DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Coral Springs Rehab & Healthcare Ctr **DATE SURVEY COMPLETED:** September 17, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care Quality. The facility was found to not be in substantial compliance with 42 CFR 483. Survey Dates: 09/14/26 to 09/17/26 Survey Census: 165 Sample Size: 61 Supplemental Residents: 24		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed September 17, 2026: cross refer: F558, F580, F582, F584, F600, F602, F628, F657, F658, F677, F679, F684, F686, F689, F695, F760, F804, F806, F812 and F880.	Cross Reference F558, F580, F582, F584, F600, F602, F628, F657, F658, F677, F679, F684, F686, F689, F695, F760, F804, F806, F812 and F880.	11/2/2026

Provider's Signature [signature] Title CNHA Date 10/7/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085004	A. BUILDING B. WING	09/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coral Springs Rehab & Healthcare	505 GREENBANK ROAD , WILMINGTON, Delaware, 19808

(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 A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care Quality on 09/07/26 – 09/10/26. The facility was found to be in compliance with 42 CFR 483.73.	E0000		11/02/2026
F0000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care Quality. The facility was found to not be in substantial compliance with 42 CFR 483. Survey Dates: 09/14/26 to 09/17/26 Survey Census: 165 Sample Size: 61 Supplemental Residents: 24	F0000		11/02/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F0812	(A) All kitchen equipment, kitchen surfaces and walls were immediately cleaned upon discovery (B) Both multi-rack carts used to store clean dishes were immediately cleaned and sanitized. All clean dishes noted with food debris were immediately rewashed. All cracked/chipped dishes and all cracked/chipped insulated plate bases were removed from service. (C) The condiment storage cart was immediately removed to allow accessibility to the handwashing sink from the dishwashing room. Paper towels were immediately replenished, and a trash receptacle was placed by the handwashing sink. (D) An internal temperature gauge was immediately replaced in the reach-in-freezer. The floor and back wall in the walk-in freezer were immediately cleaned. All 3 gallons of ice cream were immediately discarded.	10/02/2026

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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F0812 SS = F	Continued from page 1 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to maintain a clean and sanitary kitchen environment by not ensuring equipment and walls were routinely cleaned, staff were knowledgeable regarding operation of the dish machine, the handwashing sink was accessible for use and cracked/chipped dishes were removed from service. These failures had the potential to cause food-borne illnesses for 144 of 144 residents who received meals prepared in the facility's one of one kitchens. Findings include: On 09/14/26 at 9:40 AM, a tour of the kitchen was conducted with the Dietary Manager (DM). The following sanitation concerns were identified: The dish machine was observed in operation. As Dietary Aide (DA)2 unloaded clean dishes, two bowls contained visible food debris. Additional food debris was observed on the clean-side platform, and several insulated plate bases were cracked and chipped. The DM confirmed the presence of food debris on the bowls and on the clean side of the dish machine. Although the dish machine reached the required wash and rinse temperatures and the sanitizer concentration was within the acceptable range, the machine failed to stop between the wash and rinse cycles during one load. The DM acknowledged the dish machine was not functioning properly. Review of the September 2026 dish machine temperature log revealed the sanitization column did not accurately document sanitizer concentrations in parts per million (PPM). Dietary Aide (DA)1 reviewed the log and admitted she did not know how to document the PPM reading. On 09/15/26 at 1:52 PM, a follow-up tour was conducted with the Regional Dietary Manager. The following sanitation concerns were identified: The handwashing sink was obstructed on the open	F0812	Continued from page 1 (E) The interior and exterior surfaces of both convectional ovens were immediately cleaned. (F) The Maintenance director was contacted regarding the dish machine's failure to stop between the wash and rinse cycle upon discovery. The maintenance director immediately readjusted the connection to ensure the dish machine was stopping between the wash and the rinse cycle. All residents have the potential to be affected. The facility cannot retroactively correct this issue. A root cause analysis revealed the need for re-education of the dietary staff on the Sanitation of the Dietary Department policy and the FDA Food Code on Handwashing Sinks and Hand Drying Provisions. A root cause analysis further revealed the need for re-education of the dietary staff on documenting the dish machine sanitizer concentration in parts per million (PPM). The Food Service Director/Director of Dining Services will re-educate the dietary staff on the facility's Sanitation of the Dietary Department policy and the FDA Food Code on Handwashing Sinks and Hand Drying Provisions. Additionally, the Food Service Director/designee will provide the dietary staff with re-education on documenting the dish machine sanitizer concentration in parts per million (PPM). The NHA will oversee all interventions of the PoC and will be responsible for corrective actions and the success of this PoC. The Director of Dining Services/Assistant Director of Dining Services/Dietary Cooks will perform daily inspections of the cleanliness of all kitchen equipment, kitchen surfaces and kitchen walls and floor to validate the daily cleaning check of list is completed. All task completion will be documented directly within Reqqer. Printed copies of the assigned checklists will be completed by staff and reviewed by the Director of Dining Service (FSD). Following verification, the FSD will enter the completed status into the Reqqer system to ensure accurate electronic recordkeeping. Written documentation will be maintained in a dedicated compliance binder on-site for surveyor review. Electronic documentation will remain stored within the Reqqer platform as part of our permanent digital record. The dietary aid assigned to the dish room's	10/02/2026

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F0812 SS = F	Continued from page 2 side, requiring dishwashing staff to bypass the sink and walk through the kitchen and cooking equipment aisle to access handwashing facilities. The sink also lacked paper towels and a trash receptacle, and the drain was not functioning properly. Two multi-rack carts used to store clean plate tops and insulated plate bases contained accumulations of dried food debris. Several insulated plate bases were cracked and chipped. Multiple soiled dishes returned to the dish room were cracked and chipped. The wall surrounding the dish machine and the column separating the dish room from the kitchen contained accumulations of dried food debris and food splatters. The reach-in freezer lacked an internal temperature gauge. The floor and back wall of the walk-in refrigerator were soiled with food debris, trash, and dried splatters. The walk-in freezer contained a three-gallon container of ice cream with the lid unsecured, exposing the product, and a second three-gallon container of ice cream with evidence of re-frozen leakage beneath the container. The interior and exterior surfaces of two convection ovens and two conventional ovens were soiled with accumulated grease and charred food debris. A soiled pan containing a scoop was stored inside the conventional oven on the right side. The DM stated the ovens were cleaned daily. Review of the kitchen's Weekly Cleaning Assignments," dated for the week of 09/14/26, provided by the facility revealed "deep clean ovens" and "walk-in refrigerator" were marked as cleaned for Monday, 09/14/26 and Tuesday, 09/15/26. The assignments did not include the cleaning of walls and columns. During an interview on 09/16/26 at 1:22 PM, the Registered Dietitian (RD) stated she did not conduct kitchen inspections because her role was "clinical." During an interview on 09/16/26 at 1:33 PM, the DM confirmed the multi-rack carts required cleaning and stated the carts were difficult to move outside due to the stairwell. The DM acknowledged awareness of the broken and chipped dishes. The DM further	F0812	Continued from page 2 assignment will be updated to include daily cleaning and sanitizing of the milti-rack carts used to store clean dishes. The Director Dining Services will educate current and new dining staff on the daily cleaning and sanitizing of the multi dish storage rack process. The dietary aid assigned to loading clean dishes after each wash on the multi-rack carts will inspect the clean dishes for food and debris prior to placing them on the carts. The Director of Dining Services will educate current and new dining staff on carefully inspecting clean dining utensils to ensure they are free from food debris. While loading clean dishes on the multi-rack carts the dietary aid will inspect all dishes and insulated plates for cracks and chips. If dishes or insulated plates are noted with cracks and chips the dietary aid will immediately remove them from service. The Director of Dining Services will educate current and new dining staff on inspecting dishes and insulated plates for cracks or chips and discarding them if none are found. The Director of Dining Services/Assistant Director of Dining Services/Dietary Cooks will verify that the handwashing skink is accessible from the dish room, a trash receptacle and paper towels are present by the hand-washing station. The Director of Dining Services will make rounds 3 times a day, documenting compliance during each round Sanitizer concentration will be entered into the dish machine temperature log with employee signature. FSD will ensure log is completed before each session of plate washing to ensure sanitizer is at correct (PPM) The Director of Dining Services (FSD) will conduct both morning rounds and exit rounds each day. During these rounds, the FSD will verify that all internal temperature gauges are properly placed and functioning as required reach-in-freezer. Any corrective actions taken during these rounds will be documented immediately. All findings and completed tasks will be entered into the Reqqer platform the same day to ensure accurate, real-time compliance tracking. This documentation supports our ongoing efforts to maintain regulatory readiness and strengthen daily operational controls.	10/02/2026

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F0812 SS = F	Continued from page 3 stated he was unaware that the handwashing sink could not be obstructed. Review of the facility policy titled "Sanitation of Dietary Department," undated, revealed "The dietary staff shall maintain the sanitation of the dietary department through compliance with a written, comprehensive cleaning schedule." Review of the FDA Food Code https://www.fda.gov/food/fda-food-code/food-code-2022 revealed "5-204.11 Handwashing Sinks. (A) A handwashing sink shall be maintained so that it is accessible at all times for employee use." "Handwashing Sinks. Handwashing sinks that are blocked by portable equipment or stacked full of soiled utensils and other items, are rendered unavailable for employee use. Nothing must block the approach to a handwashing sink thereby discouraging its use, plus it must be kept clean and well stocked with soap and sanitary towels to facilitate frequent use." Review of the FDA Food Code https://www.fda.gov/food/fda-food-code/food-code-2022 revealed "6-301.12 Hand Drying Provision. Each handwashing sink or group of adjacent handwashing sinks shall be provided with: (A) Individual, disposable towels;" Review of the FDA Food Code https://www.fda.gov/food/fda-food-code/food-code-2022 revealed "6-301.20 Disposable Towels, Waste Receptacle. A handwashing sink or group of adjacent handwashing sinks that is provided with disposable towels shall be provided with a waste receptacle as specified under ¶ 5-501.16(C)."	F0812	Continued from page 3 The Director of Dining Services/Assistant Director of Dining Services/Dietary Cooks will perform daily observation inspection of the cleanliness of the floor and back wall of the walk in freezer. The Director of Dining Services will perform daily inspections for the foods kept in the freezer and refrigerator to ensure they are wrapped and sealed properly and are not open to air. The dietary cooks will ensure the interior and exterior surfaces of both convectional ovens are cleaned before and after each use. The Director of Dining Services/Assistant Director of Dining Services will perform daily inspections to ensure both convectional ovens are clean. The Director of Dining Services will Conduct morning rounds and exit rounds ensuring equipment is in proper working order, Documentation will be entered into Reqqer that this has occurred with maintenance being notified through Regger of repair need. The Food Service Director/Assistant Food Service Director/Cook/The Regional Director of Food and Dining/ Travel Administrator will conduct cleaning audits on kitchen surfaces, kitchen equipment, serving utensils to ensure they are free from cracks and chips, accessibility to the hand-washing stations, availability of paper towels and trash receptacle, internal temperature gauge present in the reach-in refrigerator, documentation accuracy of dish machine sanitizer concentration and proper functioning of the dish machine. These audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations.	10/02/2026
F0804 SS = E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;	F0804	1 R86 and R43 still reside in the facility. The dietician met with R86 and R43 on 9/15/26 to review documented food preferences. The facility cannot retroactively correct this issue. 2 All residents with food preferences have the potential to be affected. A verification audit was conducted on documented food preferences with residents to ensure accuracy. 3 A root cause analysis revealed the need for re-education of the dietary cooks on food	10/02/2026

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F0804 SS = E	Continued from page 4 §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to serve palatable food for two of eight residents(Residents (R)86 and R46) reviewed for food palatability and five of five residents who attended the resident council meeting, out of a total sample of 34 residents. This deficient practice had the potential to cause weight loss and decreased quality of life. Findings include: Review of the "Food Committee" meeting minutes, provided by the facility revealed ongoing resident concerns regarding meal quality and service, dated 01/20/26, included complaints that food was served cold, vegetables were overcooked, tomatoes were sometimes watery, and coffee was cold or not always included on meal trays. Meeting minutes, dated 02/17/26, documented concerns that food was not hot enough. On 04/21/26, residents reported that food was not always appealing. Meeting minutes, dated 05/19/26, reflected concerns that meal trays remained in the hallway for an extended period before being distributed and that excessive gravy was being served. Meeting minutes, dated 08/18/26, revealed resident complains that food lacked sufficient seasoning. Review of the grievances provided by the facility revealed multiple resident complaints related to food quality revealed the following" A grievance, dated 04/14/26, documented concerns that a grilled cheese sandwich was burned on 04/01/26 and that a grilled cheese served on 04/14/26 was toasted on one side and plain bread on the other. The documented resolution indicated the Food Service Director (FSD) provided tray line education. A grievance, dated 05/10/26, revealed the resident reported not receiving syrup with pancakes and not receiving milk or sugar with oatmeal. The documented resolution indicated the FSD met with the resident on 05/14/26, addressed the food concerns, and planned corrective action with the dietary team. The resolution further documented that additional training, and education would be provided to tray line staff regarding meal accuracy, completeness of meal trays, attention to resident preferences, and ensuring condiments were included	F0804	Continued from page 4 preparation, food appearance, adhering to food preferences listed on meal tickets, and appropriate serving temperature of hot and cold food items. A root cause analysis further revealed the need for re-education of dietary aids on accurately communicating what is written on the meal ticket to the cook to ensure meal accuracy. A root cause analysis also revealed the need for re-education of the dietary aids on ensuring all condiments listed on the meal ticket are placed on the tray. 4 The Regional Director of Food and Dining Services/Director of Dining Services will provide re-education to the dietary cooks on following receipts while preparing food, acceptable food presentations, appropriate food temperatures for hot and cold food items. The Regional Director of Food and Dining Services/Director of Dining Services will also provide re-education to the dietary aids on accurately reading and communicating to the cook items written on the meal tickets as well as ensuring all condiments listed on the meal tickets are placed on the meal tray. During meal preparation times the Director of Dining Services/Assistant Director of Dining Services/Regional Director of Dining Services/Manager on Duty will conduct observational and temperature testing audits on 1 meal service per day to ensure that food preparations are acceptable, hot and cold food temperatures are adhered to, food presentations are acceptable, food preferences are observed and all condiments listed on meal tickets are placed on the trays. 1 meal observational and temperature testing will include weekends and holidays. Random meal services will be selected for auditing to include all 3 meals. The dietician will meet with meet with current and new residents to discuss food preferences and verify preferences are documented. The Food Service Director/Director of Dining Services/Cooks/Regional Director of Food and Dining will conduct observational and temperature testing audits on adherence to food preferences, food appearance, food temperatures and meal accuracy. These audits will be conducted daily X 7 days until 100% compliance is verified, then weekly (7 days per week) X 4 weeks until 100% is verified, then monthly (every day) X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations.	10/02/2026

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F0804 SS = E	Continued from page 5 before trays left the kitchen. Ongoing monitoring was also planned. A grievance, dated 05/26/26, revealed complaints that chicken was burned, sherbet was melted, and milk was served warm. The documented resolution indicated the FSD met directly with the resident, reviewed and updated the resident's preferences in [meal ticket program], and provided staff in-service education regarding allergies, substitutions, and serving the correct meal items. A grievance, dated 08/05/26, revealed concerns that a resident was served a meal consisting of a biscuit, chicken with gravy, and spinach on a plate that was cracked and chipped on both sides. The grievance further alleged the meal was served on a dirty plate, resulting in a request for an alternative meal. The documented resolution indicated the FSD spoke with dietary employees, immediately removed chipped and damaged plates from inventory, noted that new replacement plates had been received, and provided education regarding proper cooking techniques and meal presentation. A grievance, dated 08/11/26, documented concerns from 07/28/26 regarding the absence of hot plates, warm milk, and burned hot dogs. The documented resolution indicated the FSD addressed concerns related to missing silverware, condiments, specific meal items, and milk temperature. 1. Review of R43's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/07/26 located in the Electronic Medical Record (EMR) under the "MDS" tab revealed an admission date of 04/01/26 and a "Brief Interview for Mental Status (BIMS)" score of 12 out of 15, indicating R43's cognition was intact. The "MDS" also indicated R43 had a therapeutic diet and diagnose of heart failure, diabetes mellitus (DM), and renal insufficiency. Review of R43's diet order, dated 09/10/26, located in the EMR under the "Order" tab revealed "LCS [low concentrated sweets]/NAS [no added salt] diet, Regular texture, Thin Liquids consistency." Review of R43's "care plan," dated 09/09/26, located in the EMR under the "Care Plan" tab revealed "R43 is at nutrition/hydration risk r/t [related to] AKI [acute kidney injury], an dx [diagnosis] that include CKD [chronic kidney disease], T2DM [type 2 diabetes mellitus], R [right] hemiplegia, a fib [atrial fibrillation], CHF [congestive heart failure]. She receives a	F0804		10/02/2026

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F0804 SS = E	Continued from page 6 therapeutic/texture-modified diet." An intervention included "Provide, serve diet as ordered. Monitor intake and record q [every] meal." During an interview on 09/14/26 at 11:34 AM, R43 revealed dissatisfaction with the meals served. R43 stated she did not want eggs but was frequently served eggs for breakfast. R43 reported she only wanted toast and bacon and indicated her meals were generally served cold. Observation of R43 during breakfast on 09/16/26 at 8:55 AM revealed the resident was served breakfast in bed and her meal included scrambled eggs. R43 revealed continued dissatisfaction with the meal served. R43 stated she was always served eggs despite not liking eggs. R43 further stated her toast "wasn't toasted, it was bread," explaining the bread was not toasted and had become soggy from being dipped in butter. Observation of R43 during the dinner meal on 09/17/26 at 5:50 PM revealed the resident was served dinner in bed. Interview with R43 revealed the grilled sandwich served was not hot and the bread was stale. R43 stated the bread "wasn't toasted enough." 2. Review of R86's quarterly "MDS" with an ARD of 06/30/26 located in the EMR under the "MDS" tab revealed an admission date of 11/12/25 and a "BIMS" score of 15 out of 15, indicating R86's cognition was intact. The "MDS" also indicated R86 had diagnoses of DM, hypertension (HTN), and anemia. Review of R86's diet order, dated 11/12/25, located in the EMR under the "Order" tab revealed "Regular diet, Regular texture, Regular (Thin) consistency." Review of R86's "care plan," revised 07/07/26, located in the EMR under the "Care Plan" tab revealed "R86 is at nutrition/hydration risk r/t recent fx's[fractures] s/p [status post] ORIF [open reduction and internal fixation], DM, COPD [chronic obstructive pulmonary disease], HTN, HLD [hyperlipidemia], post-op[operation] anemia, osteopenia, need for therapeutic diet, potential for weight flux [fluctuation]/ and appetite flux, hx [history] of wt [weight] changes; hx of altered lab [laboratory] values; modified nutritional needs and at risk for clinical changes including wt [weight]/skin & lab changes." An intervention included "Provide, serve diet as ordered. Monitor intake and record q [every] meal."	F0804		10/02/2026

