepted more than 90 pills from home, and they should have counted out what was in the bottle and sent the rest home. 2. On 4/01/26 at 11:35 AM, observation was made of the A-Hall medication cart narcotic drawer and records. The narcotic drawer contained 38 medication cards/liquid narcotic medication and there were 38 Utilization Sheets (record of an individual resident's narcotic prescription including when doses were given, and how many doses remained). The Inventory Sheet (record of the total number of medications in the narcotic drawer at shift change which included date, time, nurse signatures, number of medications and number of Utilization Sheets) entry on 3/31/26 at 7:00 PM showed a count of 33 medication cards/liquid narcotic medication and 33 Utilization Sheets. In the space after the 3/31/26 at 7:00 PM entry on the Inventory Sheet, an additional undated entry was observed at 11:00 PM indicating a count of 33 medication cards/liquid narcotic medication and 33 Utilization Sheets. In the space after the undated 11:00 PM entry, there was no record of a narcotic count completed for the shift change on 4/1/26 at 7:00 AM. A review of the A-Hall pharmacy delivery record of controlled substances with a date of 3/31/26 and document time stamp of 8:22 PM, was cosigned as received by Nurse #10 and revealed delivery of 5 medication cards/liquid narcotic medication: Morphine Sulfate 20 milligrams per milliliter (mg/ml), one 30 ml bottle for Resident #40 Lorazepam 0.5 mg tablets, one medication card of 30 tablets for Resident #40 Hydrocodone-Acetaminophen 5 mg-325 mg, three cards of 30 tablets totaling 90 tablets for Resident #88 During an interview with the A-Hall nurse who was Nurse #9 on 4/01/26 at 11:36 AM, she stated at 7:00 AM on 4/1/26 she and the off-going night nurse, (Nurse #10) had counted all the narcotic medications in the A-Hall medication cart narcotic drawer and there had been a corresponding	F0755		05/05/2026

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F0755 SS = E	Continued from page 34 Utilization Sheet for each medication. Nurse #9 revealed she and Nurse #10 had not counted the total number of Utilization Sheets to realize the number of medications for 4/1/26 at 7:00 AM should have been 38 to account for the 5 medication cards/liquid narcotic medication from the night pharmacy delivery added to the 11:00 PM count of 33. She further explained that the count on 4/1/26 at 7:00 AM must have been recorded on a different page of the Inventory Sheets. During the interview, additional observation of the A-Hall narcotic records with Nurse #9 revealed an Inventory Sheet with entries dated 3/22/26, 3/23/26, 3/24/25, 3/25/26, and 4/1/26. The 4/1/26 entry was untimed and signed by Nurse #10 as the off-going nurse. The space for the on-coming nurse was not signed. The medication count indicated 37 and the Inventory Sheet count indicated 37. Nurse #9 revealed that this was the count she and Nurse #10 had done that morning on 4/1/26 at 7:00 AM and she had not signed as the on-coming nurse because she was out of sorts and was going to go back and do it. Nurse #9 explained the count of 37 on the 4/1/26 untimed entry was the total of 32 from the 3/25/26 untimed entry and the 5 medication cards/liquid narcotic medication delivered overnight to make 37 but realized now that this was not correct. Observation made of the previous entry prior to the 4/1/26 untimed entry revealed an untimed entry dated 3/25/26 with a prescription count of 32 and an Inventory Sheet count of 32 and contained the following information in the Medications Added column: Morphine Sulphate for Resident #40 - 1 Lorazepam for Resident #40 - 1 Hydrocodone-Acetaminophen for Resident #88 – 3 A telephone interview was conducted with Nurse #10 on 4/2/26 at 3:37 AM. Nurse #10 stated she was the A-Hall nurse on night shift the night of 3/31/26 at 11:00 PM into 4/1/26 at 7:00 AM. She revealed she had taken delivery of 5 narcotic medications (four medication cards and one bottle of liquid morphine) delivered from pharmacy overnight and had written them on the A-Hall Inventory Sheet and had updated the count by 5. Nurse #10 did not recall if her entry of the delivered medications was on the 3/31/26 at 11:00 PM entry line. Nurse #10 explained that she and the on-coming nurse (Nurse #9) had counted at	F0755		05/05/2026

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F0755 SS = E	Continued from page 35 7:00 AM and Nurse #10 had documented the count on the Inventory Sheet. Nurse #10 also did not recall having put the 4/1/26 at 7:00 AM count entry in the space after the 3/25/26 untimed entry. Nurse #10 stated she had also worked on C-Hall on 3/31/26 and left to go to that hall to give report and did not see if Nurse # 9 signed the Inventory Sheet. On 4/1/26 at 12:29 PM an interview was conducted with the Director of Nursing (DON). She stated whenever the number of narcotic medications did not match the number on the Inventory Sheets that nurses and medication aides should have investigated why they did not match. She explained nurses and medication aides were trained to call the DON if they had not been able to reconcile the number of medications with the Inventory Sheets and the Utilization Sheets. The DON explained that narcotic shift change counts should have been dated and timed and the off-going and on-coming nurses or medication aides should have signed indicating the medications, Inventory Sheets, and Utilization sheets all matched. The DON further explained when the Nurse #9 and Nurse #10 had counted and seen there was a medication for every Utilization Sheet in the narcotic binder and they probably thought it was alright when in fact they had not added the 5 newly delivered medication cards/liquid narcotic medication to the count number. An interview was completed on 4/2/26 at 9:25 AM with the Assistant Director of Nursing (ADON). During the interview, observation was made of the A-Hall narcotic record Utilization Sheet with dates of 3/22/26, 3/23/26, 3/24/26, 3/25/26, and 4/1/26. The ADON stated entries for 3/25/26 and 4/1/26 on this page were incorrect with two missing times, a missing signature, missing strengths on the 5 medication cards/liquid narcotic medication added, and incorrect counts of the number of medications and Utilization Sheets. She explained the count of 37 on the 4/1/26 entry which she presumed to have been at 7:00 AM, should not have been added to the 3/25/26 count of 32 but should have been added to the count of 33 on the 3/31/26 entry presumed to be 11:00 PM, to make 38. The ADON further explained she and Nurse #9 had been doing a narcotic audit on 3/23/26 to review previous narcotic documentation concerns. She stated during the audit she started a new Utilization Sheet, and it may have caused confusion that she didn't cross out the remaining open spaces on the previous sheet resulting in entries not all being in chronological order. The ADON revealed Nurse #9 and Nurse #10	F0755		05/05/2026

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F0755 SS = E	Continued from page 36 should have been more careful to ensure the 4/1/26 AM count was added to the correct previous count and made sure they were counting the number of Utilization Sheets to compare with the number of medications in the drawer. In a follow-up interview with the DON on 4/2/26 at 11:34 AM she explained it was never alright to adjust the narcotic count without making sure the medication count and documentation were correct. The DON stated she thought sometime staff giving meds got confused where they were supposed to write when adding and subtracting meds on the Utilization Sheets. The DON revealed they had done narcotic medication education on 2/3/26 to 2/3/36 after a previous discrepancy and was not sure what went wrong here and that she planned to revisit documentation training. In an interview with the Administrator on 4/01/26 at 12:51 PM she stated the expectation was that documentation for narcotic counts should be done accurately at every shift change. She explained that not having an accurate count documented could open up the door to multiple problems including diversion and this was something they usually did not have a problem with.	F0755		05/05/2026
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to	F0880	The Director of Nursing/designee performed unannounced observations of wound care for Resident #8 and Resident #34 on 4/29/2026. Resident #102 was discharged from the facility on 4/16/2026. Residents currently under Enhanced Barrier Precautions as well as those receiving wound care were assessed by direct observation by the Director of Nursing/designee on 4/28/2026 through 5/4/2026 for proper personal protective equipment, handwashing/sanitizing, gowning, and gloving protocols. The Enhanced Barrier Precaution (EBP) signs located on the Resident doors were framed with a contrasting color as a visual aid to promote observation of the EBP protocol signage. The Director of Nursing and Assistant Director of nursing created a portable supply carrier for the wound nurse to include hand sanitizer. The Director of Nursing provided education to the staff regarding the Enhanced Barrier Precautions protocols as well as handwashing/gowning during peri-care on	05/05/2026

