STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175298	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND POST ACUTE REHABILITATION	7850 FREEMAN AVENUE , KANSAS CITY, Kansas, 66112

(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
F0558 SS = E	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: The facility identified a census of 123 residents. The sample included 25 residents, with seven reviewed for reasonable accommodation of needs related to call lights and wheelchair foot pedals. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 84 had a call light he could functionally activate for staff assistance and ensure R96, R47, and R81 had foot pedals on their wheelchairs while being pushed. The facility additionally failed to provide R10's sensory hand item. Findings Included: - On 11/18/25 at 08:55 AM, R84 (severely cognitively impaired resident) sat in his bed with his bedside table over him. He stated he was done with his breakfast tray and needed staff to assist him. R84's call light was placed inside the dresser next to his bed and out of his reach. R84's low air-loss mattress was set to 200 pounds (lbs). On 11/18/25 at 09:00 AM, R96 (severely cognitively impaired resident) was pushed into the dining room in his wheelchair. His feet slid on the floor as he was pushed from his room to the dining room table. His wheelchair had no foot pedals attached. On 11/18/25 at 01:02 PM, R96, R47 (severely cognitively impaired resident), and R81 (severely cognitively impaired resident) were pushed from their rooms to the dining room table without foot pedals. Their feet slid on the ground as staff pushed them in their wheelchair. On 11/19/25 at 09:55 AM, Certified Nurse's Aide (CNA) M stated staff should use the foot pedals while pushing	F0558		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175298	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

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F0558 SS = E	Continued from page 1 the residents in their wheelchairs. On 11/19/25 at 10:00 AM, Licensed Nurse (LN) G stated all residents had foot pedals for their wheelchairs and staff were expected to use them while pushing the residents. On 11/19/25 at 12:05 PM, Administrative Nurse D stated staff were never to allow the residents' feet to drag while being pushed in their wheelchairs. The facility's "Fall Management System," dated 06/2018, indicated the facility promoted an environment that remains free from accident hazards. The policy indicated that the facility assessed and provided the appropriate equipment to ensure resident safety. The policy indicated the facility appropriately assessed and implemented interventions to prevent falls and minimize complications if falls occurred. - R10's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of cerebrovascular accident (CVA: stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hypertension (elevated blood pressure), chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing, need for assistance), and dysphagia (swallowing difficulty, and contracture- abnormal permanent fixation of a joint). The "Annual Minimum Data Set" (MDS) for R10, dated 08/16/25 recorded a Brief Interview for Mental Status (BIMS) score of 99, which indicated severely impaired cognition. The MDS documented R10 had an impairment in his upper and lower extremities on one side of his body. The MDS documented R10 required staff assistance for all activities of daily living (ADL). The MDS documented that R10 had a tracheostomy (an opening through the neck into the trachea, through which an indwelling tube may be inserted) and a tube feeding (the administration of nutritionally balanced, liquefied foods or nutrients through a tube). R10's "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 08/16/25 documented R10 had an alteration in cognition related to dementia (progressive mental disorder characterized by failing memory and confusion). The CAA documented R10 was at risk for complications due to restricted mobility and being unable to communicate.	F0558		