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

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F0804 SS = E	Continued from page 7 Interview on 09/14/26 at 11:34 AM, R86 revealed concerns regarding food quality and temperature. R86 stated, "The food is not always hot or good." Observation on 09/16/26 at 9:04 AM, of R86 in her room following breakfast service revealed continued concerns with meal quality. R86 stated her toast was not fully toasted and became soggy from butter. R86 further stated she was routinely served hot dogs for dinner and had previously informed the Dietary Manager (DM) of her concern. R86 stated there were times when the food was so poor that she requested a peanut butter and jelly sandwich instead of the meal served. During the dinner meal on 09/16/26 at 5:55 PM, R86 revealed the resident was served dinner in her room. The meal included a hot dog. Interview with R86 at that time revealed the hot dog was cold. 3. During the resident council meeting on 09/15/26 at 2:00 PM, residents (R12, R52, R61, R72, and R122) expressed complaints that sausage, potatoes, French fries, steak fries, and string beans were undercooked. Residents also complained that the food was cold overall and stated the food was cold all the time. On 09/16/26 at 8:45 AM, a breakfast test tray was sampled. The toast was not well toasted, and the tips of the bread were soggy with butter. The DM confirmed he instructed his staff to toast the bread more. The milk temperature measured 50 degrees Fahrenheit (F). When asked about cold food complaints, the DM stated he had been working on the problem during his short time as the dietary manager at the facility. The DM stated, "It doesn't help maintaining the heat when staff have to push the meal carts with the doors open because there are no handles on the carts, and the wheels don't roll straight." The DM acknowledged that cold items, such as milk, are kept in the meal carts on the same tray next to the hot foods. Review of the facility's policy titled "Palatability and Nutritive Value," revised 03/09/23, provided by the facility, revealed "Food will be prepared, held, and served in a manner that preserves nutritive value and palatability… 4. Best efforts will be made to present hot food hot and cold foods cold at point of service by using thermal lids and bases, heated or chilled plates and thermal pellets as necessary."	F0804		10/02/2026

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F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to reasonably accommodate the needs of one of one residents (R132) reviewed for call-light accessibility out of 61 residents. On three consecutive days, staff placed R132's call light on the floor or wrapped it around a stationary chair outside R132's reach. This deficient practice created the potential for delayed assistance with toileting, repositioning, food and fluids, comfort, and an emergency. Findings include: Review R132's "Admission Record:" located under the "Face Sheet" tab of the Electronic Medical Record (EMR) she was readmitted to the facility on 08/05/22 with diagnoses that included vascular dementia, a psychotic disorder with delusions, major depressive disorder with psychotic symptoms, generalized anxiety disorder, chronic kidney disease stage 3, dysphagia, and visual impairment. Review of the annual Minimum Data Set (MDS) under the tab titled "MDS" tab of the EMR, Assessment Reference Date (ARD) of 06/09/26 identified no upper- or lower-extremity limitations and indicated that R132 required setup or cleanup assistance for eating. In the MDS, "set up or clean up assistance is defined as "Helper sets up or cleans up; resident completes the activity. Helper assists only prior to or following the activity." Review of the quarterly MDS assessment with an ARD of 09/08/26 also indicated that R132 required setup or cleanup assistance for eating. The resident had Brief Interview for Mental Status (BIMS) score of 99 indicating that the resident was unable to complete the interview. Review the care plan under the tab titled "Care Plans" of the EMR directed staff to anticipate and meet R132's needs; assess food, thirst, toileting, comfort, body positioning, and pain; conduct frequent safety rounds; assist with incontinence care and repositioning every two hours and as	F0558	1 R132 still resides in the facility, and the call light was immediately placed within the resident's reach. LPN 4 is still employed with the facility and was immediately re-educated on ensuring that calls lights are always assessable to residents. 2 All residents have the potential to be affected An audit was conducted to ensure that call lights were within reach of all residents. 3 A root cause analysis revealed that the staff failed to ensure that that call lights are always accessible to residents after care to prevent the potential for delayed residents' assistance The nursing staff will be re-educated by the Staff Developer/Designee on ensuring that call lights are always assessable to residents to prevent the potential of delayed residents' assistance. Newly hired nursing staff will be educated during orientation by the Staff Developer/Designee on ensuring that call lights are always assessable to residents to prevent the potential of delayed residents' assistance. 4 The Director of Nursing/ ADON/Unit Managers/Supervisors/Manager on Duty will conduct an audit of all occupied beds in the facility to ensure that the call lights are assessable to the residents. These audits will be conducted daily on all shifts X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations.	11/02/2026

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F0558 SS = D	Continued from page 9 needed; assist with food and fluids as needed; address contributing sensory deficits; and support R132 in communicating basic needs. During an observation of R132 on 09/14/26 at 11:17 AM, the call bell was wrapped around the stationary chair. Interview during the observation, Licensed Practical Nurse (LPN) 4 stated that R132 yelled out most of the time and that staff wrapped the call light around itself "so she (R132) doesn't use it." LPN4 stated that staff entered the room every two hours. During an observation on 09/14/26 at 11:19 AM, R132s call bell was wrapped around a stationary chair. Interview during the observation Certified Nursing Assistant (CNA) 5 stated that R132 could not use the call light and that staff had wrapped it around the stationary chair. CNA5 further stated that staff should have kept the call light within R132's reach and pinned it to the bed. During observations on 09/15/26 at 9:33 AM and 9:38 AM, R132 lay in bed while the call light remained on the floor. During an interview on 09/15/26 at 9:38 AM, CNA8 stated that staff should always keep the call light within R132's reach. During an observation on 09/16/26 at 12:25 PM, R132 lay in bed while the call light remained on the floor near the stationary chair. Staff had also placed R132's lunch tray on an overbed table against the wall and outside her reach. During an interview at 09/16/26 at 12:28 PM, CNA7 stated that she gave R132 the call bell and placed it across R132's body after she found it where it should not have been. During an interview at 09/16/26 at 12:32 PM, Registered Nurse (RN) 2 stated that R132 could not use the call light and instead screamed or yelled for help. The nurse stated that staff entered the room periodically and that R132 sometimes yelled that she needed to use the bathroom. RN2 further stated, ="I don't care if she can't use it, it should still be available." During an interview on 09/17/26 at 10:59 AM, the Administrator stated that staff should have kept R132's call light within reach and that R132 yelled out when she wanted something. The Administrator expressed concern after learning that a staff member had reported taking the call light away so R132 would not use it. During an interview on 09/17/26 at 11:45 AM, Unit	F0558		11/02/2026

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F0558 SS = D	Continued from page 10 Manager (UM) 3 stated that the facility expected staff to keep call lights within R132's reach or in a location where R132 could tap the call bell. The facility did not provide a policy that addressed these issues.	F0558		11/02/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F0580	1 R165 was discharged from the facility. The facility cannot retroactively correct this issue. 2 All current residents who had room changes and all residents who were transferred to the hospital have the potential to be affected. Social Services will review residents with room changes in the last 14 days to ensure family notification is documented. DON/ADON will review residents transferred to the hospital in the last 14 days to ensure family/representative notification is documented. 3 A root cause analysis revealed that staff did not consistently document the resident or representatives' notification when there is a room change or a transfer to the hospital. All licensed nursing staff will be re-educated by the Staff Developer/DON/ADON on the facility's Notification of Change policy. During morning meeting, room changes and hospital transfer will be reviewed to ensure notification is documented in the medical records. The DON/ADON will review daily room changes and hospital transfer to ensure notification is documented in the medical records. On weekends and holidays the Nursing Supervisor will review room changes and hospital transfers to ensure notification is documented in the medical records. 4 The Director of Nursing/ADON/Unit Managers will conduct a daily audit on residents transferred to the hospital to ensure that their responsible parties were notified and there is documentation to reflect the notification. These audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations. Social Services/Admissions will conduct a daily audit on residents with room changes to ensure that their responsible parties were notified and there is documentation to reflect the notification. These	10/02/2026

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F0580 SS = D	Continued from page 11 representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and facility policy review, the facility failed to notify the resident representative of a room change and transfer to the hospital for one of five residents reviewed for notification of changes (Resident (R)165), in a sample of 61 residents. Specifically, the facility failed to notify R165's resident representative when R165's room was changed on 07/29/26 and when R165 was transferred to the hospital on 07/30/26. This deficient practice had the potential to prevent the resident representative from being informed of changes affecting R165's location and condition and had the potential to cause psychosocial distress for R165 and the resident representative. Findings include: Review of R165's "Admission Record" found under the "Profile" tab in the electronic medical record (EMR) indicated an admission date of 06/03/26 with diagnoses of atherosclerotic heart disease, hypertension, bradycardia, coronary angioplasty implant with graft, dementia, communication deficit, osteoarthritis, lupus, muscle weakness and abnormalities of gait and mobility, and depression. Review of R165's "Minimum Data Set (MDS)" found under the "MDS" tab in the EMR with an Assessment Reference Date (ARD) of 08/09/26 indicated a "Brief Interview for Mental Status (BIMS)" of four out of 15 which indicated severe cognitive impairment. Review of the "Census" found under the "Census" tab in the EMR indicated that on 06/03/26 R165 was admitted transferred to another room on 07/29/26.. Review of R165's EMR did not reveal documentation that Family Member (F) 2 was notified about the	F0580	Continued from page 11 audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations.	10/02/2026

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F0580 SS = D	Continued from page 12 hospital transfer on 07/30/26. On 09/16/26 and 09/17/26 resident representative notification documentation was requested from the Administrator and none was provided. During an interview on 09/15/26 at 11:18 AM F2 stated that notification was not received for the room change on 07/29/26 or the hospital transfer on 07/30/26. Review of R165's EMR did not reveal documentation that the resident representative was notified about the 07/29/26. On 09/16/26 and 09/17/26 resident representative notification documentation was requested from the Administrator and none was provided. Review of the facility's policy titled, "Notification of Changes" dated 01/2026 provided by the facility indicated: "The purpose of the policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. 4. A transfer or discharge of the resident from the facility."	F0580		10/02/2026
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered	F0582	1 R72 and R149 are still residents in the facility; The facility cannot retroactively correct this issue. 2 Current residents who were discharged from Medicare Part A services before the benefits were exhausted have the potential to be affected. The Social Services Director will review current residents who were discharged from Medicare Part A services to ensure that an Advanced Beneficiary Notice of Noncoverage was issued. 3 A root cause analysis revealed the need for re-education of the social worker on the Advanced Beneficiary Notice of Noncoverage policy. The Social Service Director and Assistant Social Service Director will be re-educated by the NHA /Regional Director of Social Services on the Advanced Beneficiary Notice of Noncoverage policy. The NHA will provide education to social services hired in the future on the Advanced Beneficiary Notice of Noncoverage policy. 4 The Director of Social Services will conduct an audit of all current and future residents who were discharged from Medicare Part A services in the last 30 days to ensure they were issued an ABN. These audits will be conducted daily X 5 days until 100%	10/02/2026

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F0582 SS = D	Continued from page 13 under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the facility failed to ensure that staff provided Advance Beneficiary Notice of Noncoverage (ABN) for two of three residents (Resident (R) 72 and R149) reviewed for ABN. Without the ABN residents may not know the potential costs of services and options/appeals available to them. Findings include: 1. Review of R72's "Admission Record," located under tab "Census" in the electronic medical record (EMR), indicated that R72 was admitted to the facility on 03/22/26 with a diagnosis of dementia, end stage renal disease (ESRD), and chronic kidney disease. Review of "Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review," (paperwork provided	F0582	Continued from page 13 compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations.	10/02/2026

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F0582 SS = D	Continued from page 14 to facility to fill out) indicated that Medicare Part A skilled services episode start date: 04/01/26 and last covered day of Part A service: 06/12/26. The facility/provider initiated the discharge from Medicare Part A services when benefit days were not exhausted. There was no evidence that an ABN was provided to R72. 2. Review of R149's "Admission Record," located under tab "Census" in the EMR indicated that R149 was re-admitted to the facility on 05/30/26 with a diagnosis of ESRD, major depressive disorder, and cognitive communication deficit. Review of "Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review," (paperwork provided to facility to fill out) indicated that Medicare Part A skilled services episode start date: 05/30/26 and last covered day of Part A service: 07/06/26. The facility/provider initiated the discharge from Medicare Part A services when benefit days were not exhausted. There was no evidence that an ABN was provided to R149. During an interview on 09/17/26 at 11:15 AM, the Social Services Director (SSD) confirmed R72 and R149 had remained in the facility and did not receive an ABN. Review of facility policy titled, "Advance Beneficiary Notices," revised January 2026, indicated, "It is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage. Policy Explanation and Compliance Guidelines: . . . 6. Additional notices shall be issued to Medicare beneficiaries when appropriate . . . b. If services are being terminated and the beneficiary wants to continue receiving care that is no longer considered medically reasonable and necessary, the facility shall issue an ABN prior to furnishing non-covered care. . ."	F0582		10/02/2026
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F0584	1 R110 and R86 still reside in the facility. R110's bathroom was cleaned immediately upon discovery by the housekeeper. The black and brown stains on the floor under the sink were scrubbed and removed. The black spots between the back of the toilet base and the wall were all removed. The floor Infront of the toilet under the leg of the raised toilet seat was repaired by the maintenance staff to ensure the subfloor is no longer exposed. All shower rooms were immediately inspected and cleaned by the	10/02/2026

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F0584 SS = D	Continued from page 15 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, interviews, and facility policy review, the facility failed to maintain a homelike environment for two of four residents (Resident (R) 110 and R86) reviewed for homelike environment. This has the potential to lead to a negative effect on the residents' psychosocial health. Findings include: 1. Review of R110's "Admission Record" located	F0584	Continued from page 15 housekeeper. Both residents were offered showers. 2 All current residents have the potential to be affected. An observation audit was conducted by the Mobile Administrator who is an LHNA building support on all the bathrooms and shower rooms to ensure they were thoroughly clean. 3 A root cause analysis revealed the lack of detail by the housekeeping staff on ensuring bathrooms and shower rooms are properly cleaned. The housekeeping staff will be re-educated by the Director of Environmental Services/Designee on the Safe Homelike Environment policy and thorough cleaning of bathrooms and shower rooms. The Director of Environmental Services/Mobile Administrator will conduct observational routine daily audits on 10 bathrooms and all shower rooms to ensure they are thoroughly cleaned. 4 The Director of Environmental Services/Mobile Administrator will conduct audits of the bathrooms and shower rooms to ensure they are thoroughly cleaned. These audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations.	10/02/2026

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F0584 SS = D	Continued from page 16 under the "Profile" tab in the electronic medical record (EMR) revealed R110 was admitted to the facility on 10/07/21 with diagnoses including hemiplegia and vascular dementia. Review of R110's quarterly "Minimum Data Set (MDS)" located under the "MDS" tab in the EMR with an Assessment Reference Date (ARD) of 09/03/26 revealed a "Brief Interview for Mental Status (BIMS)" score of 15 out 0f 15, which indicated R110 was cognitively intact. The MDS indicated R110 needed supervision or touching assistance with toilet transfers. The MDS also indicated R110 needed partial to moderate assistance with toilet hygiene. R110 was also occasionally incontinent of bladder and always continent of bowel. Review of R110's "Care Plan," dated 12/30/24, located under the "Care Plan" tab in the EMR, revealed a focus that indicated R110 had occasional incontinence of bowel and bladder. A care plan, dated 10/30/25, revealed a focus that indicated R110 had alteration in mobility due to cardiovascular accident (stroke) and abnormality of gait and mobility. Review of resident council minutes provided by the facility revealed that on 04/14/26, residents reported, "Bathrooms are not being cleaned properly on C-Wing and D-Wing. Staff were educated and in-serviced on the importance of cleaning." The minutes further revealed that on 07/14/26, residents reported, "Bathrooms are not being cleaned properly on C-Wing and E-Wing. Concerns about not having paper products." The documented facility response was that staff were educated and in-serviced on the importance of cleaning and ensuring paper products were always available. During an interview on 09/14/26 at 12:16 PM, R110 stated her bathroom was "disgustingly filthy," especially the bathroom floors. In an observation during the interview with R110 of R110' bathroom, black and brown stain on the floor approximately 12 by 12 inches under the sink, a circle approximately three inches wide under the front left leg of the raised toilet seat had rubbed down and was now exposing the subfloor. Additionally, there were approximately 10 half inch black spots between the back of the toilet base and the wall. During an interview on 09/15/26 at 2:45 PM the Resident Council reported there was an overall problem with the cleanliness of the bathrooms. They added that the floors rarely get mopped and buffed.	F0584		10/02/2026