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F0880 SS = E	Continued from page 37 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F0880	Continued from page 37 4/29/2026 through 5/1/2026. The Director of Nursing/designee also provided education for the wound care nurse and general nursing staff on 4/29/2026 through 5/1/2026 regarding the correct process for gloving and hand sanitizing during wound care. The staff education regarding Enhanced Barrier Precautions to include handwashing and gowning as well as proper gloving and hand sanitizing during wound care will be provided during orientation. The Director of Nursing/designee will perform Quality Improvement Monitoring for Residents under Enhanced Barrier Precautions and those receiving wound care by monitoring incontinence care for Residents with EBP and dressing changes for Residents receiving wound care five (5) X week for four weeks; three (3) X week for four (4) weeks then weekly for four weeks. Any interventions will be documented and reviewed with the QAPI team for necessary revisions. The Director of Nursing introduced the plan during the monthly QAPI Committee meeting on 4.29.2026. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report the final findings to the Quality Assurance Performance Improvement Committee during the regularly scheduled QAPI meetings. Alleged Date of Compliance: 05/05/2026	05/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345447	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/09/2026

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F0880 SS = E	Continued from page 38 This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to follow their infection control policies and procedures for Enhanced Barrier Precautions and hand hygiene when Nurse Aide (NA) #8, Medication Aide #1 and NA #10 did not wear personal protective equipment during incontinence care and when NA #8 did not change gloves and perform hand hygiene after contact with a soiled brief. In addition, the Treatment Nurse failed to change her gloves and perform hand hygiene during wound care. This deficiency occurred for 4 of 8 staff members observed for infection control practices (NA #8, NA #10, Medication Aide #1 and Treatment Nurse). The findings included: A review of the facility's policy titled "Enhanced Barrier Precautions," revised on 6/4/25, indicated: Enhanced Barrier Precautions (EBP) referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) by using gowns and gloves during high-contact resident care activities. High-contact activities included dressing, bathing, transferring, providing hygiene, changing linens or briefs, assisting with toileting, device care or use (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters), and wound care if deemed chronic by a medical provider or if MDRO was present. A review of the facility's policy entitled, "Hand Hygiene," reviewed and revised on 11/13/25 indicated: Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table: either soap and water or alcohol based hand rub for the following procedures: After handling contaminated objects Before applying and after removing personal protective equipment (PPE) including gloves Before and after handling clean or soiled dressings, linens, etc. After handling items potentially contaminated with	F0880		05/05/2026

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F0880 SS = E	Continued from page 39 blood, body fluids, secretions, or excretions When, during resident care, moving from a contaminated body site to a clean body site Additional considerations: The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. a. An observation of incontinence care provided to Resident #102 by Nurse Aide (NA) #8 and Medication Aide (MA) #1 was made on 3/30/26 at 1:50 PM. Resident #102 had a sign for Enhanced Barrier Precautions posted on her door. The sign indicated all healthcare personnel must wear gloves and gown for high contact resident care activities which included changing briefs or assisting with toileting. Both NA #8 and MA #1 were observed entering Resident #102's room, washing their hands and putting gloves on both hands. Neither aide put a gown on before they approached Resident #102's bed. Gowns were available at a receptacle inside Resident #102's bathroom. Both aides proceeded to unfasten Resident #102's brief while NA #8 started to clean Resident #102's front perineal area with a disposable wipe. They turned Resident #102 towards her right side. While MA #1 held on to Resident #102 who was turned towards her, NA #8 started to clean stool off Resident #102's buttocks with a disposable wipe using both hands. Without removing her gloves, NA #8 reached into Resident #102's drawer for a tube of moisture barrier cream and applied the cream to Resident #102's buttocks and on her abdominal fold. NA #8 removed the soiled brief underneath Resident #102's bottom as well as the drawsheet and placed both at the foot of Resident #102's bed. NA #8 placed a new brief and a drawsheet underneath Resident #102's bottom and then rolled her onto her back. Both aides fastened the new brief, replaced Resident #102's covers and re-adjusted her bed. NA #8 removed her glove from the left hand while she held the soiled brief and drawsheet with her gloved right hand, walked out of Resident #102's room and into the soiled utility room where she placed the soiled drawsheet in a bin and the soiled brief in the trash. NA #8 removed her glove from the right hand and proceeded to wash her hands. An interview with NA #8 on 3/30/26 at 2:32 PM revealed she was not paying attention to the sign on Resident #102's door about enhanced barrier precautions, but she should have worn a gown when she provided incontinence care to her. NA #8 stated she felt overwhelmed about being observed doing	F0880		05/05/2026

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F0880 SS = E	Continued from page 40 incontinence care and forgot to remove her gloves and do hand hygiene after cleaning Resident #102's stool off her buttocks. NA #8 stated that she usually removed her gloves from both hands and washed her hands after she threw away the brief in the trash. An interview with MA #1 on 3/30/26 at 2:34 PM revealed she did not notice the sign on Resident #102's door about enhanced barrier precautions, but she should have worn gown and gloves when she and NA #8 provided incontinence care to Resident #102. MA #1 stated that there were supposed to be gowns and gloves available in a cart outside the resident's room, but she did not see a cart. b. An observation of incontinence care provided to Resident #102 by NA #8 and NA #10 was made on 3/30/26 at 2:20 PM. Resident #102 stated to both nurse aides who were preparing to get her out of the bed that she needed to be changed again. Both nurse aides entered Resident #102's room without putting a gown on. Resident #102 had a sign on her door for enhanced barrier precautions which indicated all healthcare personnel must wear gloves and gown for high contact resident care activities which included changing briefs or assisting with toileting. They washed their hands and put gloves on both hands. Gowns were available at a receptacle inside Resident #102's bathroom. Both nurse aides unfastened Resident #102's brief while NA #10 proceeded to clean Resident #102's front perineal area with a disposable wipe. Both aides turned Resident #102 to her left side while NA #10 grabbed another disposable wipe and cleaned Resident #102's buttocks. NA #10 removed both gloves and washed her hands while NA #8 fastened Resident #102's brief and changed her gown. NA #10 put another set of gloves on both hands and assisted NA #8 in transferring Resident #102 off the bed using a total mechanical lift. After positioning Resident #102 in her wheelchair, both nurse aides removed their gloves and washed their hands at Resident #102's bathroom sink. An interview with NA #8 on 3/30/26 at 2:32 PM revealed she was not paying attention to the sign on Resident #102's door about enhanced barrier precautions, but she should have worn a gown when she provided incontinence care to her. An interview with NA #10 on 3/30/26 at 2:29 PM revealed she did not see the sign on Resident #102's door about enhanced barrier precautions. NA #10 stated there was normally a cart outside the room with gowns and gloves, but Resident #102 did	F0880		05/05/2026

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F0880 SS = E	Continued from page 41 not have one. NA #10 stated that she knew she was supposed to wear gown and gloves when providing incontinence care to a resident on enhanced barrier precautions. c. An observation of wound care for Resident #8 by the Treatment Nurse was made on 4/1/26 at 10:54 AM. The Treatment Nurse entered Resident #8's room, washed her hands at the sink, obtained a gown from a receptacle inside the bathroom door, put the gown on and put gloves on both hands. While Resident #8 was turned towards his right side in the bed, the Treatment Nurse proceeded to remove the dressing from his pressure ulcer on the left posterior thigh and then she removed the dressing from his pressure ulcer on his left buttock. Without removing her gloves and doing hand hygiene, she obtained a disposable wipe and wiped Resident #8's left buttock. She then removed the dressing from the pressure ulcer on his right heel. The Treatment Nurse removed both gloves and without performing hand hygiene, put new gloves on. She cleaned the left posterior thigh wound with gauze moistened with wound cleanser. Without changing gloves, she wiped the left buttock wound with another gauze moistened with wound cleanser and then she wiped the right heel ulcer with another gauze moistened with wound cleanser. She then removed her gloves, washed her hands and put new gloves on. The Treatment Nurse applied calcium alginate to the left posterior thigh wound and covered it with a bordered dressing. Without changing gloves and performing hand hygiene, she proceeded to apply calcium alginate to the wound on the left buttock and covered it with a bordered dressing. She then continued to apply calcium alginate to the wound on the right heel and covered it with a bordered dressing. The Treatment Nurse tucked Resident #8's brief underneath him and placed a new brief on while turning him towards his back. She fastened Resident #8's brief and applied soft boots to both feet. She removed her gown and gloves and washed her hands in the resident's bathroom sink. An interview with the Treatment Nurse on 4/2/26 at 8:23 AM revealed she knew that she was supposed to do hand hygiene before doing wound care, after the procedure and after discarding everything used during the procedure and in between cleaning and changing the bandage. The Treatment Nurse stated that she knew she was supposed to do hand hygiene after removing gloves and before applying new gloves, but she forgot to bring a hand sanitizer with her, and there was no hand sanitizer inside Resident #8's room. She also stated that she	F0880		05/05/2026

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F0880 SS = E	Continued from page 42 realized she should have used one glove for each of Resident #8's wounds and she should have cleaned and dressed them separately to prevent cross-contamination of the wounds. d. An observation of wound care for Resident #34 by the Treatment Nurse was made on 4/2/26 at 7:52 AM. The Treatment Nurse washed her hands, put a gown on and put gloves on both hands. She placed a barrier on Resident #34's bedside table where she put his wound supplies. She touched the trash can with her gloved hand and moved it closer to her. She removed her gloves and put new gloves on without performing hand hygiene. She then opened the dressings for Resident #34's wound care. While Resident #34 was turned towards his left side, the Treatment Nurse pulled down his brief and removed the old dressing from his pressure ulcer on his sacrum. The old dressing had moderate amount of light brown drainage. The Treatment Nurse cleaned the wound with gauze moistened with wound cleanser and then removed her gloves. Without performing hand hygiene, she put new gloves on and applied collagen to the wound bed and then covered it with a hydrocolloid dressing. She then pulled Resident #34's brief up and repositioned his pillow underneath his head. She lowered Resident #34's bed, removed her gown and gloves and washed her hands in Resident #34's bathroom sink. An interview with the Treatment Nurse on 4/2/26 at 8:23 AM revealed she knew that she was supposed to do hand hygiene before doing wound care, after the procedure and after discarding everything used during the procedure and in between cleaning and changing the bandage. The Treatment Nurse stated that she knew she was supposed to do hand hygiene after removing gloves and before applying new gloves, but she forgot to bring a hand sanitizer with her, and there was no hand sanitizer inside Resident #34's room. An interview with the Director of Nursing (DON) on 4/3/26 at 9:22 AM revealed she was also the facility's current Infection Preventionist. She stated that she placed residents with urinary catheters, feeding tubes, central lines, open wounds and residents with multi-drug-resistant organism (MDRO) in their urine on enhanced barrier precautions (EBP) and staff should be wearing PPE that included gowns and gloves when providing care to these residents. The DON stated that the purpose of EBP was to protect staff and the residents and keep infection from spreading to other residents. The DON shared that Resident #102 was on EBP because she had a wound and also had MDRO in her urine. She	F0880		05/05/2026

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F0880 SS = E	Continued from page 43 stated that they kept the PPE in a receptable inside the bathroom doors for each resident and she tried to educate staff where to find them. The DON stated staff sometimes did not pay attention to the EBP signs, but they should be wearing gown and gloves when taking care of residents on EBP. She stated that NA #10, MA #1 and NA #8 should have worn gown and gloves when they provided incontinence care to Resident #102. The DON also stated that NA #8 reported to her that she got flustered while being observed doing incontinence care, and that she knew what she was supposed to do. The DON stated that she hoped NA #8 would not have made the same mistake of not changing gloves and doing hand hygiene after she touched soiled items when she was not being observed. The DON also added that NA #8 should have removed her gloves and performed hand hygiene to prevent contamination of everything else in the resident's room. She also stated that the Treatment Nurse should have changed her gloves and performed hand hygiene in between doing wound care for each of Resident #8's wounds and she should have done hand hygiene each time she removed her gloves during wound care for both Resident #8 and Resident #34.	F0880		05/05/2026
F0919 SS = E	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility failed to provide a functioning resident call system for 1 of 2 residents reviewed for resident call system (Residents #1). The findings included: Resident #1 was admitted on 6/2/25 with diagnoses of acute and chronic respiratory failure with hypoxia, cerebrovascular accident (CVA) with hemiplegia (paralysis on one side of the body) and hemiparesis	F0919	Resident #1 was provided with a manual bell on 4/2/2026 by the Maintenance Director, until the call bell module was replaced. The Maintenance Director performed a test on the call light system on 4/23/2026. The system was found to be functional based on the criteria noted in the TELS system. (Attachment) The dome lights outside the Resident rooms were visible, the indicator lights at the head of each hallway were illuminated, the indicator station at the nursing station was lighting with the correct room number, the emergency lights were illuminated outside the Resident room and at the head of the hallways. The nurse call system is routinely tested weekly. In the event Residents with hallway dome lights outside the room which are found to be glowing dimly, the Resident will be provided a manual bell, available at the nursing station, and an urgent work order entered into the TELS system. The Executive Director provided education on 4/28/2026 to the Maintenance Director and Assistant Director of Maintenance regarding the importance of maintaining a functioning call light system based on the TELS criteria. The education was based on the TELS inspection process for determining if the call system is working properly. The Executive Director also	05/05/2026

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F0919 SS = E	Continued from page 44 (weakness on one side), chronic kidney disease, and chronic pain syndrome. The Care Plan revised 2/20/26 for Resident #1 had a focus for ADL (activities of daily living) self-care performance deficit with interventions to encourage the resident to use the bell to call for assistance and required supervision by 1 staff for toileting and personal hygiene. Resident #1's quarterly Minimum Data Set (MDS) on 3/25/26 indicated she was cognitively intact with adequate hearing and vision. She was coded as no impairment for upper extremity functional mobility. An interview was conducted with Resident #1 on 3/30/26 at 2:45 PM. At the start of the interview an observation was made of Resident #1 in her wheelchair at her doorway calling for staff. She stated the call bell didn't always work and sometimes she had to yell out for someone passing by her room. When asked if she had let someone know, she replied they knew and had spoken with the aides about it multiple times. Resident #1 explained there had been times when she pushed the call bell and saw the small light on the call bell panel in her room light up yellow and if she was up in her wheelchair she could see the light next to her door in the hall hadn't lit up. She stated she had been independent her whole life and it made her anxious to have to wait for help from others. An interview was conducted on 4/2/26 at 2:56 PM with Nurse #8 who was Resident #1's nurse that shift and had worked on Resident #1's hall in recent weeks. Nurse #8 revealed she had known that Resident #1's call bell did not always light up but did not recall the date she knew. Nurse #8 explained she left a note at the receptionist's desk earlier this week to enter this into the electronic work order system because she did not know how to put work orders in the system. Nurse #8 also explained that Resident #1 had anxiety and would sometimes get anxious if no one came as soon as she wanted them and would call out. She stated the resident did not have a hand bell to ring. On 4/2/26 at 2:57 PM an observation was made of Resident #1 pushing her call bell. After she pushed the bell a small yellow light lit up on the call bell panel in her room. An immediate observation of the	F0919	Continued from page 44 provided education to the staff on 4/29/26 thru 5/1/2026 regarding the process to enter work orders into the TELS monitoring system, as well as the importance of submitting work orders timely. For after-hours call light issues, the staff have been instructed to provide the Resident with a manual call bell and enter an urgent work order in the TELS monitoring system. Education to include information regarding the call light system and TELS work orders will be provided to new staff during orientation. The Maintenance Director will continue to monitor the call bell system weekly as per the TELS scheduled maintenance. The documentation from the TELS system will be submitted as the Quality Improvement Monitor and tracked for twelve (12) weeks. Any interventions will be documented and reviewed with the QAPI team for necessary revisions. The Executive Director introduced the plan during the monthly QAPI Committee meeting on 04/29/2026. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report the final findings to the Quality Assurance Performance Improvement Committee during the regularly scheduled QAPI meetings. Alleged Date of Compliance: 05/05/2026	05/05/2026

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F0919 SS = E	Continued from page 45 call bell system light in the hall on the side of the door next to Resident #1's room appeared white as if it hadn't lit up. Close observation from 3 feet away looking directly up at the light in the hall on the side of the door revealed a dim yellow color not visible from other locations in the hallway. No hand bell was observed in Resident #1's room. An interview was conducted on 4/2/26 at 3:26 PM with the Maintenance Director who stated he had been aware of the general problem with the call lights in the halls but not specific rooms except for another resident's room on another hall. He explained they had replaced the call bell panel in that other resident's room three times in the past week which did not help the hall light. The Maintenance Director revealed that if more than one light was on, the hall lights were so dim you could not see them light up yellow. He explained the call bell system functioned with sound and lights and that a bell sounded at the nurses station which could be heard on the halls, but there was no local sound associated with a specific room. He further explained there was one ceiling light for each hall and there was a light outside each resident room which lit up yellow when the call bell was pushed. The Maintenance Director stated he had been unaware that Resident #1's room on D Hall was also a problem to the point you could not see the light in the hall because it was so dim. He stated they had just given Resident #1 a hand bell and was going to have an electrician look at the system. While discussing whether there had been any work orders for call bells The Maintenance Director did not recall specific dates of work orders or how long he had known there had been a problem other than with the other resident's room within the past week. During the interview an observation was made of the Maintenance Director's work order system on his tablet which listed zero pending work orders. He stated he was unable to show a work order history because they cleared from the system as they were completed. In an interview with Nurse Aide (NA) #5 on 4/2/26 at 3:40 PM, she revealed she knew Resident #1 well. NA #5 stated the call light system did work but the lights outside resident's rooms sometimes were really dim, especially on D Hall. She explained when more lights got pushed at the same time they got dimmer to where you couldn't tell they were lit up. She elaborated that some rooms seem to get dimmer than others and Resident #1's room was consistently one of the rooms that barely showed	F0919		05/05/2026