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F0584 SS = D	Continued from page 17 During an interview on 09/17/26 at 10:40 AM, the Housekeeping Supervisor confirmed the condition of the floor. She added that the stains on the floor do not come off, even when scraped. She then stated she would not want to use the bathroom with the current condition of the floors. During an interview on 09/17/26 at 12:15 PM, the Maintenance Director also confirmed the condition of R110's bathroom floor. He added the floors do not come clean, and it has been discussed to replace the bathroom floors on R110's unit, however, there is no specific plan in place. During an interview on 09/17/26 at 6:23 PM, the Director of Nursing (DON) reported a knowledge of R110's Resident Representative grievance but had not been informed of any other concerns. The DON stated there were conversations about remodeling the front half of the building, which included R110's room. She added, however, at this point there was no further discussion about remodeling the front half of the building. 2. Review of R86's quarterly "MDS" with an ARD of 06/30/26 located in the EMR under the "MDS" tab revealed an admission date of 11/12/25 and a "BIMS" score of 15 out of 15, indicating R86's cognition was intact. The "MDS" also indicated R86 had diagnoses of diabetes mellitus (DM), hypertension (HTN), and anemia. Review of R86's "care plan," revised 01/27/25, located in the EMR under the "Care Plan" tab revealed "R86 has ADLs [activities of daily living] self care deficit and toileting deficit r/t [related to]." Interventions included "Staff to assist with ADLs as needed" and "Encourage independence to the extent of ability and praise efforts." Review of R86's "nurse note," dated 06/18/26, located in the EMR under the "Progress Note," revealed "...Resident continued to refuse shower after multiple attempts were made." Review of R86's "Shower Days" documentation, dated from 08/17/26 to 09/15/26, located in the EMR under the "Task" tab revealed bed baths or washed head to toe in bathroom. On 09/14/26 at 11:34 AM, R86 was observed sitting in her wheelchair, dressed and groomed. R86 stated she went to her sister's home once weekly to bathe because the facility shower room was dark, unkempt, and had a drain that frequently backed up with	F0584		10/02/2026

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F0584 SS = D	Continued from page 18 sewage. R86 further stated there were often feces on the shower room floor. R86 reported that, due to the condition of the shower rooms, she performed a sink bath independently each day without staff assistance rather than using the facility shower. R86 also stated the facility's laundry washing machines were broken and, as a result, the facility experienced a shortage of linens, including bed linens, over the weekend. During an interview on 09/14/26 at 12:10 PM, Housekeeper (HSK)2 was asked if housekeeping provided plastic bags to Certified Nurse Aides (CNAs) for soiled laundry. HSK2 stated, "Yes." When asked who cleaned the showers, HSK2 stated housekeeping mopped the shower floors. Observation of E hall shower on 09/17/26 at 9:24 AM, the revealed two wet towels with feces on them in the right-side stall, two clothes hangers on the floor, two geriatric-chairs, a mechanical lift, clothes labeled with a resident name piled in the hand sink, a pair of shoes, and a large wheelchair with a set of footrests and other equipment in the left stall. Both shower stalls contained a mildew-like substance along the edges of the walls. During an interview on 09/17/26 at 9:26 AM, CNA10 was asked about the condition of the E hall shower room. CNA10 went into the shower room and stated the towels and resident shoes and clothes should have been picked up by the CNA who gave the shower. CNA 10 stated housekeeping cleans the rest of the room. Observation of the E hall shower on 09/17/26 at 10:10 AM, revealed two wet towels with feces on them in the right-side stall, two clothes hangers on the floor, two geriatric-chairs, a mechanical lift, clothes labeled with a resident name piled in the hand sink, a pair of shoes, and a large wheelchair with a set of footrests and other equipment in the left stall. Both shower stalls contained a mildew-like substance along the edges of the walls. Review of facility policy titled "Safe and Homelike Environment," dated 01/2026, specified " In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility, both inside and outside, maximizes resident independence and does not pose a safety	F0584		10/02/2026

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F0584 SS = D	Continued from page 19 risk…Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment."	F0584		10/02/2026
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, interviews, and facility policy review, the facility failed to protect one of 18 residents reviewed for abuse, (Resident (R) 165), from sexual abuse byR138. This failure had the potential to result in psychosocial harm, emotional distress, fear, humiliation, loss of dignity, and diminished quality of life for R165. Findings include: 1. Review of R165's "Admission Record" found under the "Profile" tab in the electronic medical record (EMR) indicated an admission date of 06/03/26 with diagnoses of atherosclerotic heart disease, hypertension, bradycardia, coronary angioplasty implant with graft, dementia, communication deficit, osteoarthritis, lupus, muscle weakness and abnormalities of gait and mobility, and depression. Review of R165's "Minimum Data Set (MDS)" found under the "MDS" tab in the EMR with an Assessment Reference Date (ARD) of 08/09/26 indicated a "Brief Interview for Mental Status (BIMS)"score of four out of 15 which indicated severe cognitive impairment.	F0600	1 R165 was discharged from the facility. R138 still resides in the facility. R165 and R138 were seen by Social Services the day following the incident for emotional support. R165 and R138 were seen by Ejike Ibekaku, CRNP PMHNP-BC psychiatry services, on 8/4/26 for additional emotional support. The facility cannot retroactively correct this issue. 2 All residents have the potential to be affected. The nursing staff will provide close supervision of residents with cognitive communication deficits to ensure personal space boundaries are being kept. The nursing staff is currently providing safety checks every 15 minutes to monitor R138's activities and location. 3 A root cause analysis revealed lack of supervision of residents with cognitive communication deficits in knowing boundaries of personal space. The Staff Developer/Nursing Supervisor will re-educate all staff on the importance of supervision of cognitively impaired residents and facility's Abuse Neglect and Exploitation policy to ensure residents are free from sexual abuse. The Staff Developer/Nursing Supervisor will educate new staff during general orientation on the importance of supervision of cognitively impaired residents and facility's Abuse Neglect and Exploitation policy to ensure residents are free from sexual abuse. The DON/ADON/Nursing Supervisor will review residents who are cognitively impaired with new onset of behaviors to ensure appropriate interventions are initiated to assure residents are free from abuse and neglect 4 DON/ADON/Nursing Supervisor will conduct observation audits daily on all 3 shifts to ensure cognitively impaired residents are free from sexual abuse X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations.	10/02/2026

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F0600 SS = D	Continued from page 20 2. Review of R138's "Admission Record" found under the "Profile" tab in the EMR indicated an admission date of 09/30/25 with diagnoses of cognitive communication deficit, chronic obstructive pulmonary disease, type 2 diabetes, congestive heart failure, benign prostatic hyperplasia, hyperlipidemia, and muscle weakness. Review of R138's quarterly "MDS "found under the "MDS" tab in the EMR with an ARD of 06/23/26 indicated a BIMS score of four out of 15 which indicated severe cognitive impairment. Review of the "Facility Investigation Incident Details" indicated that on 07/29/26 at 7:15PMR138 was observed to be in the hallway with R165 talking. When staff approached the residents, R138 was observed with his hand on R165's chest. The residents were immediately separated. Review of R165's interview statement on 07/29/26 revealed that she did not respond when questioned about the incident. Review of R138's interview statement on 07/29/26 indicated that he could not provide an account of the event, stating, "Nothing, I been asleep all day." Review of Certified Nurse Aide (CNA) 13's statement dated 07/29/26 indicated "I last saw R138 at approximately 6:30 AM in his room watching television on his bed. At approximately 7:15 AM, I was coming out of a resident room after providing care and saw him standing next to R165, speaking with R165. As I passed them, R138 was still talking to R165, standing next to R165. When I turned the corner, I saw R138's hands go near R165, and R138 touched R165's chest. I was able to immediately step in and separate them." During an interview on 09/15/26 at 10:49AM, R138 stated that he did not recall a time that he touched another female resident's breast. During an interview on 09/16/26 at 11:00AM the Infection Preventionist (IP), stated that CNA 13 reported that R138 as observed with both hands on R138's chest, which was an inappropriate behavior for a male resident to express to a female resident. During an interview on 09/17/26 at 12:00PM, the Administrator stated that the incident on 07/29/26 was the first sexual abuse incident for R138 and there had not been a recurrence. Review of the facility's policy titled "Abuse, Neglect and Exploitation" 07/2026 indicated: "It is the policy	F0600		10/02/2026

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F0600 SS = D	Continued from page 21 of this facility to provide protections for the health welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. III. Prevention of Abuse, Neglect and Exploitation A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by who determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; …."	F0600		10/02/2026
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interviews, and policy review, the facility failed to protect the resident's right to be free from misappropriation of property by a staff member for one of three residents (Resident (R) 133) reviewed for personal property out of a total sample of 61 residents. This deficient practice resulted in a staff member using R133's debit and credit cards to make unauthorized personal purchases. Findings include: Review of R133's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed she was admitted to the facility on 08/01/24. R133 had diagnoses of malignant neoplasm (cancer) of the right bronchus or lung and also of the endometrium. Review of R133's "Admission Agreement," signed by R133 on 08/02/24, located in the EMR under the "Miscellaneous (Misc)" tab, revealed, ". . . the Resident may request to have locked storage space in his or her room . . . All personal belongings are required to be inventoried and recorded on Resident's personal inventory log in Resident's	F0602	1 R133 still resides in the facility. R133's personal debit and credit cards were secured by the DON and Charge Nurse upon discovery of the incident. HKS 1 no longer works for the facility. 2 Residents who wish to have valuables at bedside have the potential to be affected. Social Services/Admissions will review active residents who wish to keep debit/credit or money at bedside are offered a locked drawer. 3 A root cause analysis revealed lack of securing personal debit/credit card in a secured area. The Staff Developer/ NHA/ DON/ADON will provide re-education to the staff on the facility's Abuse Neglect and misappropriation Exploitation policy. The Admission's Director/designee will re-inform all current residents and or their responsible parties on the facility's personal item inventory process and process when residents wish to keep monetary valuables at bedside on section 10 titled "Residents Personal Property" of the facility's admission agreement. Admissions Director during admission review will ensure resident/representative is fully aware of the process when the resident wishes to keep monetary valuables at bedside. 4 Admissions/Guest Services will conduct daily audits of new admissions to ensure there are no unsecured monetary valuables at bedside X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations.	10/02/2026

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F0602 SS = D	Continued from page 22 Medical Records. The Facility shall have no responsibility for belongings that are not inventoried and recorded . . . The social worker can also assist in obtaining a lock for the resident's nightstand so that items of value can be safeguarded." Review of R133's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 03/22/26, located in the EMR under the "MDS" tab, revealed R133 scored 15 out of 15 on the "Brief Interview for Mental Status (BIMS)," which indicated intact cognition. Review of R133's "Misc" tab of the EMR revealed no personal inventory sheet. Review of an "Incident Online Submission Form," dated 06/05/26, provided by the facility, revealed that the facility became aware of "Theft/Missing Items" on 06/05/26 at 8:40 AM and contacted the police. Review of the facility's "FRI [facility reported incident] 5 Day Follow Up Report," dated 06/12/26 and provided by the facility, revealed the resident's Family Member, (F) 1, reported to the facility on 06/05/26 that R133's credit and debit cards had unauthorized charges. When staff went to R133's room, they found no credit or debit cards in R133's purse or wallet. A Certified Nurse Assistant (CNA) reported having assisted R133 with the use of one of the cards while she was accompanying R133 at an appointment. The CNA reported placing the card back in the purse's front zipper. The report further indicated that "A state investigator arrived to the facility on 06/12/26 and advised they have a person of interest observed at a location using the residents [sic] card. Picture was shown to DON [Director of Nursing] and the staff member was identified as [Housekeeper (HSK) 1]." Review of R133's significant change "MDS" with an ARD of 06/22/26, located in the EMR under the "MDS" tab, revealed R133 scored 13 out of 15 on the "BIMS," which indicated intact cognition. During an interview on 09/14/26 at 10:34 AM, R133 reported, "The facility stole from me. They arrested the girl . . . She got into my purse. I lost my credit card and debit card . . . It made me feel like they're picking on an old person." R133 stated she normally kept her purse unlocked in the bottom drawer of the chest of drawers. The top drawer was observed to have a lock; however, R133 reported she did not have a key to it and could not recall being offered one. R133 reported she now has gift cards, which	F0602		10/02/2026

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F0602 SS = D	Continued from page 23 the facility kept locked up at the nurses station. R133 stated she would prefer they were in her possession. R133 could not recall filling out a personal inventory sheet. During an interview on 09/16/26 at 11:45 AM, the Admissions Director (AD) stated that on admission she communicated to the resident or their responsible party that the facility discouraged bringing valuables into the building and that they can request a key and lock for a drawer in the resident's room for valuables. The AD further stated that inventory sheets were available at the front desk and in the welcome bags provided to residents upon admission. She stated she instructs families to obtain an inventory sheet and document any items brought into the facility. During an interview on 09/16/26 at 2:00 PM, the DON, who served as the facility's abuse coordinator, stated F1 had notified the facility of fraudulent charges on R133's debit and credit cards and requested staff check her room to determine whether she had the cards in her possession. Staff found no cards in the resident's room and both the facility and F1 filed police reports. The DON stated that the investigator came to the facility following the submission of the reports and said he had video footage of a person using one of R133's cards. When the investigator showed a photo from the footage to the facility's Infection Preventionist (IP), the IP identified the picture as being HSK1. The DON stated that HSK1 punched out and left the facility the day the missing debit and credit cards were reported, never returned to work, never called to say she was not coming in to work, and did not answer phone calls from the facility. The DON stated R133's family decided to have her use gift cards following the theft. During an interview on 09/17/26 at 12:22 PM, F1 reported R133 liked to use her credit and debit cards for purchasing food when she went out to appointments. F1 stated he spoke to R133 about some transactions he noticed on one of her cards prior to reporting any concerns to the facility. When additional charges occurred, including charges originating in California, F1 stated he notified the facility and requested staff verify whether R133 had the cards in her possession. The police were notified, a staff member was identified as using the cards, and the bank refunded approximately $300 in unauthorized charges. The family now brings in gift cards for R133 to use.	F0602		10/02/2026

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F0602 SS = D	Continued from page 24 When asked if R133 was ever offered a key to the drawer with the lock in her room, F1 stated he felt it would just come up missing as other, unreported, items such as phone chargers had. F1 reported he had not filled out an inventory sheet. During an interview on 09/17/26 at 12:56 PM, the Administrator and DON reported that the facility disclosed to residents or representatives upon admission that they can request a locked drawer in their room. The availability of a locked drawer was not routinely discussed following admission, except during care plan meetings; however, R133's family chose to provide gift cards instead of pursuing a locked drawer. The Administrator stated it was the responsibility of the resident or resident representative to ensure personal inventory sheets were completed. The facility scanned the sheets into the EMR. During an interview on 09/17/26 at 1:23 PM, the Social Services Director (SSD) stated that she would put in a request to maintenance if a resident requested a locked drawer in their room. The SSD denied initiating any conversations with residents or their families in care plan meetings or at other times about the availability of locked drawers. Review of the facility's policy titled "Abuse, Neglect and Exploitation," revised July 2026, revealed, "The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse . . . and misappropriation of resident property . . . The facility will implement policies and procedures to prevent and prohibit all types of abuse, . . . misappropriation of resident property, and exploitation . . ."	F0602		10/02/2026
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner	F0628	1 R7, R8, R17, R149 still resides in the facility. R177 was discharged from the facility. The facility cannot retroactively correct the issue. 2 All current residents who are transferred to the hospital have the potential to be affected. Current residents who were transferred to the hospital were reviewed by the Admissions Director/Guest Service, to ensure the Bed Hold Communication of Hospital Transfer and Therapeutic Leave was provided to the resident or resident representative in writing. The Admissions Director/Guest Service will maintain a copy of the bed Hold Communication of Hospital Transfer and Therapeutic Leave that was provided in writing as well as a copy of the addressed and stamped envelope the document was mailed in.	10/02/2026

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F0628 SS = D	Continued from page 25 responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this	F0628	Continued from page 25 3 A root cause analysis revealed lack of understanding by the Admissions Director on providing the Bed hold Communication of Hospital Transfer and Therapeutic Leave in writing to the resident or resident representative. The NHA/designee will re-educate the Admissions Director on providing the Bed hold Communication or Hospital Transfer and Therapeutic Leave form to the residents or resident representatives All current residents who transfer to the hospital is being reviewed daily, including weekends and holidays by the Admissions Director/Guest Service, to ensure the Bed Hold Communication of Hospital Transfer and Therapeutic Leave is being provided to the resident or resident representative in writing. 4 The Admissions Director/ Guest Services will conduct audits for all residents transferred to the hospital to ensure that a copy of the Bed hold Communication Hospital Transfer and Therapeutic Leave form was provided to them or their responsible party. These audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations.	10/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085004	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0628 SS = D	Continued from page 26 section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.	F0628		10/02/2026

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F0628 SS = D	Continued from page 27 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary	F0628		10/02/2026

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F0628 SS = D	Continued from page 28 When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and policy review, the facility failed to ensure written notices for transfers were provided to residents and/or resident representatives for five of seven Residents (R)8, R7, R149, R17, and R177) reviewed for hospitalization out of a total sample of 61 residents. These failures had the potential to cause confusion for residents and their representatives regarding the reason for their hospitalization, their ability to return to the facility, and their ability to appeal the discharge. Findings include: 1. Review of R8's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed she was admitted to the facility on 06/10/26 with a diagnosis of chronic obstructive pulmonary disease, respiratory failure, and chronic kidney disease. Review of R8's Discharge – Return Anticipated "Minimum Data Set (MDS)," dated 06/05/25 and located under the "MDS" tab of the EMR, revealed R8 had an unplanned discharged to the hospital. Review of R8's "Nurse's Note," dated 06/05/26 and located in the EMR under the "Progress Notes" tab, revealed R8 was complaining of pain in the left shoulder, was evaluated by the nurse practitioner and sent to the hospital. Review of R8's "Resident Transfer/Discharge Notification," dated 06/25/26 and provided on paper by the Administrator revealed it did not provide the	F0628		10/02/2026