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F0919 SS = E	Continued from page 46 when pushed and if one light was reset the others would become brighter. She stated Resident #1 did not have a hand bell until maintenance had given her one today. NA #5 further explained there was a light on the ceiling at the beginning of each hall visible from the nurse's station. Staff knew a call light was going off on that hall from this ceiling light even if the light in front of the resident's room was not visible. NA #5 revealed they could not always see that ceiling light from the far end of the hall and staff would search down the hall to see who needed help. NA #5 further explained at the nurse's station there was a light control switch board that had lights with room numbers that lit up when a resident in that room pushed the call bell. She stated it usually worked maybe 90% of the time but had seen when the lights on the switchboard would not light up, especially on D Hall. NA #5 stated she had been aware of the problem with the lights for maybe a few months and did not remember putting in a work order for the call bell system because staff in general had been aware of the problem. She explained they had switched from putting paper work orders in a box to an electronic work order system sometime last fall and staff had gotten training on the system right after it had been installed. Nurse Aide #6 was interviewed on 4/2/26 at 3:46 PM. NA #6 explained she thought the call bells had been a problem for a couple months and sometimes the lights outside the resident's rooms would be too dim to see from the nurse's station. She further explained they could see each hall's ceiling light from the nurse's station to know that someone on that hall was calling. NA #6 stated you couldn't always tell which room it was, but they might see the dim light when they went to find out who it was. She revealed she hadn't put in a work order for the call bells but had used the electronic work order system maybe twice for little things like a doorknob and noticed repairs completed same day. An interview was conducted on 4/3/26 at 1:18 PM with the Administrator with the Director of Nursing present. The Administrator stated she did not know the call bell system was having problems. She explained that staff needed to put a work order in if something wasn't working and they had been trained on use of an electronic work order system that had been implemented a few months ago. She further explained that maintenance staff would let her know if there were any trends related to work orders.	F0919		05/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345447	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and resident and staff interviews, the facility failed to provide care in a manner that maintained the resident's dignity by not providing incontinence care when needed. Resident #102 stated it made her feel bad having to wait a long time to be changed. This occurred for 1	F0550	Resident #102 was provided incontinence care on 3/30/2026 by NA #8 and Medication Aide #1. Resident discharged on 4/16/2026. Interviewable Residents were surveyed from 4/29/26 through 5/1/2026 to determine if they felt their Right to a dignified existence with regards to incontinence care was being violated by waiting for incontinence care. Any Resident has the potential to be affected by the alleged deficient practice. The Interdisciplinary Team (IDT) will make inquiries with interviewable Residents regarding dignity and incontinence care during their weekday morning rounds; the Nursing and/or Administrative Manager on Duty will speak with Residents on the weekends. Interventions will be provided as indicated based on the Residents' responses and may include staffing changes. The IDT will also observe non-interviewable Residents to ensure incontinence care has been provided. The Executive Director and Director of Nursing/Designee provided education to the nursing staff from 4/29/26 through 5/1/2026 regarding the Residents' Right of a dignified existence and overall well-being as it relates to receiving timely incontinence care. The full Residents' Bill of Rights were reviewed at the same time. The staff education regarding Residents' Rights, with special attention to dignity and incontinence care for new staff will be provided during orientation. The Director of Nursing/Designee also will perform Quality Improvement Monitoring for ensuring Residents' Rights with specific attention to dignity and timely incontinence care five (5) X per week for four (4) weeks; three (3) time a week for four (4) weeks and then one (1) X week for four (4) weeks. Any interventions will be documented, reviewed, and corrected. Any interventions will be reviewed with the QAPI team for necessary revisions. The Director of Nursing/Designee introduced the plan during the monthly Quality Assurance and Performance Improvement (QAPI) Committee meeting on 04/29/2026. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report the findings to the	05/05/2026

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F0550 SS = D	Continued from page 48 of 3 residents reviewed for dignity (Resident #102). The findings included: Resident #102 was admitted to the facility on 2/7/26. The admission Minimum Data Set assessment dated 2/13/26 indicated Resident #102 was cognitively intact, had adequate vision, required substantial/maximal assistance with toileting hygiene and was frequently incontinent of both urine and bowel. During a continuous observation on 3/30/26 from 1:24 PM to 2:00 PM, an interview was conducted with Resident #102 who was lying in bed in her room. Resident #102's call light was not on at the start of the observation. There was a faint odor of urine and feces upon entry into Resident #102's room. Resident #102 stated that she always had to wait long to be changed. Resident #102 stated that she was incontinent of urine and stool at 11:45 AM and turned her call light on at 11:45 AM and had been waiting to be changed since then. She indicated she knew this because she looked at her cellphone and noted the time when she asked Nurse Aide (NA) #8 to change her. Resident #102 stated that NA #8 told her that she needed to get somebody to help her. Resident #102 further stated that staff probably needed to serve lunch trays first before she could be changed. Resident #102 stated that it made her feel bad having to wait a long time to be changed. Resident #102 shared that she did not usually eat breakfast or lunch. At 1:36 PM, NA #8 was observed walking up and down the hall twice without stopping at Resident #102's room. On 3/30/26 at 1:45 PM, NA #8 was interviewed and she stated that Resident #102 had asked her to change her, but she couldn't remember what time she had asked her, and she couldn't say if it was before or after lunch. NA #8 stated that she was getting ready to do her incontinence rounds soon and she would get to Resident #102 eventually during her rounds. NA #8 stated that Resident #102 wanted her to find somebody to help her because she did not like to be changed by one person. NA #8 shared that she had asked the other nurse aides, but they were all busy at that time. NA #8 could not say which staff members she had asked to assist her. At 1:50 PM on 3/30/26, NA #8 walked into Resident #102's room with Medication Aide (MA) #1 and provided incontinence care to Resident #102. Resident #102's brief was heavily soiled with urine and feces. Her drawsheet was also visibly wet	F0550	Continued from page 48 Quality Assurance Performance Improvement Committee during the regularly scheduled QAPI meetings. Alleged Date of Compliance: 05/05/2026	05/05/2026

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F0550 SS = D	Continued from page 49 underneath her brief. An interview with NA #8 on 3/30/26 at 2:18 PM revealed she did not normally work on day shift (7:00 AM to 3:00 PM) and she just picked up an extra shift today. NA #8 stated that they usually staffed the hall with one nurse aide and one nurse, and that she was working as the only nurse aide on the hall. NA #8 stated that she felt overwhelmed especially when she was observed providing incontinence care to Resident #102. NA #8 confirmed that she responded to Resident #102's call light and Resident #102 had asked to be changed but NA #8 could not say if it was before or after lunch. NA #8 stated that she told Resident #102 that she had to get another staff member to help her because Resident #102 required two staff members to provide incontinence care to her. An interview with MA #1 on 3/30/26 at 2:34 PM revealed NA #8 asked her for help with Resident #102 about five minutes before they both went in to provide incontinence care to Resident #102. MA #1 stated that NA #8 did not ask her for help prior to that. An interview with NA #9 on 3/30/26 at 2:08 PM revealed she was working on C hall that day and that NA #8 did not ask her for help with Resident #102. NA #9 stated the rehabilitation hall where Resident #102 resided should have at least two nurse aides for residents who required two staff members to assist them. NA #9 stated it was hard to get everything done on the rehabilitation hall when there was only one nurse aide working. An interview with NA #10 on 3/30/26 at 2:29 PM revealed NA #8 did not ask her to help change Resident #102. An interview with NA #12 on 3/30/26 at 2:47 PM revealed NA #8 did not ask her for help with changing Resident #102 before lunch. NA #12 stated she remembered NA #8 asking her for help, but it was after lunch and she was giving a shower to another resident at that time. An interview with NA #11 on 3/30/26 at 2:49 PM revealed she was working on another hall and NA #8 did not ask her for help on the rehabilitation hall. An interview with Nurse #4 on 3/30/26 at 2:31 PM revealed she was assigned to Resident #102, but she was not aware that Resident #102 had been waiting to be changed since before lunch. Nurse #4 stated NA #8 did not ask her for help with Resident #102,	F0550		05/05/2026

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F0550 SS = D	Continued from page 50 but she would have if she knew about it. An interview with the Director of Nursing (DON) on 3/30/26 at 4:25 PM revealed that it was not ok for Resident #102 to have waited two hours to be changed, and she told her staff to provide assistance to residents within 15 to 20 minutes maximum. She further stated that to maintain Resident #102's dignity, she shouldn't have to wait long for incontinence care especially after a bowel movement. An interview with the Administrator on 4/3/26 at 1:40 PM revealed any resident should only had to wait 10 to15 minutes maximum especially if there was bowel movement involved. She stated that the nurse aide should have asked their nurse for help. The Administrator stated that in order to maintain a resident's dignity during incontinence care, staff should provide privacy by pulling the curtain or shutting the door, and let them wait for 10 to 15 minutes at the most while immediate response was always better.	F0550		05/05/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the	F0609	Resident #105 was deceased on 07/24/2025. Surveyor BH advised the Executive Director there was no need to send the report from 4/22/2025 to the Health Care Personnel Registry (HCPR). The Executive Director completed a 90-day look-back in the Facility Risk log to ensure the timeliness of reporting and notifications. There were no other Residents with similar issues regarding late reporting to the Healthcare Personnel Registry (HCPR). The Executive Director and/or Director of Nursing/Designee will submit all Health Care Personnel Registry reported to the Regional Director for Clinical Services for review and evaluation of timely external notifications and submission to the HCPR. The Executive Director, Regional Director of Clinical Services and/or Regional Vice President of Operations will perform a review of all Health Care Personnel Registry reports prior to submission, to ensure all external notifications are completed timely. The Regional Director of Clinical Services provided education to the Executive Director, Director of Nursing and Assistant Director of Nursing on 4/30/2026 regarding the importance of adhering to the rules regarding the timing and reporting of incidents to the HCPR. Specifically, education was provided to ensure the required external notifications were completed timely, as well	05/05/2026

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F0609 SS = D	Continued from page 51 alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to notify law enforcement and Adult Protective Services (APS) for an initial allegation of injury of unknown origin. The facility also failed to submit a 5-day investigation report to the state agency within the required timeframe for 1 of 1 resident with an allegation of injury or unknown source (Resident #105). 1. Review of the facility policy dated 6/1/25 “abuse, neglect and exploitation” stated the facility was to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prevent abuse, neglect, exploitation and misappropriation of resident property. 2. The procedure included: 7. (A) The facility will have written procedure for reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (law enforcement when applicable) within specified timeframes. A. Immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury. B. Not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury. 7. (B) The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. Review of the initial allegation report (24-hour report) dated 4/20/25 revealed an allegation of injury of unknown source. The details of the report stated Resident #105 was noted during rounds to have externally rotated right leg. Resident #105 was sent to the emergency room for evaluation and treatment of externally rotated right leg. All other residents assessed with no additional findings. It was documented that law enforcement was not notified, and the report did not indicate if APS was notified.	F0609	Continued from page 51 as maintaining proof of the email/fax confirmation report. The staff education regarding the reporting and documentation for HCPR reports for new staff who are responsible for reporting to the HCPR will be provided during orientation. The Executive Director will perform Quality Improvement Monitoring for reports sent to the HCPR to ensure timeliness and confirmation documentation weekly for twelve (12) weeks. Any exceptions will be documented and reviewed with the QAPI team for necessary revisions. The Executive Director introduced the plan during the monthly QAPI Committee meeting on 4/29/2026. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report the final findings to the Quality Assurance Performance Improvement Committee during the regularly scheduled QAPI meetings. Alleged Date of Compliance: 5/5/2026	05/05/2026

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F0609 SS = D	Continued from page 52 The 24-hour report was completed by the Director of Nursing (DON). Review of the investigation report dated 4/22/25 revealed staff interviews were conducted with no evidence of a fall noted. Per documentation Resident #105 ambulated on the unit unassisted with unsteady gait at times. Skin assessments showed no bruising or edema consistent with a fall. All other residents on the locked unit were assessed with no additional findings. The investigative report did not indicate if law enforcement or APS was notified. The investigation report was completed by the DON on 4/22/25. An email from the complaint intake unit of the state agency on 4/30/25 to the Administrator indicated that the investigation report related to the 4/20/25 initial allegation report for Resident #105 with allegation of injury of unknown source had not been received. On 4/1/26 at 2:30 pm an interview was conducted with the Director of Nursing (DON). She stated that she remembered investigating the injury of unknown source by interviewing staff and doing complete assessments of all the residents on the locked dementia unit. The DON stated she could not remember if law enforcement or if APS was notified of the investigation. The DON did not recall if the 5-day report was faxed to the state agency. On 4/2/26 at 4:15 PM an interview was held with the Administrator. She stated that back in April 2025 the facility was using efax (digital version of traditional faxing) to send out reports and she should have an email showing that she had faxed the investigation report. The Administrator searched for the efax but was unable to find it. She stated the investigation report should have been faxed to the state agency within 5 days of the initial incident, but it appeared it had not been.	F0609		05/05/2026
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the	F0627	Resident #101 was discharged to acute psychiatric care on 2/6/2026. The Executive Director reviewed the discharge/readmission logs for the last six (6) months on 5/1/2026. There have been no other Residents affected by the alleged deficient practice. The Executive Director and Director of Nursing determine a Resident's suitability to return to the facility after a hospitalization. In the event the facility	05/05/2026

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F0627 SS = D	Continued from page 53 resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of	F0627	Continued from page 53 is unable to accept the Resident's readmission, the Medical Director will be asked to provide documentation to support the decision in the event the facility believes they are unable to meet the Resident's ongoing needs. The Regional Director of Clinical Services provided education on 4/30/2026 to the Executive Director, Director of Nursing, Assistant Director of Nursing, and the Admissions Director regarding the alleged deficient practice of not accepting a Resident back after being discharged to acute care. The staff education regarding Resident readmission after discharge to acute care for new staff with decision making authority will be provided during orientation. The Executive Director will perform Quality Improvement Monitoring for the readmission process weekly for twelve (12) weeks. Any interventions will be documented and reviewed with the QAPI team for necessary revisions. The Executive Director introduced the plan during the monthly QAPI Committee meeting on 04/29/2026. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Executive Director will report the monthly findings to the Quality Assurance Performance Improvement Committee during the regularly scheduled QAPI meetings. Alleged Date of Compliance: 05/05/2026	05/05/2026

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F0627 SS = D	Continued from page 54 this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct	F0627		05/05/2026

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F0627 SS = D	Continued from page 55 part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other	F0627		05/05/2026

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F0627 SS = D	Continued from page 56 appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by:	F0627		05/05/2026

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F0627 SS = D	Continued from page 57 Based on record review, and Power of Attorney, staff, Ombudsman, Hospital Case Manager and Medical Director interviews, the facility failed to allow a resident to return to the first available bed at the facility after being sent to the hospital for a medical and psychiatric evaluation. Resident #101 remained in the hospital for 11 days despite being cleared to return to the nursing home and was eventually discharged home. This deficient practice was evidenced for 1 of 3 residents reviewed for transfer and discharge (Resident #101). The findings included: Resident #101 was admitted to the facility on 1/26/26 with diagnoses that included major depressive disorder, post-traumatic stress disorder (PTSD), bipolar disorder, delusional disorders and cataract. A review of a Change in Condition form for Resident #101 dated 2/6/26 at 8:47 AM indicated the resident was found lying in bed with a safety razor in hand and copious amount of blood on hands, wrists and abdomen. Multiple shallow lacerations noted to bilateral wrists, bilateral antecubital (inner crook of the elbow) areas and right neck. Interventions listed were to call for 911 for an emergency medical transport. The discharge Minimum Data Set assessment dated 2/6/26 indicated Resident #101 had modified independence with making decisions regarding tasks of daily life and had no behavioral symptoms. Resident #101's discharge was coded as an unplanned discharge with return anticipated. A review of the hospital case manager notes for Resident #101 dated 2/6/26 through 2/17/26 indicated: 2/6/26 – Patient is being referred out by Psychiatry. She has been placed into ED (Emergency Department) observation status due to this potentially taking a significant amount of time to transfer out. 2/10/26 – The case manager discussed with nurse at rounds. It is anticipated that patient will be psychiatrically cleared soon. She is being treated for UTI (urinary tract infection) currently. The case manager called the facility to confirm if they are planning to accept her back. Spoke with the Assistant Nursing Director and she reported that they have discharged her from their facility due to a suicidal attempt. She stated that they informed her	F0627		05/05/2026