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F0628 SS = D	Continued from page 29 reason for the transfer and documentation there is no documentation the Resident Representative was notified. Review of R8's "Bedhold [sic] Communication of Hospital Transfer and Therapeutic Leave," dated 06/25/26 and provided on paper by the Administrator revealed there was no documentation the resident representative received written notice of transfer or bed hold. 2. Review of R7's "Admission Record," located under the "Profile" tab in the EMR, indicated R7 was readmitted to the facility on 06/17/25 with diagnoses that included chronic systolic (congestive) heart failure and type 2 diabetes mellitus. Review of R7's "Nursing Progress Note," located under the "Progress Note" tab in the EMR, indicated that on 06/30/26 at 3:40 PM, R7 was sent to the emergency room due to lethargy, change in status, and hematuria (blood in the urine) per physician. Nursing noted the family was notified. Review of R7's EMR, transfer documentation, social services records, and admissions records failed to reveal evidence that written transfer and bed-hold notices were provided to the resident and/or resident representative following the transfer to the emergency department on 06/30/26. During an interview on 09/17/26 at 4:00 PM, the Director of Nursing (DON) confirmed the Admissions Director (AD) was responsible for sending transfer and bed-hold notifications to the resident and/or resident representative (RR) when a resident was transferred to the ER. During an interview on 09/17/26 at 4:19 PM, the AD stated she had called the R7's RR the day after the resident was transferred to the emergency room. When asked when the written notifications were sent to the resident and/or RR, she reviewed her records and stated, "I failed to do that on this resident." 3. Review of R149's "Admission Record," located under the "Profile" tab in the EMR, revealed R149 admitted to the facility on 09/14/24. Review of R149's "Progress notes" dated 07/14/26 revealed R149 was sent back from dialysis early and transferred to the hospital due to a clotted dialysis port. There was no evidence of a written transfer notice. Review of R149's EMR, transfer documentation,	F0628		10/02/2026

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F0628 SS = D	Continued from page 30 social services records, and admissions records failed to reveal evidence that written transfer and bed-hold notices were provided to the resident and/or resident representative following the transfer to the hospital. 4. Review of R17's "Admission Record," located in the EMR under the "Profile" tab, revealed she was originally admitted to the facility on 02/21/25 and was admitted again on 07/05/26 with diagnoses of chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure, and obstructive sleep apnea. a. Review of a "Nurses Note," dated 05/08/26, located in the EMR under the "Progress Notes" tab, revealed that R17 reported feeling short of breath and had an oxygen saturation of 72%, which improved when her oxygen was increased from 6 liters per minute (LPM) to 15 LPM. The facility notified the on-call provider and sent the resident to the hospital for evaluation. Review of a "Nurses Note," dated 05/14/26, located in the EMR under the "Progress Notes" tab, revealed R17 returned from the hospital. Review of the "Bedhold Communication of Hospital Transfer and Therapeutic Leave" form, dated 05/08/26, located in the "Miscellaneous (Misc)" tab of the EMR, revealed that R17's resident representative was contacted regarding holding the bed. The AD completed the form and wrote "holding bed" but did not indicate whether it was provided in writing to the resident or resident representative. Review of R17's "Resident Transfer/Discharge Notification" form, dated 05/08/26, located in the "Misc" tab of the EMR, revealed it indicated the hospital R17 was transferred to; however, the reason for transfer/discharge and the resident representative contacted areas were not completed. The form did not document that it was provided to the resident or resident representative. b. Review of "Nurses Notes," dated 05/26/26, located in the EMR under the "Progress Notes" tab, revealed that R17 reported chest pain and requested to go to the hospital. The on-call provider was notified, and the facility sent the resident to the hospital where she was admitted with a COPD exacerbation. Review of a "Nurses Note," dated 07/05/26, located in the EMR under the "Progress Notes" tab, revealed R17 was admitted from the hospital.	F0628		10/02/2026

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F0628 SS = D	Continued from page 31 Review of the "Bedhold Communication of Hospital Transfer and Therapeutic Leave" form, dated 05/26/26, located in the "Misc" tab of the EMR, revealed that R17's representative was contacted regarding holding the bed. The AD completed the form and handwrote that Medicaid bed hold days were exhausted but did not indicate whether it was provided in writing to the resident representative. Review of R17's "Resident Transfer/Discharge Notification" form, dated 05/26/26, located in the "Misc" tab of the EMR, revealed it indicated the hospital R17 was transferred to; however, the reason for transfer/discharge and the resident representative contacted areas were not completed. The form did not document that it was provided to the resident or resident representative. c. Review of "Nurses Notes," dated 08/05/26, located in the EMR under the "Progress Notes" tab, revealed that R17 experienced a change in condition and was lethargic, drooling, and responsive only to sternal rub. The provider was notified, and the resident was sent to the hospital for evaluation. Review of a "Nurses Note," dated 08/22/26, located in the EMR under the "Progress Notes" tab, revealed R17 was readmitted to the facility from the hospital. Review of the "Bedhold Communication of Hospital Transfer and Therapeutic Leave" form, dated 08/05/26, located in the "Misc" tab of the EMR, revealed that R17's representative was contacted regarding holding the bed. The AD completed the form and indicated holding the bed with Medicaid but did not indicate whether it was provided in writing to the resident representative. Review of R17's "Resident Transfer/Discharge Notification" form, dated 08/05/26, located in the "Misc" tab of the EMR, revealed it indicated the hospital R17 was transferred to; however, the reason for transfer/discharge and the resident representative contacted areas were not completed. The form did not document that it was provided to the resident or resident representative. 5. Review of R177's "Admission Record," located in the EMR under the "Profile" tab, revealed he was admitted to the facility on 03/25/26 with diagnoses of colostomy status and encounter for surgical aftercare following surgery on the digestive system. R177 was discharged from the facility on 03/29/26. Review of a "Nurses Note," dated 03/29/26, located	F0628		10/02/2026

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F0628 SS = D	Continued from page 32 in the EMR under the "Progress Notes" tab, revealed that R177 was on anticoagulant therapy and was observed with a moderate amount of blood and thick clots around his stoma and inside the colostomy bag. The facility notified the on-call provider and sent the resident to the hospital for evaluation. Review of the "Bedhold Communication of Hospital Transfer and Therapeutic Leave" form, dated 03/29/26, located in the "Misc" tab of the EMR, revealed that R177's representative was contacted regarding holding the bed. The AD completed the form and wrote that the resident did not want to return but did not indicate whether it was provided in writing to the resident or resident representative. Review of R177's "Resident Transfer/Discharge Notification" form, dated 03/29/26, located in the "Misc" tab of the EMR, revealed it indicated the hospital R177 was transferred to; however, the reason for transfer/discharge and the resident representative contacted areas were not completed. The form did not document that it was provided to the resident or resident representative. During an interview on 09/16/26 at 5:38 AM, Registered Nurse (RN) 3 reported that when she sent a resident to the hospital, she filled out the bed hold and transfer notification forms. RN3 reported she did not send the forms to the hospital or provide them to the resident or resident representative because it was uncertain whether the resident would be admitted. RN3 further reported she gave the forms to the unit manager. During an interview on 09/16/26 at 11:08 AM, Unit Manager (UM) 2 reported that nursing staff filled out the resident's name and room number, as well as the date, on the bed hold form and transfer notification forms. A copy of the bed hold form was either sent with the resident to the hospital, or the AD followed up. Copies of the forms went to the unit clerk. During an interview on 09/16/26 at 11:48 AM, the AD stated that she called the resident's family once she knew a resident was admitted to the hospital. The AD reported she verbally reviewed the bed hold policy to the resident representative and wrote the conversation on the bottom of the form but did not provide the form to the resident or resident representative. For the "Resident Transfer/Discharge Notification" form, the AD stated she filled out the resident's name and room number as well as the date but left the remainder of the form blank. The AD reported that bed-hold forms were occasionally	F0628		10/02/2026

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F0628 SS = D	Continued from page 33 mailed to the resident representative; however, she had not been mailing transfer/discharge notices. During an interview on 09/17/26 at 12:56 PM with the Administrator and Director of Nursing, the Administrator reported the expectation that the bed hold and notice of transfer forms were provided in writing to the resident and/or resident representative. Review of the facility's policy titled "Transfer and Discharge," reviewed/revised April 2026, revealed, "The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided: a. The specific reason and basis for transfer or discharge. b. The effective date of transfer or discharge. c. The specific location . . . to which the resident is to be transferred . . ." The policy further indicated that for emergency transfers or discharges to an acute care setting, "Provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated."	F0628		10/02/2026
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F0657	1 R133 still resides in the facility, and her care plan was updated immediately to reflect the misappropriation of her property. R 168 was discharged from the facility. 2 Current residents have the potential to be affected. Social Services will review current and future residents with a misappropriation of property complaint in the last 30 days to ensure a plan of care is updated. Current and future residents with behaviors related to tube feeding will be reviewed to ensure appropriate and timely plan of care is place. 3 A root cause analysis revealed an oversight to revise the plan of care related to include misappropriation of property and behaviors related to tube feeding. The Director of Nursing/ADON will provide re-education to the MDS Coordinators on revision of plan of care related to new interventions related to misappropriation of property and behaviors related to tube feeding. During morning meeting, the MDS Coordinators/ DON/ ADON/ Nursing Supervisors will review any reported misappropriation of property and any behaviors related to tube feeding to ensure plan of	10/02/2026

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F0657 SS = D	Continued from page 34 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the facility failed to revise the comprehensive care plans for two of 61 residents reviewed (Resident (R) 133 and R168). Specifically, R133's care plan was not updated following the misappropriation of her property to include interventions implemented after the incident, and R168's care plan did not address behaviors related to pulling on his feeding tube. This failure had the potential for staff to be unaware of the residents' current needs and interventions, resulting in inconsistent implementation of care and services. Findings include: 1. Review of R133's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed she was admitted to the facility on 08/01/24. Review of the facility's "FRI [facility reported incident] 5 Day Follow Up Report," dated 06/12/26 and provided by the facility, revealed the resident's Family Member (F) 1 reported to the facility on 06/05/26 that R133's credit and debit cards had unauthorized charges. When staff went to R133's room, they found no credit or debit cards in R133's purse or wallet, and the facility notified the police department. The report further indicated that "a state investigator arrived to the facility on 06/12/26 and advised they have a person of interest observed at a location using the residents [sic] card. Picture was shown to DON [Director of Nursing] and the staff member was identified as [Housekeeper (HSK) 1]." Review of R133's significant change "Minimum Data Set (MDS)" with an Assessment REfernce Date (ARD) of 06/22/26, located in the EMR under the "MDS" tab, revealed R133 scored 13 out of 15 on the "BIMS," which indicated intact cognition. Review of R133's "Care Plan Report," located in the EMR under the "Care Plan" tab, revealed no documentation of her missing credit and debit cards or any intervention placed to protect her from further misappropriation.	F0657	Continued from page 34 care is revised. On the weekends and holidays the Nursing Supervisors/Charge Nurse will review any reported misappropriation of property and any behaviors related to tube feeding to ensure the plan of care is revised. 4 The MDS Coordinators/Nursing Supervisor will conduct daily audits to ensure care plans are revised when there are interventions to address misappropriation of property and behaviors related to tube feeding. These audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations.	10/02/2026

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F0657 SS = D	Continued from page 35 During an interview on 09/14/26 at 10:34 AM, R133 reported, "The facility stole from me. They arrested the girl . . . She got into my purse. I lost my credit card and debit card." R133 reported she now has gift cards, which the facility kept locked up at the nurses' station. During an interview on 09/17/26 at 12:22 PM, F1 reported R133 liked to use her credit and debit cards for purchasing food when she went out to appointments. F1 stated the family now brings in gift cards for R133 to use. During an interview on 09/17/26 at 12:56 PM, the Administrator and Director of Nursing (DON) stated that R133's family chose to provide gift cards following the theft of the credit and debit cards. During an interview on 09/17/26 at 2:19 PM, MDS Coordinator (MDSC) 1 and MDSC2 reported care plans were updated quarterly and as needed with changes in care. They reported a care plan should reflect any specific interventions put into place following misappropriation of property, and MDSC1 verified that R133's care plan did not address the theft of her credit and debit cards or the subsequent use of gift cards. During an interview on 09/17/26 at 6:23 PM, the DON stated that there should have been a care plan update addressing the situation with R133's credit and debit cards and the interventions implemented thereafter so that staff were aware of her current needs. Review of the facility's policy titled, "Abuse, Neglect and Exploitation," revised July 2026, revealed, "The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: . . . Revision of the resident's care plan if the resident's medical nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse." 2. Review of 168's "Admission Record," located under the "Profile" tab of the EMR, revealed he was originally admitted to the facility on 04/29/26 with a diagnosis of moderate protein-calorie malnutrition and disorders of phosphorus metabolism (hypophosphatemia). Review of R168's admission "MDS" with an ARD of 05/03/26, located under the "MDS" tab of the EMR,	F0657		10/02/2026

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F0657 SS = D	Continued from page 36 revealed R168's Staff Assessment for Mental Status (SAMS) indicated R168 had short- and long-term memory problems and had severely impaired decision making. Review of R168's encounter note in "Progress Notes," dated 06/15/26, located under the "Progress Note" tab in the EMR revealed R168 was sent out to the hospital due to percutaneous endoscopic gastrostomy (PEG) tube (feeding tube) dislodgement; within 24 hours readmission into the facility R168 dislodged his PEG tube again and was sent back to the hospital. Review of R168's encounter note in "Progress Notes," dated 06/22/26 and located under the "Progress Note" tab in the EMR revealed recurrent dislodgement of PEG tube; continue abdominal binder and redirect when patient was observed to be handling the area. Review of R168's nurses note in "Progress Notes," dated 06/23/26 and located under the "Progress Note" tab in the EMR, revealed R168 was sent out to the hospital due to dislodging PEG tube. Review of R168's nurses note in "Progress Notes," dated 07/03/26 and located under the "Progress Note" tab in the EMR, revealed R168 had removed his PEG tube and was being transferred to the hospital. Review of R168's encounter note in "Progress Notes," dated 07/11/26 and located under the "Progress Note" tab in EMR, revealed between 07/04/26 and 07/09/26 R168 experienced recurrent PEG tube dysfunction and dislodgement. Review of R168's "Order Summary Report," located under the "Orders" tab in the EMR revealed an order, dated 06/18/26, for abdominal binder to be worn at all times as the resident allows. Review of R168's "Care Plan Report," revealed a focus, dated 05/01/26, that R168 was reliant on tube feeding for 100% of his estimated nutrition/hydration needs. The care plan did not address R168's consistent dislodging of his feeding tube. During an interview on 09/17/26 at 10:20 AM, the Registered Dietician (RD) stated R168 had an abdominal binder to help prevent R168 from dislodging his feeding tube however, he still managed to dislodge it. The RD added it should have been mentioned in a care plan.	F0657		10/02/2026

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F0657 SS = D	Continued from page 37 During an interview on 09/17/26 at 2:19 PM, the MDSC1 stated R168's behaviors should have been care planned. MDSC1 added it is a "team effort" on revisions but nursing can revise the care plans. During an interview on 09/17/26 at 6:23 PM, the DON stated the care plan should speak to the overall care of the residents as well as unique situations or behaviors. The DON confirmed R168's behaviors regarding his dislodging of his feeding tube should have been care planned or mentioned in a care plan. The DON stated R133 should have also had a care plan that addressed the situation with her credit cards. Staff need to be aware of any interventions that were put into place. Review of facility policy titled "Comprehensive Care Plans," January 2026, specified " It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment . . . 3. The comprehensive care plan will describe, at a minimum, the following . . . a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise furnished but are not provided due to the resident's exercise of his or her right to refuse treatment."	F0657		10/02/2026
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation, interviews, and policy review, the facility failed to follow a physician order and accepted professional standards of practice by failing to instruct a resident to rinse her mouth after administration of an inhaled corticosteroid medication for one of one resident (Resident (R) 61) observed receiving an inhaled steroid medication. This deficient practice had the potential to increase the risk for thrush and oral or	F0658	1 R61 still resides in the facility. LPN3 went back to R61's room and instructed her to rinse her mouth with water and spit per the physician order. 2 Current residents with an order for Breo Ellipta Aerosol Powder Breath Activated/steroid medication inhaled have the potential to be affected. Active residents with steroid medication inhaled will be identified, and licensed staff will be educated on the post administration of care. 3 A root cause analysis revealed the need for re-education of all licensed nursing staff on medication administration of steroid medication inhaled. The Staff Developer/DON/ADON will provide re-education to the licensed nursing staff and new hires on medication administration of steroid medication inhaled post administration care. Licensed staff will be re-assessed for competency	10/02/2026

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F0658 SS = D	Continued from page 38 throat irritation. Findings include: Review of R61's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed she was admitted to the facility on 09/03/20 with a diagnosis of chronic obstructive pulmonary disease (COPD). Review of R61's "Order Summary Report," located in the EMR under the "Orders" tab, revealed an order for "Breo Ellipta Aerosol Powder Breath Activated 100-25 mcg/inh [micrograms per inhalation] . . . 1 puff inhale orally one time a day for COPD *instruct resident to rise [sic] and spit after administration*," dated 09/23/20. During an observation on 09/16/26 at 8:28 AM, Licensed Practical Nurse (LPN) 3 brought R61's morning medications into her room along with a glass of water. After administering R61's pills, LPN3 left the glass of water at R61's bedside, opened the Breo Ellipta inhaler and handed it to R61, who inhaled the medication. R61 stated she was going back to sleep and closed her eyes without rinsing her mouth. LPN3 did not instruct R61 to rinse her mouth and left the room. During an interview on 09/16/26 at 8:41 AM, LPN3 reported she knew that for "a lot of steroid inhalers, you're supposed to rinse your mouth" and further stated that some residents refused. Upon review of the medications in the Breo Ellipta with LPN3, it was noted to contain a corticosteroid. When asked if she had instructed R61 to rinse her mouth after inhaling the medication or if R61 refuses, LPN3 reported that R61 does not like the taste of the inhaler and so she leaves the water for her to use after but acknowledged that she did not instruct her to rinse her mouth. During an interview on 09/16/26 at 2:00 PM, the Director of Nursing (DON) reported she expected staff to follow orders and professional standards of practice and instruct residents to rinse their mouths with water following the administration of inhaled steroid medications. Review of the facility's policy titled "Medication	F0658	Continued from page 38 with steroid medication inhaled annually. 4 The Director of Nursing/ADON/Staff Developer/Pharmacy Consultant will conduct an observation audit of 3 licensed nurse's medication administration for residents with orders for Breo Ellipta Aerosol Powder Breath Activated/steroid medication inhaled to ensure that the physician order is being followed. These audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations.	10/02/2026