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F0627 SS = D	Continued from page 58 POA (Power of Attorney) of this. 2/11/26 – Behavioral health cleared patient, doesn't need inpatient psychiatry. Social Work to work on placement to SNF (skilled nursing facility). 2/12/26 – The case manager received call back from the Ombudsman. She is going to investigate the issues with the facility and talk with the APS (Adult Protective Services) worker. 2/13/26 – The case manager called the facility to discuss with staff if patient is able to go to the facility. Left voicemail with the front desk staff requesting a call back. 2/16/26 – Spoke with the Ombudsman and she stated the facility will not take patient back and she will follow up with the state on a report and recommending to call APS at discharge to make another report. The case manager and charge nurse visited patient at bedside to share results and that discharge is likely tomorrow based on no options for SNF placement. The case manager left message with patient's healthcare POA that discharge would be tomorrow, and we need her keys to get patient in the house. Asked for a callback to arrange. 2/17/26 – All other SNF, ALF (assisted living facility) have declined this patient going to their facility. Reported that the facility had declined taking her back and will accept the penalty fee for this act. Patient will be set up with home health, choice provided. Will notify APS following discharge. Healthcare POA is able to meet patient at her house. Discharge note: Patient is a 65-year old female and she has been here for 270 hours. We have had every social worker in the hospital try to help us get a good patient plan for her. Patient is not interested in giving up her trailer. Patient is blind but has an opportunity to get cataract surgery but does not want it. We have arranged for meals on wheels, in-home health care. And also talked to her POA. We believe the safest plan is for her to return home and we are going to get her home safely. We have offered as much as we can here from this hospital. A phone interview with the Hospital Case Manager on 4/6/26 at 11:19 AM revealed Resident #101 was seen by psychiatry on 2/6/26 at the ED and was being discharged back to the facility but they refused to accept her. On 2/10/26, she spoke with the Assistant Director of Nursing who told her that they had discharged Resident #101 from their facility due to her suicide attempt. The Hospital Case	F0627		05/05/2026

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F0627 SS = D	Continued from page 59 Manager stated that she got in touch with the Ombudsman to report that the facility refused to take Resident #101 back and that she had difficulty finding another nursing facility to accept her. The Hospital Case Manager stated that she left a voicemail at the front desk at the facility on 2/13/26, but they were not great about returning phone calls. On 2/17/26, she talked to the Ombudsman who reported that the facility had declined taking Resident #101 back and would accept the penalty fee. A phone interview with Resident #101's POA on 3/31/26 at 1:06 PM revealed the nurse called her on 2/6/26 and notified her about Resident #101 being sent to the hospital because she had been given a razor and had cut herself. The POA stated that she was not told anything about Resident #101 returning to the facility, but it was her understanding that she would return to the facility when discharged from the hospital. She stated that she received a phone call on 2/16/26 from the Social Worker at the hospital to pick up Resident #101's belongings from the nursing home because she was going to be discharged home. On 2/17/26, Resident #101 was sent home because no nursing facility would accept her according to the hospital and the nursing home refused to take her back. The POA further stated that this was Resident #101's third recorded suicide attempt and the hospital had checked surrounding counties, but no nursing facility would accept her. She shared that the Hospital Case Manager told her that they were releasing her because she was not a danger to herself anymore, but the POA did not think she was stable to be released home because she lived alone, was "blind" and did not have anyone. A phone interview with the Ombudsman on 3/31/26 at 11:58 AM revealed the hospital called her on 2/12/26 because the facility refused to take Resident #101 back and they had a hard a time finding another nursing facility that would accept her. During a follow-up phone interview with the Ombudsman on 4/8/26 at 9:17 AM, the Ombudsman stated that after she received a phone call from the hospital on 2/12/26, the Ombudsman called the facility and left a message for the Director of Nursing to call her back, but she never got a return call. The Ombudsman stated that she did not come by to the facility because she thought there was no use in arguing with the facility staff since they had already discharged Resident #101. She further stated that when she visited the facility a couple of weeks ago, it was for her quarterly visit, and she did not	F0627		05/05/2026

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F0627 SS = D	Continued from page 60 mention anything to the staff about Resident #101's discharge. A phone interview with the Assistant Director of Nursing (ADON) on 3/31/26 at 1:55 PM revealed she did not get a phone call from the hospital about Resident #101 coming back. The ADON stated that they discussed at the next morning meeting after Resident #101 was sent to the hospital that a decision was made that Resident #101 was not coming back to the facility because of safety reasons. The ADON stated that Resident #101 was adamant she was going to take her own life no matter what they did. The ADON stated that she did not know if Resident #101's POA was told about Resident #101 not coming back to the facility, but that the POA came to get Resident #101's belongings and told them that she would not be returning because she was discharged to a behavioral health facility. An interview with the Social Services Manager on 4/1/26 at 11:56 AM revealed he did not know what the Administrator or the Director of Nursing said about Resident #101 returning to the facility after she was sent to the hospital. He stated that he did not know if the POA got notified whether Resident #101 could return to the facility and he did not recall discussing anything about Resident #101's discharge at the morning meeting. An interview with the Admissions Director on 4/3/26 at 10:04 AM revealed the Hospital Case Manager called the day after Resident #101 went back to the hospital asking about what happened to Resident #101 at the facility. The Admissions Director stated there was no official referral put in the system from the hospital about Resident #101 coming back to the facility. He said he did not recall any other call or conversation with hospital staff. The Admissions Director explained that the facility worked with a Central Admissions team who handled admissions and re-admissions to the facility especially complex cases such as Resident #101, and they sometimes had to check with the Regional Vice President of Operations before admitting or re-admitting residents with complex cases. An interview with the Director of Nursing (DON) on 4/1/26 at 2:26 PM revealed Resident #101 was accepted into their facility through Central Admissions, and they followed a clinical grid which indicated the facility could not meet Resident #101's needs if she came back after a suicide attempt. The DON stated they could not meet her needs at the facility and asked how she could keep her safe if	F0627		05/05/2026

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F0627 SS = D	Continued from page 61 she tried to kill herself. The DON stated Resident #101's POA called the facility 2/16/26 asking about Resident #101's belongings, and she did not talk to her or the ADON about Resident #101 coming back to the facility. The DON stated that she would have to look at notes about the morning meetings but ultimately, the Administrator and the Regional Vice President of Operations would make a decision about not allowing Resident #101 to return to the facility. The DON stated that it would have been possible that the hospital contacted Central Admissions. An interview with the Administrator on 4/3/26 at 1:40 PM revealed she did not know what Central Admissions told the hospital, but she did not deny Resident #101's readmission to the facility. The Administrator stated that she spoke with Resident #101's POA on 2/16/26 but all she said was that Resident #101 was being discharged home the next day. The Administrator stated that the POA never said anything about Resident #101 coming back to the facility. She shared that the Ombudsman came to the facility, but she did not say anything to them about Resident #101 needing a facility to discharge to. The Administrator stated that Resident #101 probably chose to go elsewhere and they did not track her any further than that. A phone interview with the Medical Director on 4/1/26 at 1:54 PM revealed Resident #101 was appropriate to be at the facility, and they could not refuse to admit her. The Medical Director stated that if Resident #101 was saying that she had no suicidal ideations, they had no leg to stand on about refusing to take her back because she won't be admitted to inpatient psychiatry if she was denying any suicidal ideation and then there was nowhere else for her to go. The Medical Director stated that she remembered speaking to facility staff about what happened to Resident #101, but she was not consulted about whether to let her return to the facility.	F0627		05/05/2026
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:	F0645	A Level II Preadmission Screening and Resident Review (PASRR) was not obtained for Resident #101 as the Resident discharged to the hospital on 2/6/2026 and did not return to the facility. Residents with the potential for a Level II PASRR as well as those possessing a Level II were reviewed on 04/28/2026 through 05/01/2026 to ensure they had the correct PASRR Level based on their diagnosis(es). There were no indicators noted which would have required intervention.	05/05/2026