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F0658 SS = D	Continued from page 39 Administration," reviewed/revised 03/06/26, revealed, "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . . . Administer medication as ordered in accordance with manufacturer specifications . . ." Review of the U.S. Food and Drug Administration's guidance for Breo Ellipta, dated May 2023, located at www.accessdata.fda.gov/drugsatfda, revealed that "after inhalation, the patient should rinse his/her mouth with water without swallowing to help reduce the risk of oropharyngeal candidiasis [thrush]."	F0658		10/02/2026
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 observation, interview, and record review, the facility failed to provide meal set-up and eating assistance for one of five residents (Resident (R) 132) reviewed for activities of daily living (ADLs) in a sample of 61. Specifically, staff left meals covered and unopened, placed meal trays outside R132's reach, and failed to consistently awaken, cue, redirect, and assist R132 with meals despite assessed visual and cognitive impairments, and a documented need for meal set-up assistance. The failure to provide necessary assistance placed R132 at risk for inadequate food and fluid intake, further significant weight loss, worsening malnutrition, dehydration, and avoidable decline. Findings include: Review of 132's electronic medical record (EMR) tab titled "Face Sheet" showed R132 was admitted on 01/24/19 and readmitted on 08/05/22 with diagnoses that included vascular dementia, oral-phase dysphagia, unspecified protein-calorie malnutrition, chronic systolic congestive heart failure, chronic kidney disease stage 3, major depressive disorder with psychotic symptoms, psychotic disorder with delusions, and colostomy status. Review of R132's annual "Minimum Data Set (MDS)"	F0677	1 R 132 still resides in the facility. Assistance with meal set-up, queuing, and re-directing is provided with each meal. 2 Current residents needing assistance with meals have the potential to be affected. Residents who are dependent on staff with meals will be identified and reviewed to ensure plan of care reflects assistance with meals. 3 A root cause analysis revealed the need for re-education of the nursing staff on providing the necessary assistance at mealtimes for each resident who requires assistance with meals. The staff Developer/ADON/Unit Manager will provide re-education to the nursing staff on providing the necessary assistance at mealtimes for each resident who require assistance to maintain good nutrition and prevent weight loss. The staff Developer/ADON/Unit Manager will provide education to the newly hired nursing staff on providing the necessary assistance at mealtimes for each resident who require assistance to maintain good nutrition and prevent weight loss during general orientation. Unit Managers/Supervisors during their daily rounds will include observations of dependent residents during mealtimes. The Staff Developer/DON/ADON will educate current and new Unit Managers/Supervisors on including observation of dependent residents during mealtimes to ensure they are receiving the required assistance. 4 The Director of Nursing/ADON/Staff Developer/Unit Manager will conduct an audit of 5 residents from each unit of the facility who require assistance with meals to ensure that the necessary	10/02/2026

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F0677 SS = D	Continued from page 40 with an Assessment Reference Date (ARD) of 06/09/26, located in the EMR under the "MDS" tab, documented a "Brief Interview for Mental Status" score of 99 (indicating the "BIMS" could not be completed) and no bilateral upper- or lower-extremity limitations. The assessment identified eating as requiring set-up or clean-up assistance. Review of R132's quarterly "MDS" with an Assessment Reference Date of 09/08/26, located in the EMR under the "MDS" tab, identified eating as requiring set-up or clean-up assistance. Review of the EMR tab titled "Care Plans" revealed the nutritional-risk care plan, dated 02/04/20, identified advanced dementia, a mechanically altered diet, meal refusal at times, variable intake, depression, protein-calorie malnutrition, heart failure, and a history of weight loss. Staff planned interventions that included encouraging food and fluid intake and providing assistance with food and fluids as needed. The vision care plan, dated 06/18/25, identified moderately impaired visual function. The cognitive and behavioral care plans, dated 06/23/26, directed staff to cue and reorient R132, break tasks into one step at a time, anticipate and meet needs including food and thirst, and re-approach R132 when calm. Review of the EMR tab titled "Vitals' documented the following weights in pounds: On 03/09/26, 138.1. On 08/05/26, 139.4. On 09/10/26, 123.0. A significant weight loss of 15.1 pounds (10.9%) in six months from 03/09/26. A weight loss of 16.4 pounds (11.8%) in approximately one month from 08/05/26. Review of a "Nutrition Assessment," dated 06/08/26 and located in the EMR "Assessments" tab, documented R132 received a regular mechanical soft diet with daily nutritional supplements and required staff assistance with tray set-up. The assessment identified vascular dementia, dysphagia, and the need for a texture-modified diet as nutritional risk factors. The dietitian documented that R132 fed herself independently with tray set-up assistance by staff and recommended continuing current nutrition interventions. A "Dietitian Quarterly Nutrition Review," located in the EMR under the "Progress Notes" tab and dated	F0677	Continued from page 40 assistance is being provided at mealtimes. These audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations.	10/02/2026

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F0677 SS = D	Continued from page 41 09/07/26, identified variable oral intake ranging from less than 25% to greater than 75% of meals. The review documented that R132 received oral nutritional supplements and recommended continuation of nutrition interventions. During an observation in R132's room on 09/14/26 at 10:55 AM, the surveyor observed R132 asleep in her bed and did not respond to her name. R132's breakfast tray sat untouched on the bedside table with a newsletter placed on top of the covered plate. The table was not positioned near R132, and the food and beverage remained uneaten. On 09/14/26 at 11:08 AM, the surveyor observed the complete meal remained untouched on the overbed table and outside R132's reach. During an interview on 09/14/26 at 11:18 AM, Licensed Practical Nurse (LPN) 4 verified R132 had not eaten breakfast, and stated staff did not awaken R132 if she was asleep because she chased staff away. During an interview on 09/14/26 at 11:20 AM, Certified Nurse Assistant (CNA) 5 stated R132 required meal set-up, had been sleeping when she delivered the breakfast tray, and had not eaten breakfast. CNA5 then removed the untouched tray out of the room. During an interview on 09/15/26 at 12:13 PM, a certified nurse assistant delivered R132's lunch tray, did not set up the meal, and left the room. At 12:14 PM, the surveyor observed R132 lying in bed with her eyes closed and not responding when her name was called. At 12:18 PM, CNA9 entered the room to assist with the meal. At 12:35 PM, CNA9 sat beside the bed and fed R132. R132 stated the food was good. During an observation on 09/16/26 at 12:25 PM, staff delivered R132's lunch tray and placed it on an overbed table positioned against the wall and outside R132's reach. R132 remained in bed. During an observation and interview on 09/16/26 at 12:28 PM, CNA7 removed R132's lunch tray from her room CNA7 stated she had asked R132 if she was done and to take her meal away. CNA7 opened the dome and the meal was untouched. CNA7 stated R132 could feed herself but could not see some items and sometimes needed assistance. During an interview on 09/16/26 at 12:32 PM, Registered Nurse (RN) 2 stated R132 was legally blind and required meal set-up that included waking	F0677		10/02/2026

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F0677 SS = D	Continued from page 42 her, ensuring she was alert enough to swallow safely, removing lids, opening beverages, showing her where the utensils were located, redirecting her as needed, and checking on her continuously during meals. During an interview with the Administrator on 09/17/26 at 2:00 PM said residents should eat their meals with whatever assistance is needed at the time. The Administrator stated, maybe she is set up only or maybe the care plan needed updated. During an EMR review of the tab titled "task" revealed the facility's eating-task documentation reflected inconsistent coding during the survey period. Staff documented eating as not applicable at 2:40 AM, set-up at 1:35 PM, and independent at 10:59 PM on 09/14/26. Staff documented eating as independent at 5:36 AM, set-up at 1:20 PM, and independent at 9:11 PM on 09/15/26. Staff documented eating as not applicable at 3:09 AM and independent at 2:55 PM and 10:22 PM on 09/16/26. These entries did not consistently reflect R132's assessed need for meal set-up assistance or the assistance observed and described by staff. The facility did not provide a policy addressing these issues.	F0677		10/02/2026
F0679 SS = D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure activities were provided in accordance with residents' assessed interests, preferences, and activity choices for two (Residents (R)132 and R73) of two residents reviewed for activities. Specifically, staff failed to consistently offer and assist R132 to engage in preferred group, individual, or independent activities	F0679	1.R132 and R73 still reside in the facility. Facility cannot retroactively address tis issue. 2. All residents have the potential to be affected. Residents who a dependent on staff for assistance with transporting them to and from activities will be identified and asked if they would like to participate to ensure they are helped with transportation to and from activities of their choice. 3. A root cause analysis revealed the need for re-education of the Activity Assistants on the facility's Activities Policy to ensure that all residents are given an opportunity to participate in their activity of choice and ensure accommodation is made for them to do so. The Director of Activity will provide re-education to the Activity Assistance on the facility's Activities Policy. Also, The Staff developer will provide re-education to the nursing staff on the facility's Activities Policy. The education will include ensuring that all residents are given an opportunity to participate in their activity of choice and ensuring accommodations are made for them to do so. The Activity/ Nursing staff will verbally inform all	10/02/2026

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F0679 SS = D	Continued from page 43 and R73 was not provided with the opportunity or necessary assistance to attend preferred evening activities despite repeatedly expressing a desire to participate. This failure had the potential to diminish residents' quality of life, social engagement, autonomy, and overall psychosocial well-being. Findings include: 1. Review of the electronic medical record (EMR) tab titled "Face Sheet" showed that R132 was admitted on 01/24/19 and readmitted on 08/05/22 with diagnoses that included vascular dementia, major depressive disorder with psychotic symptoms, generalized anxiety disorder, and psychotic disorder with delusions due to a known physiological condition. The Annual Minimum Data Set (MDS) assessment, with an assessment reference date of 06/09/26, recorded a Brief Interview for Mental Status (BIMS) score of 99, which indicated staff did not complete the interview. Review of R132's activity care plan, revised on 06/30/19, located in the EMR revealed the facility identified R132 as being at risk for decreased social interaction and activity participation related to cognitive impairment and impaired physical mobility. The care plan listed R132's preferred activities as exercise, music, reading, religious services, outdoor activities in appropriate weather, cooking club, special themed events, and manicures. Interventions directed staff to invite R132 to daily group programs; assist her to activity locations; provide cues, task assistance, and offer individualized activities. The care plan also directed staff to provide a monthly activity calendar and encourage R132 to participate in Resident Council and Food Committee. Review of the August and September 2026 activity participation records and one-to-one visit logs revealed the resident did not attend any outdoor activities. Review of the logs for the months of July 2026, August 2026, and September 2026 revealed R132 had not participated in exercise, religious services or church groups, outdoor activities, cooking classes or cooking club, special themed events, manicures, Resident Council, or Food Committee. The records did not identify routine offers; assistance, refusals, or individualized alternatives related to these care-planned preferences. During an observation on 09/14/26 at 10:53 AM, R132 was in bed with her eyes closed. R132 did not respond when her name was called, and the	F0679	Continued from page 43 residents of scheduled activities at the beginning of each day as well as handing them a copy of the daily activity schedule and invite them to attend. In addition, the monthly activity calendar is posted on each unit. If the resident chooses to attend an activity, the Activity/ Nursing staff will make accommodations to ensure they can attend and participate. 4. The Director of Activity/Nursing Supervisor will conduct an audit to ensure that all residents who require assistance with transportation and has the desire to participate in evening activities and given an opportunity to do so. These audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations	10/02/2026

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F0679 SS = D	Continued from page 44 television remained on (but not to one of her preferred activities). At 10:55 AM, R132 was observed in bed with the door open. Staff had placed a newsletter on top of the covered breakfast tray on the bedside table, out of R132's reach. During an interview on 09/16/26 at 3:36 PM, the Regional Coordinator of Social Services and Activities (RSSD) stated the Activity Director was unavailable. At 4:04 PM, the RSSD provided the participation records and one-to-one visit logs for August 2026 and September 2026. She confirmed that R132 had not gone outside. At approximately 4:15 PM, the RSSD and the Activity Staff (ACT) reviewed the care plan and participation records. The ACT stated that during July, August, and September 2026, R132 had not participated in exercise or church groups, had not received manicures or outdoor activities, and had no documented group attendance. The ACT stated that staff had a better chance of engaging R132 by playing music in her room. The ACT confirmed the one-to-one visit documentation did not reflect R132's preferences, and staff needed to revise and update the care plan. During an interview on 09/17/26 at 10:59 AM, the Administrator stated that staff should have continued to ask R132 to participate, documented refusals, and updated the care plan. 2. Review of R73's quarterly "MDS with an Assessment Reference Date (ARD) of 07/11/26 located in the EMR under the "MDS" tab revealed an admission date of 10/10/25 and a BIMS score of 15 out of 15, indicating R73's cognition was intact. The "MDS" also indicated R73 had diagnoses of cerebral palsy, asthma, and acute on chronic systolic (congestive) heart failure (CHF). Review of R73's "care plan," revised on 09/24/25, located in the EMR under the "Care Plan" tab revealed "R73 is at risk for decreased social interaction and activity participation due to impaired physical mobility." Interventions included "R73's preferred activities are card/board games, cooking club, music, religious services, special themed events, Bingo, Women's group, trivia, manicures, community outing, reading, pet visit, outdoors (in appropriate weather conditions)" and "Invite the resident to scheduled activities/provide reminders of times." Review of R73's "Recreation Evaluation," dated 09/08/26, located in the EMR under the	F0679		10/02/2026

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F0679 SS = D	Continued from page 45 "Assessment" tab, revealed R73 was moderately dependent with physical limitations, some of R73's general activity preferences included cards/other games, party/socials, music, and bingo. Music, do things with groups of people, and do your favorite activities were very important to R73. Review of the facility's September 2026 Activity Program Calendar revealed evening activities scheduled at 7:00 PM. Scheduled evening activities included Ice Cream Socials on 09/01/26, 09/08/26, and 09/15/26; Movie Nights on 09/03/26 and 09/10/26; and Bingo on 09/07/26 and 09/14/26. Review of R73's September 2026 Participation Log, provided by the facility, the Bingo section was blank, and the log did not include sections for Movie Night or the Ice Cream Social. There were no documented refusals by the resident. On 09/14/26 at 1:05 PM, R73 stated she wanted to attend activities scheduled after 6:00 PM but was routinely placed in bed after dinner approximately 6:00 PM. R73 stated she had informed her Certified Nurse Aide (CNA) and nurse of her desire to attend evening activities; however, staff did not honor her request. R73 further stated no one discussed evening activity opportunities with her. During an interview on 09/16/26 at 10:18 AM, CNA1 stated R73 regularly attended daytime activities and commented, "Yes, every day, as she likes the daytime activities." On 09/16/26 at 11:50 AM, R73 again stated she was not given the opportunity to attend evening activities because staff placed her in bed and she was unable to get up independently. R73 stated she had asked staff to assist her out of bed so she could participate in evening activities. During the interview, Activity Staff (ACT) approached R73, and R73 informed ACT staff were not assisting her in attending the evening activities. During a follow-up interview on 09/16/26 at 4:31 PM with the ACT, she stated nursing staff were responsible for offering evening activities and ensuring R73 was out of bed because ACT was not permitted to transfer residents. ACT confirmed R73 enjoyed daytime activities and primarily wanted the	F0679		10/02/2026

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F0679 SS = D	Continued from page 46 opportunity to be out of her room during the evening. ACT further confirmed that, according to the activity participation log, R73 participated in the daytime activities but had not attended evening activities, including Bingo. ACT also confirmed the participation log did not track attendance for Movie Nights or Ice Cream Socials. Review of the facility policy titled "Activities," dated 01/01/26, provided by the facility revealed "It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community… 10. All staff will assist residents to and from activities when necessary… 13. The facility will consider accommodations in schedules, supplies and timing in order to optimize a resident's ability to participate in an activity of choice."	F0679		10/02/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review interviews, and review of the National Library of Medicine, the facility failed to ensure timely assessment, follow-up, and intervention related to signs and symptoms of a potential deep vein thrombosis (DVT) for one reviewed out of a sample of 61 residents (Resident (R) 180). Specifically, after a physician ordered a stat ultrasound due to swelling in an extremity containing a peripherally inserted central catheter (PICC) line, the facility failed to follow up on the delayed diagnostic testing, notify the provider of the delay, and obtain further direction while the resident awaited evaluation for approximately 32.5 hours.	F0684	1. R180 is discharged from the facility. The facility cannot retroactively address the issue. 2. Residents with an order for an ultrasound have the potential to be affected. DON/ADON will review residents with an order for ultrasound to ensure provider is notified of any delay in completing the testing for further direction. 3. Root cause determined that staff lacked thorough understanding of the process to follow when testing is not completed as scheduled. Staff Educator/DON/ADON will educate licensed nurses and new hires on the process to follow when testing is not completed as scheduled for further direction. The education will include the following items: When an ordered diagnostic test is not completed or delayed, the Nursing supervisor/Charge nurse will notify the provider and the DON/ADON. The Nursing Supervisor/Charge Nurse will document in medical record the provider's response, follow up instructions and responsible party's notification. The Nursing Supervisor/Charge Nurse will provide ongoing health assessments per the providers' directions. Unit Managers/Supervisors will report to incoming	10/02/2026

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F0684 SS = D	Continued from page 47 This delay had the potential to compromise timely treatment and placed R180 at risk for serious complications; the resident was subsequently hospitalized with a pulmonary embolism. Findings include: Review of R180's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed she was admitted to the facility on 03/03/26 and was discharged on 03/09/26. R180 had a diagnosis on admission of abscess of lung with pneumonia. Review of R180's "Order Recap Report," located in the EMR under the "Orders" tab, revealed an order for cefepime HCl, an intravenous (IV) antibiotic, two grams every eight hours for lung abscess for 45 days, dated 03/03/26. Review of the "Care Plan Report," located in the EMR under the "Care Plan" tab, revealed that R180 had an unspecified catheter in place for IV therapy with interventions including observing for complications due to the presence of the IV catheter and notifying the provider for abnormal findings, dated 03/03/25. Review of an "Encounter" note, dated 03/06/26, located in the EMR under the "Progress Notes" tab, revealed the facility's Medical Director documented, "[R180] is concerned that her right arm has been swelling for the last 24 hours. She does have a PICC line in that arm." The note further indicated, "Will order ultrasound of right upper extremity rule out DVT [deep vein thrombosis]. Review of a "Nurses Note," dated 03/06/26 at 12:40 PM, located in the EMR under the "Progress Notes" tab, revealed a stat (without delay) ultrasound was indicated to rule out DVT and relayed to the facility's contracted radiology company. Review of the "Orders Recap Report" for R180's stay at the facility, from 03/03/26 to 03/09/26, located in the EMR under the "Orders" tab, revealed no order for an ultrasound. Review of the "Medication Administration Record (MAR)," dated 03/06/26 through 03/07/26, revealed cefepime continued to be administered through the PICC line in the swollen arm while staff awaited completion of the ultrasound to rule out DVT. Review of R180's "Radiology Results Report," located in the EMR under the "Results" tab, revealed	F0684	Continued from page 47 shift pending ultrasound orders and provider notification if not completed. 4. The Director of Nursing/ADON/Unit Managers will conduct an audit of ultrasound orders to ensure there is documentation of provider notification when there is a delay in the completion of the test for further direction. These audits will be conducted daily X 30 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations.	10/02/2026

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F0684 SS = D	Continued from page 48 the ultrasound was completed on 03/07/26 at 9:22 PM, approximately 32.5 hours after it was indicated in the progress note on 03/06/26 at 12:40 PM. approximately 11 hours after the ultrasound was completed and more than 43 hours after the ultrasound was ordered due to swelling of the arm. The report documented findings: "There is [a] clot in the subclavian, axillary and brachial vein . . . Right upper extremity clot noted." Review of the "Progress Notes" tab of the EMR from 03/06/26 at 12:40 PM, when the stat ultrasound was ordered, through 03/08/26 at 12:51 AM, revealed no documentation of follow-up regarding the ultrasound, the delay in completion of the test, or notification of a provider regarding the delay. Review of "Nurses Note," located in the EMR under the "Progress Notes" tab, revealed the following documentation: - On 03/08/26 at 12:51 AM, "Writer noted swelling in right midline. Writer was given in report that a Doppler ultrasound of right upper arm was performed this even [sic]. Writer notified on-call @ [at] 0050 [12:50 AM]. On-call advised that IV should not be used until results have been sent back. Once results have been received, provider needs to be notified. IV ABT [antibiotic] placed on hold." - On 03/08/26 at 9:05 AM, a nurse recorded that ultrasound results were relayed to the provider and orders were received to start R180 on a blood thinner and to remove the PICC line to the right arm and place one in the left arm. - On 03/08/26 at 10:11 AM, a request was made for the facility's contracted PICC line company to place the PICC line in the left arm. - On 03/08/26 at 9:02 PM, the PICC was placed. Review of the "Order Recap Report," located in the EMR under the "Orders" tab, revealed an order for a stat x-ray, dated 03/08/26, to verify the placement of the new PICC line. Review of R180's "MAR," located in the "Orders" tab of the EMR, as well as the "Progress Notes," "Miscellaneous (Misc)," and "Results," tabs, revealed R180's IV antibiotic remained on hold, and the x-ray ordered to verify PICC placement had not been completed when R180 was transferred to the hospital on 03/09/26 at approximately 11:00 PM, more than 24 hours after placement of the new PICC line.	F0684		10/02/2026

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F0684 SS = D	Continued from page 49 Review of "Nurses Notes," located in the EMR under the "Progress Notes" tab, revealed: - On 03/09/26 at 11:43 PM, "Resident was sent to the emergency room after reporting coughing up blood. Small amounts of bright red blood were noted in the trash can and on tissues. The new IV site was noted to be infiltrated with blood . . ." - On 03/10/26, "Resident admitted to [hospital] for Pulmonary Embolism [blood clot] [in] the subsegmental Pulmonary Artery." Requests for hospital records post-discharge from the facility for R180 were unsuccessful. During an interview on 09/15/26 at 3:02 PM, Licensed Practical Nurse (LPN) 2 reported the facility utilized a contracted radiology company that provided onsite services upon request, which could be submitted by phone or through the company's online portal. LPN2 stated she needed to verify the facility's expectations regarding stat radiology requests with another nurse. LPN2 further reported that the facility utilized a contracted PICC line company for PICC line insertions. During an interview on 09/15/26 at 3:26 PM, LPN2, with the Administrator in attendance and after clarifying the facility's expectations with the Infection Preventionist (IP), reported the radiology company was expected to complete stat requests within four hours. If the radiology company did not arrive within that timeframe, facility staff were expected to notify the provider and obtain further instructions. LPN2 further reported the response time for the contracted PICC line company varied based on workload. Once a PICC line was inserted, an x-ray was required to verify placement before the line could be used. During an interview on 09/16/26 at 11:30 AM, Unit Manager (UM) 2 reported diagnostic testing could be requested from the radiology company either online or by phone. UM2 stated stat requests could be completed within 30 to 45 minutes, depending on staffing. If a stat request was delayed, nursing staff were expected to notify the on-call provider and obtain further instructions, which could include transferring the resident to the hospital. UM2 reported provider notifications and any resulting instructions should be documented in the progress notes. UM2 further reported response times for the contracted PICC line company varied according to workload. If delays occurred, she would notify the provider and document any additional orders or	F0684		10/02/2026

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F0684 SS = D	Continued from page 50 instructions received. During an interview on 09/16/26 at 1:25 PM, the Infection Preventionist (IP) reported stat radiology requests were expected to be completed within four hours and interpreted within one hour of completion. The IP stated that if a delay occurred, facility staff were expected to notify the provider of the estimated arrival time and obtain additional instructions, including whether the resident should be transferred to the hospital for evaluation. During an interview on 09/16/26 at 2:00 PM, the Director of Nursing (DON) was asked whether it was acceptable for a resident to wait from 03/06/26 at 12:40 PM until 03/07/26 at 9:22 PM for a stat ultrasound to be completed and then an additional approximately 11 hours for the results to be reviewed. The DON stated the timeframe sounded like a delay and reported she would review R180's medical record to determine what had occurred. During an interview on 09/17/26 at 1:15 PM, the DON reported she had discussed the matter with the Medical Director and did not believe a delay had occurred. The DON stated a 24-hour timeframe was appropriate for completion of a stat ultrasound. When asked to provide the facility's agreement or contract with the radiology provider, the DON stated she would look into the request. During an interview on 09/17/26 at 11:25 AM, the Medical Director reported she was not the provider on call following the ultrasound order. The Medical Director stated a stat ultrasound could take up to 24 hours to complete and that timeframe was acceptable. When asked about the ultrasound taking approximately 32.5 hours to be completed and an additional approximately 11 hours to be interpreted, the Medical Director stated, "I know in your world it might be considered a delay, but 24 hours is acceptable. I would have sent her out if I was concerned." On 09/17/26 at 6:23 PM, the DON was reminded of the request for the facility's agreement or contract with the radiology provider. The information was not provided before the end of the survey. Review of the National Library of Medicine's "Subclavian Vein Thrombosis," dated 06/17/26, located at https://www.ncbi.nlm.nih.gov/books/NBK559269, revealed subclavian vein thrombosis is an upper extremity deep vein thrombosis that may result in life-threatening complications, including pulmonary	F0684		10/02/2026

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F0684 SS = D	Continued from page 51 embolism. The authors emphasize that prompt diagnosis and initiation of anticoagulation are critical because delays in treatment increase the risk of thromboembolic complications and long-term morbidity.	F0684		10/02/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and facility policy review, the facility failed to ensure physician-ordered wound treatment was provided for one of three residents (Resident (R)189) reviewed for wound care, out of a total sample of 60 residents. Specifically, Licensed Practical Nurse (LPN)5 failed to apply Medihoney to R189's sacral wound during a dressing change as ordered by the physician. Failure to provide the prescribed wound treatment had the potential to delay wound healing, contribute to wound deterioration, increase the risk of infection, and result in a decline in the resident's condition. Findings include: Review of R189's "Admission Record" located under the "Profile" tab in the electronic medical record (EMR) indicated R189 was admitted to the facility on 09/08/26 with the following diagnoses of sepsis, unspecified organism, and type two diabetes mellitus. Review of R189's "Admit/Readmit Screener - V 24" located under the "Assessment" tab in the EMR and dated 09/08/26 at 3:07 PM indicated, R189 was alert	F0686	1. R189 is discharged from the facility. The facility cannot retroactively address the issue. 2. Residents with pressure ulcers have the potential to be affected. Licensed nurses will be educated to ensure treatments are completed as per physician's order. 3. Root cause analysis determined to be due to staff being distracted while being observed while performing the wound dressing. Staff Developer/DON/ADON will educate licensed staff and new hires on the importance of ensuring physician order is followed when performing wound dressing. Wound dressing competency will be completed on current licensed nurses and new hires and annually to ensure that the physician orders are accurately followed for wound treatments. 4. Staff Developer/DON/ADON will conduct an observation audit of 3 staffs on varied shifts to ensure licensed nurses are following physician order when performing wound dressing. These audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations	10/02/2026

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F0686 SS = D	Continued from page 52 and oriented to person, place, time, and situation. There was also documentation to reflect R189 "... seems or appears to recall after 5 minutes and seems or appears to recall long past ..." There was also documentation which indicated R189 had a wound to the coccyx area that measured seven centimeters (cm) in length by six cm wide. Review of R189's "Physician Orders" located under the "Orders" tab in the EMR indicated an order dated 09/09/26 "Wound Care: Cleanse sacrum with NSS [Normal Saline Solution], apply Medihoney, Calcium Alginate, and cover with NAD [Non-adhering dressing] every other day and prn [as needed] ..." During a wound care observation made on 09/16/26 at 4:30 PM, LPN5 cleansed the sacral wound as ordered with NSS, applied Calcium Alginate, and covered the wound with a NAD. LPN5 failed to apply Medihoney to R189's sacral wound as ordered by the physician. During an interview on 09/16/26 at 5:15 PM, LPN5 stated, "I forgot to apply the Medihoney to her [R189's] wound like the order said." During an interview on 09/16/26 at 5:30 PM, the Infection Preventionist (IP) confirmed the nurse should follow the physician orders when performing a dressing change. During an interview on 09/17/26 at 2:30 PM, the Director of Nursing confirmed the nurses should follow physician orders for any care that is being given to the residents. Review of the facility's policy, "Physician Orders" dated 04/2026 indicated, "... The orders should allow facility staff to provide essential care to the resident consistent with resident's mental and physical status ..." Review of the facility's undated "Validation Checklist Wound Care" indicated, "... Applied topical ointments or creams as ordered ... Applied dressings as ordered..."	F0686		10/02/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as	F0689	1.R133 still resides in the facility. Staff was immediately educated to ensure they are following the plan of care related to residents transfers when the incident occurred R133's care plan will be reviewed to reflect fall interventions. 2. Residents who require two staff with transfers	10/02/2026

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F0689 SS = D	Continued from page 53 free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interviews, and policy review, the facility failed to implement care-planned fall prevention interventions and failed to revise the care plan with effective interventions following recurrent falls for one of three residents reviewed for falls (Resident (R) 133) out of a total sample of 61 residents. Specifically, staff failed to consistently provide the required two-person assistance during transfers and continued to utilize interventions already in place following repeated fall incidents. This failure had the potential to increase the risk of falls, injuries, and decline in functional status. Findings include: Review of R133's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed she was admitted to the facility on 08/01/24. R133 had diagnoses of muscle weakness, unspecified abnormalities of gait and mobility, and hemiplegia (paralysis to one side) and hemiparesis (weakness to one side) following cerebral infarction (stroke) affecting the left non-dominant side. Review of R133's "Care Plan Report," located in the EMR under the "Care Plan" tab, revealed "Transfer status per therapy," initiated on 08/01/24. An additional behavior-focused care plan identified that R133 would intentionally lower herself from her wheelchair to the floor to attract staff attention. An intervention, dated 10/16/24, was for two people to assist R133 with all cares. Review of R133's quarterly "Minimum Data Set (MDS)" assessment with an Assessment Reference Date (ARD) of 03/22/26 revealed R133 scored 15 out of 15 on her "Brief Interview for Mental Status (BIMS)," which indicated intact cognition. R133 was dependent on staff for transfers to/from bed/chair, did not transfer to the tub/shower during the reference period, and required substantial/maximal assistance with showers/bathing. Review of the transfer "Task History," located in the EMR under the "Task" tab, revealed that R133 required two staff to assist with transfers from	F0689	Continued from page 53 have the potential to be affected. DON/ADON will review residents who require two staff with transfers, and staff will be educated to ensure staff are following transfer status. Residents with falls in the last 14 days will be reviewed to ensure care plans are updated and appropriate. 3. The root cause was determined due to staff failing to follow transfer status as per plan of care and consistently update care plan and appropriate intervention initiated related to the fall. Staff Development/DON/ADON/Unit Managers will educate nursing staff and new hires in ensuring staff are following plan of care for transfers. Staff Development/DON/ADON/Unit Managers will educate licensed nurses and new hires to ensure the care plan is updated with appropriate interventions related to the fall. During morning meetings, falls will be reviewed to ensure plan of care is updated, resident transfer status will be reviewed for accuracy, staff members involved in resident transfer in applicable, and appropriate interventions are initiated On the weekends and holidays the Nursing Supervisor/Charge Nurse will review resident falls to ensure that plan of care is updated, resident transfer status is accurate pr plan of care, follow up with staff members involved if applicable. The Nursing Supervisor/Charge Nurse will also review falls to ensue the appropriate interventions are initiated. 4. The Director of Nursing/ADON/Staff Developer/Unit Managers will conduct observation audits of 3 staff during transfers to ensure staff is following the plan of care. These audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations. The Director of Nursing/ADON/Staff Developer/Unit Managers will conduct audit of falls to ensure care plan is updated and appropriate interventions were initiated related to the fall. These audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance	10/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085004	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

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F0689 SS = D	Continued from page 54 03/25/26 to 06/03/26. Review of a facility-provided fall "Incident Report," dated 05/15/26 and written by Licensed Practical Nurse (LPN) 1, revealed, "Resident had finished getting a shower when staff came to me stating [R133] was on the floor in the shower room. I noted resident sitting on the floor in front of her wheel chair [sic], Staff stated she was holding her under her arms and standing [R133] to transfer to wheel chair [sic] when [R133] stated she couldn't hold her self [sic] up any longer, and staff had to lower her down to the floor." Review of a written statement by Certified Nurse Assistant (CNA) 12, dated 05/15/26 and provided by the facility with the Incident Report, revealed, "When I was moving to [sic] her from a shower chair to a wheelchair, she hold a hand bar, and I hold her under arms but she couldn't stand anymore . . . so I moved her body on the floor slowly." Review of the "Care Plan Report," located in the EMR under the "Care Plan" tab, revealed a focus area for potential for falls with a fall noted on 05/15/26. There was no evidence the care plan was revised or that new interventions were implemented following the 05/15/26 fall. Review of a "Nurses Note," dated 05/18/26, located in the EMR under the "Progress Notes" tab, revealed that the interdisciplinary team (IDT) reviewed the 05/15/26 fall and determined the root cause was an improper weight shift during transfer resulting in an assisted fall. The only documented intervention was a referral to therapy. During an interview on 09/14/26 at 11:10 AM, R133 sat in her wheelchair in her room and reported that she had fallen in the shower room when a CNA tried to transfer her by herself. R133 stated, "I think I'm supposed to be [assisted by] two [staff]. I'm not sure. I usually just have one." During an interview on 09/16/26 at 10:36 AM, LPN1 reported that on 05/15/26, the CNA had completed R133's shower and attempted to transfer her back to her wheelchair without the assistance of a second staff member. LPN1 reported she educated the CNA, who she could not recall but believed was either new or agency staff, that R133 required two staff to assist her with transfers. During an interview on 09/17/26 at 2:38 PM, the Rehabilitation Director (TD) reported that R133 was frequently on therapy's caseload. She was already	F0689	Continued from page 54 Improvement Committee for review and recommendations.	10/02/2026

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F0689 SS = D	Continued from page 55 being seen by therapy on 05/15/26 when she fell. 2. Review of the "Task" tab of the EMR revealed that R133 required two staff to assist her for all care needs related to behaviors, revised on 03/25/26. Review of the transfer "Task History," located in the EMR under the "Task" tab, revealed that R133 required two staff with a mechanical/Hoyer lift from 06/03/26 to 07/28/26. Review of R133's significant change "MDS" with an ARD of 06/22/26, located in the EMR under the "MDS" tab, revealed R133 scored 13 out of 15 on the "BIMS," which indicated intact cognition. R133 was dependent on staff for tub/shower transfers and showering/bathing self. No behaviors were documented. Review of a facility-provided fall "Incident Report," dated 07/24/26 and written by LPN1, revealed, "I was informed by staff that [R133] was slipping out of her wheel chair [sic] and was eased onto the floor in the shower room [.] I noted resident lying on the floor . . ." A note for "2 staff in shower room r/t [related to] behaviors" was added to the incident report on 07/27/26. Review of the "Care Plan Report," located in the EMR under the "Care Plan" tab, revealed that on 07/27/26, following the 07/24/26 fall, the facility added an intervention to utilize two staff during shower care. However, R133 already required two staff for cares related to behaviors and transfers. The facility failed to identify and implement any new interventions to address the recurrent falls related to not following the care plan. During an interview on 09/16/26 at 10:36 AM, LPN1 reported that on 07/24/26, the CNA reported R133 was slipping out of her wheelchair in the shower room, and the CNA assisted the resident and lowered her to the floor. LPN1 stated she educated the CNA that R133 required two staff with cares related to behaviors. LPN1 stated she did not determine the root cause analysis or further interventions beyond whatever she initiated immediately; nurse management was responsible. During an interview on 09/17/26 at 2:38 PM, the TD reported that R133 was frequently on therapy's caseload. She had stopped therapy in July prior to the fall on 07/24/26 and so was re-started on therapy on 07/28/26. 3. Review of the transfer "Task History," located in	F0689		10/02/2026