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F0645 SS = D	Continued from page 62 (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely	F0645	Continued from page 62 The Social Services Director/designee will confirm with Admissions Coordinator that the correct PASRR Level is completed. For Residents with a new qualifying diagnosis(es), a Level II PASRR an application will be submitted for review. The Regional Director of Clinical Services provided provide education on 4/30/2026 to the Executive Director, Nursing Leadership and Admissions Director regarding the rule to not accept an admission without the correct PASRR number. Education will include information regarding the Level II triggering diagnosis(es). The staff education regarding obtaining appropriate PASRR numbers prior to admission for new staff will be provided during orientation. The Executive Director and/or Admissions Director will perform Quality Improvement Monitoring for accurate PASRR screening on new admissions weekly for twelve (12) weeks. Any interventions will be documented and reviewed with the QAPI team for necessary revisions. The Executive Director introduced the plan during the monthly QAPI Committee meeting on 04/29/2026. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Executive Director will report the monthly findings to the Quality Assurance Performance Improvement Committee during the regularly scheduled QAPI meeting. Alleged Date of Compliance: 05/05/2026	05/05/2026

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F0645 SS = D	Continued from page 63 to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) evaluation for a resident with serious mental health disorders for 1 of 3 residents reviewed for PASRR (Resident #101). Findings included: A PASRR Determination Notification letter dated 9/04/25 revealed Resident #101 had a Level I PASRR with no expiration date. Resident #101 was admitted to the facility on 1/26/26 with diagnoses that included post-traumatic stress disorder, bipolar disorder in remission and delusional disorders. She was also diagnosed with major depressive disorder, single episode, severe with psychotic features. Resident #101's admission Minimum Data Set (MDS) assessment dated 2/01/26 revealed she was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Resident #101's active psychiatric/mood disorder diagnoses included depression, bipolar disorder, psychotic disorder and post-traumatic stress disorder. She received antipsychotic and antidepressant medications during the MDS assessment period. An interview with the Social Worker (SW) on 4/03/26 at 9:24 AM revealed he was responsible for submitting requests for Level II PASRR evaluations. He indicated Resident #101 came from the hospital with a Level I PASRR so it wasn't necessary for him to submit a request for a Level II PASRR as the hospital would have done so if they felt it was	F0645		05/05/2026

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F0645 SS = D	Continued from page 64 warranted based on her mental health diagnoses. The SW revealed if a resident arrived with a halted or Level I PASRR he did not review their diagnoses, but he would submit for a Level II PASRR evaluation if a new mental health diagnosis was made while the resident was living at the facility. An interview with the Administrator on 4/03/26 at 1:31 PM revealed the Admissions department should verify there was a current PASRR before a resident moved into the facility, and the Social Worker was responsible for the PASRR process beyond that. She indicated the hospital discharge information for Resident #101 did not provide a clear diagnosis of either bipolar disorder or post-traumatic stress disorder, which would have informed the facility whether a Level II PASRR evaluation was needed. The Administrator reported that someone at the facility should have identified Resident #101's mental health diagnoses and submitted a request for a Level II PASRR evaluation.	F0645		05/05/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations and interviews with residents and staff, the facility failed to provide incontinence care (Resident #102) and showers as scheduled (Resident #77) for 2 of 6 dependent residents reviewed for assistance with activities of daily living. The findings included: 1. Resident #102 was admitted to the facility on 2/7/26 with diagnoses that included pneumonia, weakness and reduced mobility. The admission Minimum Data Set assessment dated 2/13/26 indicated Resident #102 was cognitively intact, had adequate vision, required substantial/maximal assistance with toileting hygiene and was frequently incontinent of both urine and bowel. Resident #102's care plan initiated on 2/24/26 indicated Resident #102 had an activities of daily living (ADL) performance deficit. Interventions	F0677	Resident #102 was provided incontinence care on 3/30/2026 by NA #8 and MA #1. Resident #77 was assisted in getting a shower by NA assigned to the unit on 4/2/2026. (No identifying number noted.) The Interdisciplinary Team inquired with the Interviewable Residents from 4/29/26 through 05/01/2026 to evaluate if incontinence care and showers were being provided timely. Any Resident has the potential to be affected by the alleged deficient practice. The Interdisciplinary Team will make inquiries with Residents regarding their shower schedule and incontinence care during their morning rounds; the Nursing and/or Administrative Manager on Duty will speak with Residents on the weekends. Interventions will be provided as indicated based on the Residents' responses. The Director of Nursing/designee will be reviewing the daily shower sheets to ensure completion of the scheduled showers. The Executive Director and Director of Nursing provided education on 4/29/2026 through 05/01/2026 to the nursing staff regarding the importance of timely incontinence care and the provision of showers based on the Residents' preferences. Education will include information regarding information on the requirement for services to maintain grooming and personal/oral hygiene. The staff education regarding activities of daily living requirements for new staff will be provided during orientation. The Director of	05/05/2026

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F0677 SS = D	Continued from page 65 included Resident #102 required maximum assistance by 1 to 2 staff for toileting. Further review of Resident #102's care plan indicated she had bladder incontinence. Interventions included change disposable briefs frequently and as needed, clean perineal area with each incontinence episode and check frequently and as required for incontinence. During a continuous observation on 3/30/26 from 1:24 PM to 2:00 PM, an interview was conducted with Resident #102 who was lying in bed in her room. Resident #102's call light was not on at the start of the observation. There was a faint odor of urine and feces upon entry into Resident #102's room. Resident #102 stated that she was incontinent of urine and stool at 11:45 AM and turned her call light on at 11:45 AM and had been waiting to be changed since then. She stated she knew this because she looked at her cellphone and noted the time when she asked Nurse Aide (NA) #8 to change her. Resident #102 stated that NA #8 told her that she needed to get somebody to help her. Resident #102 further stated that staff probably needed to serve lunch trays first before she could be changed. Resident #102 shared that she did not usually eat breakfast or lunch. At 1:36 PM, NA #8 was observed walking up and down the hall twice without stopping at Resident #102's room. On 3/30/26 at 1:45 PM, NA #8 was interviewed and she stated that Resident #102 had asked her to change her, but she couldn't remember what time she had asked her, and she couldn't say if it was before or after lunch. NA #8 stated that she was getting ready to do her incontinence rounds soon and she would get to Resident #102 eventually during her rounds. NA #8 stated that Resident #102 wanted her to find somebody to help her because she did not like to be changed by one person. NA #8 shared that she had asked the other nurse aides, but they were all busy at that time. NA #8 could not say which staff members she had asked to assist her. At 1:50 PM on 3/30/26, NA #8 walked into Resident #102's room with Medication Aide (MA) #1. Both aides washed their hands and applied gloves. They proceeded to pull Resident #102's cover down and unfastened the resident's brief while NA #8 started to clean Resident #102's front perineal area with a disposable wipe. They turned Resident #102 towards her right side. While MA #1 held on to Resident #102 who was turned towards her, NA #8 started to clean stool off Resident #102's buttocks with a disposable wipe. There was dried feces stuck to Resident #102's buttocks and Resident #102's brief was heavily soiled with urine and feces. Her drawsheet	F0677	Continued from page 65 Nursing/Designee will perform Quality Improvement Monitoring for Residents to ensure incontinence care and showers are performed timely for five (5) X/week for four (4) weeks; three (3) X/week for four (4) weeks and one (1) X/week for 4 weeks. Any interventions will be documented and reviewed with the QAPI team for necessary revisions. The Director of Nursing introduced the plan during the monthly QAPI Committee meeting on 4/29/2026. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report the final findings to the Quality Assurance Performance Improvement Committee during the regularly scheduled QAPI meetings. Alleged Date of Compliance: 5/5/2026	05/05/2026