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F0689 SS = D	Continued from page 56 the EMR under the "Task" tab, revealed that R133 required two staff to assist with transfers from 07/28/26 to present. Review of the "POC [plan of care] Response History," for the task "Transfer: 2 person," dated 08/18/26 to 09/14/26, located in the EMR under the "Tasks" tab, revealed CNAs documented transferring R133 with one-person physical assistance on 17 of 80 documented shifts, despite care-planned instructions requiring two-person assistance. During an interview on 09/15/26 at 1:37 PM, CNA2 reported that because she was familiar with R133 and worked with her frequently, she would transfer and provide cares without a second staff member. During an interview on 09/16/26 at 11:00 AM, CNA3 reported if she was unsure what assistance a resident needed for transfers she went to the Kardex. CNA3 stated she also taught new and agency CNAs to refer to the Kardex; all CNAs had access to the Kardex. During an interview on 09/16/26 at 2:00 PM, the Director of Nursing (DON) reported she expected staff to follow the Kardex. Any CNA was able to access the Kardex. R133 required the assistance of two staff due to behaviors. During an interview on 09/17/26 at 2:38 PM, the TD reported that R133 required the assistance of two staff for transfers. Review of the facility's policy titled "Fall Prevention Program," dated March 2026, revealed, "Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. Interventions will be monitored for effectiveness . . . When any resident experiences a fall, the facility will: . . . Complete a post-fall assessment . . . Review the resident's care plan and update as indicated . . ."	F0689		10/02/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the	F0695	1. R17's oxygen order was clarified on 9/15/26. The provider clarified order to titrate oxygen to maintain goal spo2 of 88-92%. Staff ensured resident's oxygen is within reach. 2. Current residents receiving oxygen therapy have the potential to be affected. DON/ADON will review current residents with oxygen orders to ensure orders are inclusive of titration if applicable and the oxygen is administered as prescribed. The Charge Nurse/Nursing Supervisor will ensure that all oxygen orders are being administered as prescribed. The	10/02/2026

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F0695 SS = D	Continued from page 57 residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, interviews, and policy review, the facility failed to ensure oxygen therapy was administered in accordance with physician orders for one of one resident (Resident (R) 17) reviewed for respiratory care out of a total sample of 61 residents. This failure had the potential to result in ineffective management of R17's respiratory condition, placing the resident at risk for respiratory complications associated with receiving oxygen outside physician-ordered parameters. Findings include: Review of R17's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed she was originally admitted to the facility on 02/21/25 and was re-admitted on 07/05/26. Diagnoses included chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure, and obstructive sleep apnea. Review of R17's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/11/26, located in the EMR under the "MDS" tab, revealed R17 scored 14 out of 15 on the "Brief Interview for Mental Status (BIMS)," which indicated intact cognition. R17 received oxygen therapy. Review of R17's "Order Summary Report," located in the EMR under the "Orders" tab, revealed an order, dated 09/04/26, for oxygen at 6 LPM continuously via nasal cannula. The order further directed staff to titrate oxygen to maintain oxygen saturation levels between 88% and 92%. Review of the "Order Details" for the oxygen order revealed the order type was listed as "Other TAR [Treatment Administration Record]" but there was no associated schedule for it to appear on the "TAR" for staff to sign that the oxygen was administered as ordered. Review of the "Care Plan Report," located in the EMR under the "Care Plan" tab, revealed a focus area related to air movement in and out of the lungs. An intervention was for R17's oxygen to be set at 3 to 6 liters per minute (LPM), revised 02/22/25. Under a focus area of "altered respiratory status/difficulty breathing," an intervention, dated 05/01/26, was not individualized or completed and stated, "OXYGEN SETTINGS: O2 [oxygen] via (SPECIFY: nasal prongs/mask) @ (SPECIFY)L (SPECIFY FREQ). Humidified (SPECIFY)." Additionally, the care plan	F0695	Continued from page 57 Charge Nurse/Nursing Supervisor will validate in the EMAR that oxygen is being administered as prescribed by electronic signature. 3. The root cause determined to be due to licensed nurse failure to ensure the physician's order is current based on residents' needs and making sure the oxygen therapy is administered as per physician's order. Staff Developer/DON/ADON/Unit Manager will educate current and new licensed nursing staff to ensure oxygen therapy is administered per physician's order. Unit Manager/Supervisor during routine daily observation rounds will include verifying that residents are receiving oxygen therapy per doctor's orders. 4. The Director of Nursing/ADON/Staff Developer/Unit Managers will conduct an observation audit of 5 residents on each unit on various shifts to ensure oxygen is administered as per physician's order. These audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations.	10/02/2026

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F0695 SS = D	Continued from page 58 indicated R17 had a behavior problem related to adjusting her own oxygen concentrator, initiated on 08/04/25. During an observation and interview on 09/14/26 at 12:52 PM, R17 was lying in bed with the oxygen concentrator on the floor to the right side of the bed, out of reach of the resident. The oxygen concentrator was delivering oxygen to R17 via a nasal cannula at 10 LPM. R17 reported she usually received oxygen at 6 LPM, but it was turned up the other night when she could not breathe. During an observation on 09/15/26 at 12:31 PM, R17 was not in her room; however, the oxygen concentrator was turned on and was set to 10 LPM. During an observation on 09/15/26 at 2:30 PM, R17 was in her wheelchair in her room eating lunch placed on a tray table by Licensed Practical Nurse (LPN) 7. The oxygen concentrator was on the opposite side of the tray table from the resident, out of her reach. It was delivering oxygen to R17 at 10 LPM via a nasal cannula. During an interview on 09/15/26 at 2:37 PM, LPN7 stated it was her first time working with R17. LPN7 reported she believed the resident had COPD and knew she utilized oxygen but could not recall seeing any oxygen orders for her during her 7:00 AM to 3:00 PM shift. LPN7 reviewed the "Orders" tab of the EMR and confirmed that the oxygen order was for 6 LPM. Review of the "TAR" revealed that there was nowhere for LPN7 to sign during the shift verifying that R17 received oxygen at 6 LPM. LPN7 observed and verified R17's oxygen concentrator was set at 10 LPM and not the ordered 6 LPM. Review of the "Medication Administration Record (MAR)" for 09/01/26 to 09/15/26, located in the EMR under the "Orders" tab, revealed nurses documented oxygen saturations (O2 sats) every shift. Review of documented oxygen saturation readings revealed oxygen saturation levels ranging from 93% to 99%, exceeding the ordered target range of 88% to 92%. There was no supportive documentation that explained the elevated oxygen delivery or physician notification. Staff did not document the oxygen flow rate that was being administered at the time the oxygen saturation readings were obtained. Review of R17's "Progress Notes" tab in the EMR, dated 08/22/26 to 09/15/26, revealed no documentation indicating when staff increased the	F0695		10/02/2026

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F0695 SS = D	Continued from page 59 oxygen flow rate above the ordered 6 LPM During an interview on 09/16/26 at 12:08 PM, Nurse Practitioner (NP) stated he was unaware R17 was receiving oxygen at 10 LPM via nasal cannula and expressed concern. During an interview on 09/16/26 at 1:10 PM, the Infection Preventionist (IP) stated R17 had a history of adjusting the oxygen when she was in a chair. During an interview on 09/16/26 at 2:00 PM, the Director of Nursing (DON) reported the expectation was for oxygen to be delivered at the orders specified. The DON further stated that if there needed to be adjustments to the setting, nursing should document the reason in the progress notes. Review of the facility's policy titled, "Oxygen Administration," dated January 2026, revealed, "Oxygen is administered under orders of a physician, except in the case of an emergency. Staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentrations, or evidence of complications associated with the use of oxygen."	F0695		10/02/2026
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interviews, and policy review, the facility failed to administer an ordered intravenous (IV) antibiotic timely upon a resident's admission and failed to administer the final six scheduled doses before the resident discharged to the hospital for one of one resident reviewed who received IV medications (Resident (R) 180) out of a sample of 61 residents. The facility's failure to administer the antibiotic as ordered had the potential to compromise treatment of the resident's serious infection. Findings include: Review of R180's "Admission Record," located in the electronic medical record (EMR) under the	F0760	1. R180 was discharged from the facility. The facility cannot retroactively address the issue. 2. Residents receiving IV Antibiotic have the potential to be affected. DON/ADON will review current residents with antibiotic order in the last 14 days to ensure medication is administered as per physician's order and licensed nurse followed process when the IV antibiotic is not available. The process the license nurse will follow when an IV antibiotic is not available will be as follows: (a) Call the pharmacy to verify expected delivery date and time (b) Notify the provider of pharmacy response and obtain follow up instructions (c) Document in the medical records the providers response and follow up instructions. 3. The root cause was determined to be due to licensed nurse failing to follow the process when a medication is not available. Staff Developer/DON/ADON will educate licensed nurses and new hires to ensure they follow the	10/02/2026

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F0760 SS = D	Continued from page 60 "Profile" tab, revealed she was admitted to the facility on 03/03/26 and discharged on 03/09/26. Admission diagnoses included lung abscess with pneumonia. Review of "Interagency Discharge Orders," dated 03/03/26, located in the EMR under the "Miscellaneous (Misc)" tab, revealed that cefepime, an IV antibiotic, was ordered upon discharge from the hospital every eight hours for a duration of 45 days. Further instructions indicated, "Patient needs to be on antibiotics until 04/18." Review of the hospital's "Medication Administration Record (MAR)," located in the EMR under the "Misc" tab, revealed R180 received cefepime two grams IV on 03/03/26 at 12:20 PM prior to discharge from the hospital. Based on the every-eight-hour order, the next dose was due at approximately 8:20 PM on 03/03/26. Review of R180's "Order Recap Report," located in the EMR under the "Orders" tab, revealed an order for cefepime HCl, an IV antibiotic, two grams every eight hours for lung abscess for 45 days, dated 03/03/26, with a start date of 03/04/26. Review of the facility's "Medication Administration Record," dated March 2026 and located in the EMR under the "Orders" tab, revealed staff scheduled cefepime to begin on 03/04/26 at 8:00 AM. Nursing staff documented the 03/04/26 8:00 AM dose as not administered and listed the reason as "Other." Review of a "Daily Skilled Note," dated 03/04/26 at 10:08 AM and located in the EMR under the "Progress Notes" tab, revealed, "Medications from pharmacy pending delivery . . ." The note did not document notification of the pharmacy or provider regarding the delay in administering cefepime, which the hospital last administered approximately 22 hours earlier. Review of a provider "Encounter" note, dated 03/04/26 and located in the EMR under the "Progress Notes" tab, revealed the resident was to continue cefepime every eight hours through 04/18/26. The note did not address the delay in administration following admission to the facility. Review of the facility's March 2026 "MAR," located in the EMR under the "Orders" tab, revealed staff first administered cefepime on 03/04/26 at 4:00 PM, approximately 28 hours after the last dose administered by the hospital. Further review of the "MAR" revealed staff did not administer the final six	F0760	Continued from page 60 process when an IV medication is not available. The DON/ADON/Infection Preventionist/Nursing Supervisor will review all new admissions on IV antibiotics and current residents with new orders for IV antibiotics daily to ensure medication was administered as per physician's order, or process is followed when IV medication is not available. This process will be followed 7 days per week including weekends and holidays. 4. The Director of Nursing/ADON/Staff Developer will conduct an audit of new admissions to ensure IV antibiotic is administered as per physician's order or staff followed process when the antibiotic is not available. These audits will be conducted daily X 30 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations.	10/02/2026

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F0760 SS = D	Continued from page 61 scheduled doses of cefepime before the resident discharged to the hospital. Review of a "Nurses Note," dated 03/08/26 at 12:51 AM and located in the EMR under the "Progress Notes" tab, revealed the on-call provider was notified of swelling in the resident's right arm and that a Doppler study had been completed, with results pending. The note stated, "On-call advised that IV should not be used until results have been sent back. Once results have been received, provider needs to be notified." Review of R180's "Order Recap Report," located in the EMR under the "Orders" tab, revealed the cefepime was placed on hold on 03/08/26 until imaging results of the right arm were completed and that IV access was to be placed in the left arm. (Cross Reference: F684) Review of the "Nurses Note," dated 03/08/26 at 9:02 PM, located in the EMR under the "Progress Notes" tab revealed that a new PICC line was placed in R180's left arm, and staff ordered an x-ray for placement confirmation. Further review of the "Progress Notes" tab revealed no evidence that the x-ray was completed or that staff notified a provider of the continued inability to administer cefepime through 03/09/26, when the resident discharged to the hospital at approximately 11:00 PM. During an interview on 09/15/26 at 3:02 PM, Licensed Practical Nurse (LPN) 2 stated that the facility maintained a contingency medication supply behind the desk on the Greenbank unit. After staff clarified admission medications with the nurse practitioner, they sent the medication list to the pharmacy. When staff submitted orders in the mid-afternoon, they expected the pharmacy to deliver the medications with the evening shipment; otherwise, the medications typically arrived the following morning. If the pharmacy had not yet delivered an ordered medication that was available in the contingency supply, nurses obtained it from that supply. If the medication was unavailable in the contingency supply, nursing staff contacted the on-call provider for further direction. IV cefepime was not available in the contingency supply. During an interview on 09/16/26 at 2:00 PM, the Director of Nursing (DON) reported that medications ordered during the day usually arrived from the pharmacy by that night, otherwise they were delivered the next morning. When asked about	F0760		10/02/2026

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F0760 SS = D	Continued from page 62 expectations for the administration of an IV medication ordered every eight hours, last administered at the hospital at noon for a resident who was admitted to the facility at 6:20 PM, the DON stated nursing would administer the medication at 8:00 PM if they had it available. The medication should be administered prior to the next day at 4:00 PM. During an interview on 09/17/26 at 11:25 AM, the Medical Director reported that there was a concern with R180 missing doses of her IV antibiotic, "but does it happen? Yes." The Medical Director reported that the providers generally add on to the length of time the antibiotic is given at the tail end and stated that she did not feel the missed antibiotic doses affected R180's overall outcome as the resident was an incredibly sick woman with a lot of comorbidities. Review of the facility's policy titled "Medication Administration," reviewed/revised 03/06/26, revealed, "Administer [medications] within 60 minutes prior to or after scheduled time unless otherwise ordered by physician."	F0760		10/02/2026
F0806 SS = D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure residents with a documented allergy were not served a food item containing the allergen for two of two residents (Resident (R) 73 & 86) reviewed for Allergies. This deficient practice had the potential to place residents at risk for an allergic reaction, including respiratory complications. Findings include:	F0806	1 R73 and R86 still reside in the facility. Apple crisp was immediately removed from R73's tray and a suitable alternative was offered. R86's breakfast tray was discarded before the facility could verify what was served. 2 All current residents with food allergies have the potential to be affected. On 9.16.26 the Director of Dining Service conducted an observation audit of the dinner meal service to ensure that allergies were observed and adhered to. 3 A root cause analysis revealed the need for re-education of the dietary staff on accurately reading all meal tickets to ensure food allergies are observed and adhered to. The Director of Food and Dining/ Director of Food and Dining will provide re-education to the dietary staff on accurately reading all meal tickets to ensure food allergies are observed and adhered to. A root cause analysis further revealed the need for re-education of the Director of Food and Dining on the responsibility of the dining staff to ensure food allergies are observed and adhered to. The Regional Director of Food and Dining will provide re-education to the Director of Food and Dining on the meal service responsibility. During all meal service tray line the starter (the dietary aid starting the tray line) will verbally call out	10/02/2026

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F0806 SS = D	Continued from page 63 Review of resident grievances provided by the facility revealed a grievance dated 05/25/26 that documented, "allergic to carrots - got them today at lunch in Cole slaw." The follow-up documented the Food Service Director (FSD) went and personally spoke with the resident. The grievance review also revealed a grievance dated 08/11/26 that documented, "3-11/7/31 allergic to fish, got fish at lunch." The follow-up documented the FSD spoke with the resident and that specific staff would be assigned to monitor the resident's tray. 1. Review of R73's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/11/26 located in the Electronic Medical Record (EMR) under the "MDS" tab revealed an admission date of 10/10/25 and a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, indicating R73's cognition was intact. The "MDS" also indicated R73 had diagnoses of cerebral palsy, asthma, and acute on chronic systolic (congestive) heart failure (CHF). Review of R73's diet order, dated 10/15/25, located in the EMR under the "Order" tab revealed "Regular diet, Mechanical Soft texture, Thin Liquids consistency." Review of R73's "care plan," revised 02/12/26, located in the EMR under the "Care Plan" tab revealed "R73 is at nutrition/hydration risk r/t [related to]: need for snacks to help meet needs, need for therapeutic diet, need for mech alt diet, fluid restriction, variable intake, reported poor appetite, recent hospitalization, hx [history] of diuretic use; Dxs [diagnoses]: CHF, IBS [irritable bowel syndrome] with diarrhea, presence of cardiac implants/grafts, a fib [atrial fibrillation], cerebral palsy, HTN [hypertension], dysphagia, hx of TIA[transient ischemic attack], pressure wound, other disorders of plasma- protein metabolism. An intervention revealed "Provide, serve diet as ordered. Monitor intake and record q [every] meal." The allergies listed included Apples. Review of R73's allergies banner, located in the EMR above the care profile, revealed R73 was allergic to "apples." On 09/16/26 at 11:39 AM, R73 was served her lunch in the dining room . R73's meal included baked chicken, carrots, mashed potatoes, sweet potatoes, juice and an apple crisp dessert. On 09/16/26 at 11:50 AM, R73 stated the dessert contained apples and she was allergic to apples.	F0806	Continued from page 63 allergies listed on the meal tickets, the cook plating the meal will then verbally acknowledge allergies listed on the meal tickets and the finisher of the tray line (the dietary aid placing the tray on the food cart) will again compare the food items on the tray to the meal ticket before placing the tray on the food cart to ensure food allergies are observed and adhered to. 4 The Director of Food and Dining/Regional Director of Food and Dining/ Travel Administrator will conduct audits on tray line audits on all residents with food allergies on all 3 meals to ensure all food allergies are observed and adhered to. These audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations	10/02/2026

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F0806 SS = D	Continued from page 64 R73 stated she informed staff, and the apple crisp was removed from her meal tray before consumption. R73 further stated apples cause breathing problems because she had asthma. Review of R73's lunch meal ticket dated 09/16/26 revealed "Allergy: Apples." During an interview on 09/16/26 at 2:25 PM, the Dietary Manager (DM) reviewed R73's meal ticket and confirmed apples were listed as an allergy. The DM acknowledged that dietary staff made a mistake by serving the apple crisp dessert to R73. The DM stated he relied on nursing staff to also review meal trays and meal tickets to ensure residents did not receive foods to which they were allergic. 2. Review of R86's quarterly "MDS" with an ARD of 06/30/26 located in the EMR under the "MDS" tab revealed an admission date of 11/12/25 and a "BIMS" score of 15 out of 15, indicating R86's cognition was intact. The "MDS" also indicated R86 had diagnoses of diabetes mellitus (DM), hypertension (HTN), and anemia. Review of R86's diet order, dated 11/12/25, located in the EMR under the "Order" tab revealed "Regular diet, Regular texture, Regular (Thin) consistency." Review of R86's "care plan," revised 07/07/26, located in the EMR under the "Care Plan" tab revealed "R86 is at nutrition/hydration risk r/t recent fx's[fractures] s/p [status post] ORIF [open reduction and internal fixation], DM, COPD [chronic obstructive pulmonary disease], HTN, HLD [hyperlipidemia], post-op[operation] anemia, osteopenia, need for therapeutic diet, potential for weight flux [fluctuation]/ and appetite flux, hx[history] of wt [weight] changes; hx of altered lab [laboratory] values; modified nutritional needs and at risk for clinical changes including wt [weight]/skin & lab changes." An intervention included "Provide, serve diet as ordered. Monitor intake and record q [every] meal."… On 09/14/26 at 11:34 AM, R86 was observed sitting on her bed, dressed and groomed. R86 stated she continued to receive eggs at breakfast despite having an egg allergy. R86 reported she had been served scrambled eggs that morning but did not eat them because she knew she was allergic. R86 stated eggs cause stomach pain and severe gastric problems. Review of R86's breakfast meal ticket dated 09/14/26 revealed "Allergy: Eggs."	F0806		10/02/2026

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F0806 SS = D	Continued from page 65 During an interview on 09/16/26 at 2:25 PM, the Dietary Manager (DM) reviewed R86's meal ticket and confirmed eggs were listed as an allergy. When asked why R86 received eggs despite the documented allergy, the DM acknowledged dietary staff make mistakes and stated preventing residents from receiving foods to which they are allergic is a team effort. The DM stated he relied on nursing staff to review meal trays and meal tickets, in addition to dietary staff, to ensure residents are not served foods containing documented allergens Review of the facility policy titled "Food Allergies," undated, provided by the facility, revealed "Individuals with food allergies will be provided with safe foods and fluids, and appropriate substitutions to maintain health... 8. The director of food and nutrition services is responsible for training food and nutrition services staff on how to handle foods to avoid any inappropriate foods being served to individuals with food allergies..."	F0806		10/02/2026
F0880 SS = D	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 §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:	F0880	R106 1.Resident 106 still resides in the facility. The licensed nurse RN was immediately educated by the Staff Developer on the proper technique when performing wound dressing on 9/16/26. 2. Residents with wounds have the potential to be affected. Licensed staff will be educated on proper technique when cleansing wound and utilizing new gauze for each site. 3. Staff Educator/DON/ADON will educate licensed nurses and new hires on wound care competency upon hire and annually. 4. DON/ADON/Infection preventionist/Staff Developer will conduct observation audits of 3 staff performing wound dressing on various nursing units and shifts. These audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations. R189 1.R189 has been discharged from the facility. The	10/02/2026

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F0880 SS = D	Continued from page 66 (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. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, interviews, facility document review, and policy review, the facility failed to adhere to infection prevention and control practices by: (1) failing to follow infection prevention and control guidelines during wound care	F0880	Continued from page 66 facility cannot retroactively address the issue. 2.Residents with wounds have the potential to be affected. Licensed staff will be educated on proper technique when performing wound dressing to ensure gloves are removed, hand hygiene performed before applying treatment to the wound. 3. Licensed nurses will be reviewed for competency upon hire and annually. 4.DON/ADON/Infection preventionist/Staff Developer will conduct observation audits of 3 staff performing wound dressing on various nursing units and shifts. These audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations. R17 1.R17's nebulizer and bipap machine were immediately placed in a bag for storage. 2.Residents with bipap/nebulizers have the potential to be affected. Residents will be reviewed and appropriate bags for storage will be supplied 3.Root cause was determined to be due to an oversight by staff to ensure when resident is finished with nebulizer machine and bipap use is in a bag for storage. Staff Educator/DON/ADON will educate licensed nurses and new hires to ensure nebulizer machine and bipap are in a bag for storage. 4.DON/ADON/Infection preventionist/Staff Developer will conduct observation audits of 5 residents with nebulizer machines and bipap machines on various nursing units and shifts to ensure it is in a bag when not in use. These audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations	10/02/2026

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F0880 SS = D	Continued from page 67 for two of two residents observed receiving wound care (Residents (R)106 and R189); (2) failing to store respiratory equipment in a manner that minimized the risk of contamination for one resident reviewed for respiratory care (R17); and (3) failing to implement physician-ordered contact precautions for one resident reviewed for transmission-based precautions (R133). These deficient practices affected three residents within a sample of 61 residents and had the potential to expose residents to pathogenic organisms, facilitate cross-contamination, and increase the risk of healthcare-associated infections and preventable harm. Findings included: 1. Review of R106's "Admission Record" located under the "Profile" tab in the electronic medical record (EMR) indicated R106 was readmitted to the facility on 04/12/25 with the diagnoses of dementia, dysphagia (difficulty swallowing), and gastrostomy status. Review of R106's annual "Minimum Data Set (MDS)" located under the "MDS" tab in the EMR with an "Assessment Reference Date (ARD)" of 07/09/26 indicated R106 had a "Brief Interview for Mental Status (BIMS)" score of zero out of 15, which indicated R106 was severely cognitively impaired. R106 was coded as having a PEG (Percutaneous Endoscopic Gastrostomy), in which R106 received nutrition through her stomach. Review of R106's "Physician Orders" located under the "Orders" tab in the EMR indicated an order dated 09/04/26 for "Wound Care: Cleanse L [left] abdomen with NSS [normal saline solution], apply collagen and T-drain sponge BID [twice a day] and prn [as needed] …" During wound care observation on 09/16/26 at 3:50 PM, the Assistant Director of Nursing (ADON) cleansed the wound with normal saline and used a 4x4 gauze pad to pat the area dry. The ADON then folded the same 4x4 gauze pad and used it to pat dry another area of the wound. The blood-contaminated surface of the gauze was subsequently applied to another portion of the wound. This practice did not maintain clean technique and created the potential for cross-contamination during wound care. During an interview on 09/17/26 at 5:00 PM, the ADON confirmed that a clean area of the 4x4 gauze should have been used when patting dry the wound; that a portion of gauze previously used on the	F0880	Continued from page 67 R133 1.R133's contact precaution had been discontinued 9/16/2026 2.Current residents on contact isolation will be reviewed to ensure appropriate PPE supply is in place for PPE. 3.Root cause was determined to be due to miscommunication when to remove the PPE supply. Staff Educator/DON/ADON/Infection Preventionist will educate licensed nurses and new hires to ensure PPE supply is in place when there is an active order for isolation Infection preventionist/Unit Managers will review daily residents on transmission-based precautions and oversee to ensure room signage, PPE supplies and duration of Contact Precaution order. 4.DON/ADON/Infection preventionist/Staff Developer will conduct observation audits of 5 residents on transmission based precautions to ensure signage and PPE supplies are in place. various nursing units and shifts to ensure it is in a bag when not in use. These audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 weeks until 100% is verified, then monthly X 3 months until 100% is verified. Results will be presented to the Quality Performance Improvement Committee for review and recommendations.	10/02/2026

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F0880 SS = D	Continued from page 68 wound should not be reused on another area of the wound site and the area contaminated with blood touched the clean area of the wound that she was patting dry. During an interview on 09/17/26 at 5:30 PM, the Infection Preventionist (IP) confirmed that wound care should be performed using clean technique. The IP stated that a blood-contaminated portion of a 4x4 gauze pad should not be reused on another area of a wound and that only a clean, uncontaminated portion of the gauze should contact the wound. The IP further confirmed that, after completing the contaminated tasks of removing a soiled dressing and cleansing a wound, a nurse should remove contaminated gloves, perform hand hygiene, and don clean gloves before performing the clean task of applying Calcium Alginate directly to the wound bed. 2. Review of R189's "Admission Record" located under the "Profile" tab in the EMR indicated R189 was admitted to the facility on 09/08/26 with the following diagnoses of sepsis, unspecified organism, and type two diabetes mellitus. Review of R189's "Admit/Readmit Screener - V 24" located under the "Assessment" tab in the EMR and dated 09/08/26 at 3:07 PM, indicated R189 was alert and oriented to person, place, time, and situation. There was also documentation to reflect R189 "... seems or appears to recall after 5 minutes and seems or appears to recall long past ..." There was also documentation which indicated R189 had a wound to the coccyx area that measured seven centimeters (cm) in length by six cm wide. Review of R189's "Physician Orders" located under the "Orders" tab in the EMR indicated an order dated 09/09/26, "Wound Care: Cleanse sacrum with NSS [Normal Saline Solution], apply Medihoney, Calcium Alginate, and cover with NAD [Non-adhering dressing] every other day and prn [as needed] ..." During wound care observation on 09/16/26 at 4:30 PM, Licensed Practical Nurse (LPN)5 removed the old dressing, doffed her gloves, and performed hand hygiene. LPN5 donned gloves and cleansed the wound as prescribed. LPN5 did not doff her gloves, perform hand hygiene, and don clean gloves before applying Calcium Alginate directly to the wound bed. The ADON was present and assisted with positioning. During an interview on 09/16/26 at 4:50 PM, LPN5 stated that she could not remember if she had changed her gloves before applying the Calcium	F0880		10/02/2026

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F0880 SS = D	Continued from page 69 Alginate to the resident's wound. During an interview on 09/17/26 at 5:00 PM. the ADON confirmed LPN5 did not change her gloves after cleaning R189's wound and prior to applying the Calcium Alginate to the wound bed and during opening of the 4x4 gauze pad. Review of the undated facility's document "Validation Checklist Wound Care" indicated, "... Removed dressing ... Cleansed area thoroughly with prescribed cleansing agent taking care to not contaminate other skin surfaces or other surfaces of the wound... Performed hand hygiene and donned clean gloves..." 3. Review of R17's "Admission Record," located in the EMR under the "Profile" tab, revealed she was admitted to the facility on 07/05/26 with diagnoses of chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure, and obstructive sleep apnea. Review of R17's admission "MDS" with an Assessment Reference Date (ARD) of 07/11/26, located in the EMR under the "MDS" tab, revealed R17 scored 14 out of 15 on the " BIMS," which indicated intact cognition. Review of R17's "Order Summary Report," located in the EMR under the "Orders" tab, revealed an order, dated 08/24/26, for use of a BiPAP (non-invasive breathing machine) from bedtime until morning each day and an order, dated 08/24/26, for albuterol (inhaled medication used to open airways) nebulizer treatments every six hours. During an observation and interview on 09/14/26 at 12:52 PM, R17 reported she used a BiPAP machine as well as nebulizer treatments. Both machines and masks were observed on a bedside stand next to R17's roommate's bed, out of R17's reach. The masks were lying directly on the top of the stand. There were no visible plastic bags or other storage for the masks to be stored in. There was a divider curtain between R17's bed and the bedside stand, which indicated the bedside stand was for R17's roommate's use. R17 reported she was unable to reach the machines and that staff assisted her with applying the masks. During an observation on 09/15/26 at 12:31 PM, a tray table with R17's BiPAP machine and mask and nebulizer machine and mask was located next to R17's bed between the bed and the divider curtain.	F0880		10/02/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = D	Continued from page 70 R17 was not in the room. Two plastic bags were on the table. The nebulizer mask was stored inside one; however, the BiPAP mask was lying partially on top of the second bag and partially on the tray table. During an interview on 09/16/26 at 1:10 PM, the Infection Preventionist (IP) stated that nebulizer masks and BiPAP masks should be stored in bags when not in use. The IP further stated that the bags are usually changed out on Monday or Tuesday. During an interview on 09/16/26 at 2:00 PM, the Director of Nursing stated the expectation was for the nebulizer and BiPAP masks be stored in labeled bags at the bedside. During an observation on 09/15/26 at 2:30 PM, R17 was in her room eating lunch on the opposite side of the bed from the tray table. The BiPAP mask remained partially on the plastic bag and partially on the tray table. During an interview on 09/15/26 at 2:37 PM, Licensed Practical Nurse (LPN) 7 stated nebulizer and BiPAP masks should be stored in plastic bags in the residents' rooms when not in use. LPN7 stated R17's BiPAP mask was already off when she started her shift at 7:00 AM. LPN7 observed and verified R17's BiPAP mask was not in the plastic bag. Review of the World Health Organization's undated "Care, cleaning and disinfection of BiPAP/CPAP devices," located at https://www.who.int/docs/default-source, revealed BiPAP devices should be stored in an area where there is a low risk of contamination between uses. Review of The Asthma & Allergy Center's "Caring for Your Nebulizer and Compressor," dated 2026 and located at https://www.asthmaandallergycenter.com/article/caring-for-your-nebulizer-and-compressor, revealed to store nebulizer parts in a reusable plastic bag between uses. 4. Review of R133's "Admission Record," located in the EMR under the "Profile" tab, revealed she was admitted to the facility on 08/01/24. R133 had a diagnosis of malignant neoplasm (cancer) of the right bronchus or lung and also of the endometrium. A diagnosis of enterocolitis due to clostridium	F0880		10/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085004	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

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Coral Springs Rehab & Healthcare	**505 GREENBANK ROAD , WILMINGTON, Delaware, 19808**

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F0880 SS = D	Continued from page 71 difficile (C. diff) was entered with an onset date of 04/03/26. Review of R133's significant change "MDS" with an ARD of 06/22/26, located in the EMR under the "MDS" tab, revealed R133 scored 13 out of 15 on the "BIMS," which indicated intact cognition. Review of a "Nurses Note," dated 08/17/26 and located in the EMR under the "Progress Notes" tab, revealed the resident returned from a gastrointestinal (GI) appointment with order for a stool test. Review of an "Encounter" note, dated 08/18/26 and located in the EMR under the "Progress Notes" tab, revealed the resident continued to have loose stools and GI had ordered a stool specimen to test for C. diff. Review of a "Lab Results Report," dated 08/19/26, located in the EMR under the "Results" tab, revealed R133 had C. diff present but no toxin production detected and indicated "treatment not typically recommended unless symptoms are present." Review of the "Orders" tab in the EMR revealed an order for "Contact Precautions for C. Diff," which started 08/20/26. Review of R133's "Care Plan Report," located in the EMR under the "Care Plan" tab, revealed it did not address contact precautions currently or in the past. During an observation and interview on 09/14/26 from 10:34 AM to 11:20 AM, there was no observed signage on R133's door or personal protective equipment (PPE) in the vicinity of the room to indicate contact precautions. R133 reported having diarrhea for about two weeks and stated she continued to have diarrhea. R133 reported the smell was terrible and that the facility tested her for C. diff. R133 stated staff told her she had C. diff and everyone wore "protective covering [meaning PPE]" when entering the room but had not been wearing it recently. During the interview, at approximately 10:50 AM and 11:05 AM, Certified Nurse Assistant (CNA) 2 entered the room without wearing gown or gloves and delivered fresh water and sandwiches.. Review of the "Medication Administration Record (MAR)" for September 2026, located in the EMR under the "Orders" tab, revealed nurses documented each shift that "Contact Precautions for C. Diff" was completed through the day shift (7:00 AM to 3:00 PM) on 09/14/26.	F0880		10/02/2026

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F0880 SS = D	Continued from page 72 Review of the "Progress Notes" and the "Orders" tabs of the EMR revealed no mention of the discontinuation of contact precautions until after the observations on 09/14/26. During an interview on 09/15/26 at 1:37 PM, CNA2 verified she brought water and sandwiches to R133 in her room on 09/14/26 and did not wear PPE. CNA2 stated R133 was on and off of contact precautions for C. diff. CNA2 stated that R133 was not on any type of precautions on 09/14/26 because there was no sign on the door to indicate any. During an interview on 09/16/26 at 10:36 AM, LPN1 reported that R133 recently had C. diff, but she did not think she currently had it. LPN1 stated that management determined the duration of contact precautions and updated the orders. LPN1 further stated that she had not worked on 09/14/26 but had previously questioned the orders on the MAR for contact precautions because R133's room had no signage for precautions or PPE. During an interview on 09/16/26 at 1:10 PM, the IP stated that residents on transmission-based precautions, such as contact precautions, should have bags hanging on their doors with PPE as well as signage on the door as to the type of transmission-based precautions. In addition, nurses saw the orders on the MAR and CNAs could view the resident's Kardex. The IP stated that GI had ordered further stool testing and felt R133 was colonized with C. diff due to ongoing medical issues and treatment of her metastatic cancer. Whoever removed the sign and PPE from R133's door had not discontinued the order when they did so. During an interview on 09/16/26 at 2:00 PM, the DON reported the expectation that orders and signage for transmission-based precautions matched. Review of the facility's policy titled "Transmission-Based Precautions," dated January 2026, revealed, "Facility staff will apply Transmission-Based Precautions, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission . . . The order for transmission-based precautions/isolation will specify the type of precaution and reason for the transmission-based precaution. The duration will depend upon the infectious agent or organism involved . . . Signage that includes instructions for	F0880		10/02/2026

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F0880 SS = D	Continued from page 73 use of specific PPE will be placed in a conspicuous location outside the resident's room. The facility will have PPE readily available and will don appropriate PPE before or upon entry into the environment of a resident on transmission-based precautions . . . Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves . . . Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done . . . Transmission-Based Precautions remain in effect for limited periods (i.e. while the risk of transmission of the infectious agent persists or for the duration of the illness)."	F0880		10/02/2026