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F0677 SS = D	Continued from page 66 was also visibly wet underneath her brief. An observation of Resident #102's bottom revealed no red or open areas after NA #8 cleaned it. NA #8 removed the soiled brief underneath Resident #102's bottom as well as the drawsheet. NA #8 placed a new brief and a drawsheet underneath Resident #102's bottom and then rolled her onto her back. Both aides fastened the new brief, replaced Resident #102's covers and re-adjusted her bed. An interview with NA #8 on 3/30/26 at 2:18 PM revealed she did not normally work on day shift (7:00 AM to 3:00 PM) and she just picked up an extra shift today. NA #8 stated that they usually staffed the hall with one nurse aide and one nurse, and that she was working as the only nurse aide on the hall. NA #8 stated that she felt overwhelmed especially when she was observed providing incontinence care to Resident #102. NA #8 confirmed that she responded to Resident #102's call light and Resident #102 had asked to be changed but NA #8 could not say if it was before or after lunch. NA #8 stated that she told Resident #102 that she had to get another staff member to help her because Resident #102 required two staff members to provide incontinence care to her. An interview with MA #1 on 3/30/26 at 2:34 PM revealed NA #8 asked her for help with Resident #102 about five minutes before they both went in to provide incontinence care to Resident #102. MA #1 stated that NA #8 did not ask her for help prior to that. An interview with NA #9 on 3/30/26 at 2:08 PM revealed she was working on C hall that day and that NA #8 did not ask her for help with Resident #102. NA #9 stated the rehabilitation hall where Resident #102 resided normally had one nurse aide, but they should have at least two nurse aides for residents who required two staff members to assist them. An interview with NA #10 on 3/30/26 at 2:29 PM revealed NA #8 did not ask her to help change Resident #102. An interview with NA #12 on 3/30/26 at 2:47 PM revealed NA #8 did not ask her for help with changing Resident #102 before lunch. NA #12 stated she remembered NA #8 asking her for help, but it was after lunch and she was giving a shower to another resident at that time. An interview with NA #11 on 3/30/26 at 2:49 PM revealed she was working on another hall and NA #8	F0677		05/05/2026

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F0677 SS = D	Continued from page 67 did not ask her for help on the rehabilitation hall. An interview with Nurse #4 on 3/30/26 at 2:31 PM revealed she was assigned to Resident #102, but she was not aware that Resident #102 had been waiting to be changed since before lunch. Nurse #4 stated NA #8 did not ask her for help with Resident #102, but she would have if she knew about it. An interview with the Director of Nursing (DON) on 3/30/26 at 4:25 PM revealed Resident #102 did not like to be disturbed until after noon. She did not eat breakfast, and she had staff try to coordinate care for her before noon or right after. The DON stated Resident #102 always complained that she had to wait two hours to get changed, but she was not aware that it had happened today. The DON stated that it was not ok for a resident to wait long to be changed, and she told her staff to provide assistance to residents within 15 to 20 minutes maximum. She further stated that NA #8 should have asked another staff member to help her provide incontinence care to Resident #102. 2. Resident #77 was admitted to the facility on 3/25/26 (Wednesday) with diagnoses including non-pressure chronic ulcer on left lower leg. Resident was assigned to room 116 and was put on the shower sheet to receive showers on Saturday and Wednesday during the dayshift (7:00 AM until 7:00PM). The admission Minimum Data Set (MDS) dated 3/31/26 revealed that Resident #77 was cognitively intact. She did not display any behaviors. Resident #77 was supervision or touch assistance for her shower/bathing. The Staff Assessment of Daily and Activity Preferences indicated the resident preferred showers. On 3/30/26 at 3:32 PM an interview and observation was made with Resident #77. She stated that she was admitted to the facility last Wednesday (3/25/26). Resident #77 was observed to have very oily and unkempt hair. Resident #77 was asked if she had received a shower since her admission and she stated no. Resident #77 went on to say that on Saturday, 3/28/26, a Nurse Aide (NA #1) came to her room sometime between breakfast and lunch and asked her if she wanted a shower. Resident #77 informed NA #1 that she would like to have a shower. Resident #77 stated NA #1 never came back to give her a shower. Resident #77 was able to describe NA #1.	F0677		05/05/2026

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F0677 SS = D	Continued from page 68 On 3/31/26 at 2:32 PM an interview was held with the NA #1 who was assigned to Resident #77 on Saturday 3/28/26. NA #1 stated she was working on Resident #77's hall from 7:00 am to 3:00 pm as a Nurse Aide. NA #1 stated she then left the facility at 3:00 PM and returned at 7:00 PM and worked as a Medication Aide on a cart from 7:00 PM until 11:00 PM. NA #1 first stated that she did not have a conversation with Resident #77 regarding a shower. When NA #1 was informed that Resident #77 stated NA #1 did ask her about receiving a shower. NA #1 then stated that she had a conversation with Resident #77, but it was in the evening when she was on the medication cart. NA #1 indicated she asked Resident #77 if she wanted a shower, but since she was on the medication cart she could not do a shower for her. NA #1 explained she asked the NA on the evening shift to shower the resident. NA #1 stated that Resident #77's shower days were assigned for Saturday and Wednesday. The NA stated that if Resident #77 would like a shower today she would be able to give her a shower around 3:30 PM. On 4/1/26 at 9:00 AM an interview was held with a Nurse #1. Nurse #1 stated she had been assigned to the rehabilitation hall and was on the medication cart from 7:00 AM until 7:00 PM on 3/28/26. She stated NA #1 was the NA assigned to the floor and would have been responsible for doing any showers. Nurse #1 thought NA #1 left at one point and came back to take the medication cart at 7:00 PM. On 4/1/26 at 4:55 PM a second interview and observation was completed with Resident #77 and Resident #77 was still observed with oily hair. Resident #77 was asked again about when NA #1 had asked her about wanting a shower on 3/28/26. Resident #77 again stated it was sometime between breakfast and lunch. Resident #77 was asked if it could have been in the evening when NA #1 asked her about a shower and she stated that it was not in the evening. Resident #77 stated that the NA assigned to her today (Wednesday) was unable to give her a shower. The Resident indicated NA #2 told her that she would give her a shower but did not come back until later in the afternoon and told Resident #77 she had to leave in 15 minutes so she would not have time to do the shower, but she would let the next shift NA (NA #7) know and she would be able to do her shower. On 4/2/26 at 11:00 AM an interview was held with NA #2. NA #2 stated she was assigned to Resident #77 yesterday (4/1/26) from 7:00 AM until 3:00 PM	F0677		05/05/2026

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F0677 SS = D	Continued from page 69 and offered her a shower, but Resident #77 stated she was in pain and wanted to get some pain medication first. NA #2 informed the nurse about Resident #77 needing pain medication. NA #2 indicated came back about 15 minutes later and Resident #77 stated she still had pain. NA #2 stated she waited for another 15 minutes, and Resident #77 stated she still had pain. NA #2 informed Resident #77 that she would not have enough time to do a shower since it would be the end of her shift and explained to Resident #77 that NA #7 could do it. On 4/2/26 at 10:50 AM a third interview was held with Resident #77, and she stated that she still had not been given her shower. The evening NA on 4/1/26 (NA #7) told her that she did not have enough time to give her a shower. On 4/2/26 at 11:29 AM an interview was held with the Director of Nursing (DON) regarding Resident #77 being admitted on 3/28/26 and was assigned to showers on Saturday and Wednesday and on both days the assigned NAs had not given her a shower. The DON stated Resident #77 should have had showers, and she would look into it. The DON indicated she would expect residents to get showers on their shower days and times, and if staff were unable to provide a shower, then they would inform the next shift or they would get a shower the next day. On 4/2/26 at 3:00PM a fourth interview and observation was made with Resident #77. She stated that her assigned NA today had taken her to the shower room to get a shower and washed her hair. Resident #77 still had damp hair and stated she felt much better. On 4/2/26 at 4:27 PM an interview was held with the Administrator. She stated the expectation would be for the residents to get a shower on their assigned shower days.	F0677		05/05/2026
F0583 SS = A	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and	F0583		05/05/2026

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F0583 SS = A	Continued from page 70 telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interviews, the facility failed to protect a resident's private healthcare information by leaving confidential medical information unattended, visible, and accessible to others on a laptop screen for 1 of 6 medication carts observed (C hall medication cart). The findings included: A continuous observation of the C hall medication cart occurred on 4/02/26 from 11:50 AM to 11:53 AM. The medication cart was unattended in the hallway and was observed to have a laptop screen opened which showed a resident's personal identifying information including the resident's name, diagnoses, and medications. There was one resident in a wheelchair in the hallway during this time. Nurse #3 returned to the cart at 11:53 AM from the central nursing station. During an interview on 4/02/26 at 11:53 AM Nurse #3 acknowledged he did not lock the laptop screen on the medication cart when he walked away. He indicated he should have locked the laptop screen before leaving the area to ensure resident	F0583		05/05/2026

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F0583 SS = A	Continued from page 71 information was not visible to others. An interview on 4/03/2026 at 11:43 AM with the Director of Nursing (DON) revealed Nurse #3 should not have walked away and left resident information displayed on screen without locking it. She indicated screens should be locked to protect resident's privacy whenever a medication cart was left unattended.	F0583		05/05/2026