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F0558 SS = E	Continued from page 2 R10's "Care Plan," revised on 08/29/25, documented the following: - R10 had a self-care performance deficit related to bowel and bladder incontinence and required assistance with ADLs and decreased functional mobility. - R10's would maintain his current level of function in total dependence on staff with ADLs. - R10's plan of care dated 01/02/24 documented staff were to ensure R10 had one of his sensory objects in his right hand while in bed. - R10 would pull on his tracheostomy; and pull out the feeding tube and swing it around. - R10's wife preferred the flashlight be placed in R10's right hand. On 11/17/25 at 07:55 AM, R10 laid in his bed on his back with his eyes closed. R10's sign on his wall stated, "Place sensory object in R10's hand, while he was in bed." R10 did not have a sensory object in his right hand. R10's right hand was placed on his abdomen. On 11/18/25 at 08:19 AM, R10 laid in his bed on his back with his eyes open. R10's head was turned to his room door. R10's hand was under his sheet. R10 did not have a sensory object in his right hand. On 11/19/25 at 11:48 AM, Certified Nurse's Aide (CNA) stated any staff walking into R10's room should notice he did not have a sensory object in his right hand and place an object in his hand. She stated all staff were responsible for putting a sensory object in R10's hand. On 11/19/25 at 11:58 AM, Licensed Nurse (LN) K stated all facility staff can put an object in R10's hand. She stated there was a sign on his wall to apply a sensory object while he was in his bed. LN K stated it was the nurse's duty working R10's hall to ensure all tasks were completed for each resident. On 11/19/25 at 12:04 PM, Administrative Nurse D stated all staff can read the sign and ensure there was a sensory object placed in R10's right hand. She stated it was ultimately the nurses' responsibility to ensure tasks were done. The facility's "Accommodation of Needs" policy, reviewed 08/2024, documented it was the policy of the facility to ensure that a resident had the right to reside and receive services in the facility with	F0558		

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F0558 SS = E	Continued from page 3 reasonable accommodation for individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F0558		
F0689 SS = E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 123 residents. The sample included 25 residents, with five residents reviewed for accidents and/or hazards. Based on observation, record review, and interview, the facility failed to secure rooms containing hazardous materials to keep out of reach of 12 cognitively impaired /independently mobile residents. The facility additionally failed to follow Resident (R) 61 and R67's implemented fall interventions per their care plans. Findings Included: - On 11/17/25 at 07:10 AM, a walkthrough was completed in the facility's secured 2nd floor, and the following was observed: An inspection of an unsecured linen closet next to the nurse's station next to the elevator, revealed a container of purple disinfectant wipes on top of the room's counter. An inspection of the dining area revealed a cabinet next to the seating area with a container of purple wipes stored in the upper cabinet. An inspection of an unsecured soiled utility closet next to the rear nurse's station revealed two overfilled Sharps containers with syringes. An inspection of an unsecured shower room next to the rear nurse's station revealed a spray bottle of disinfectant.	F0689		

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F0689 SS = E	Continued from page 4 On 11/17/25 at 07:50 AM, Licensed Nurse (LN) G secured the doors and stated the rooms with potentially hazardous chemicals were supposed to be secured. She stated the residents were not to have access to secured areas. On 11/19/25 at 12:05 PM, Administrative Nurse D stated staff were expected to ensure hazardous chemicals were locked up and not accessible to the residents. The facility's "Fall Management System" policy, dated 06/2018, documented the facility was committed to promoting resident autonomy by providing an environment that remained as free of accident hazards as possible. Each resident was assisted in attaining or maintaining their highest practicable level of function through providing the resident adequate supervision, assistive devices, and functional programs as appropriate to prevent accidents. The facility provides each resident with appropriate assessment and intervention to prevent falls and to minimize complications if a fall occurs. The resident's care plan would be updated. - R61's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dementia (a progressive mental disorder characterized by failing memory and confusion), and anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). R61's "Annual Minimum Data Set" (MDS) dated 08/16/25 recorded a Brief Interview for Mental Status (BIMS) score of four, which indicated severely impaired cognition. The MDS documented R61 needed staff setup or clean up assistance for eating, was dependent on staff for toileting and bathing, and needed partial/moderate assistance by staff for dressing, chair to bed transfer, and toilet transfers. The MDS documented R61 had no falls since admission/entry. R61's " Falls Care Area Assessment" (CAA) dated 08/25/25 had bowel/bladder incontinence and required assistance with ADLs and was at risk for complications due to dementia, severe cognitive impairment, decreased functional mobility, and anxiety. R61's "Care Plan" documented the following fall interventions:	F0689		

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F0689 SS = E	Continued from page 5 11/21/24 - Staff to ensure the call light was within reach and encourage R61 to use it to call for assistance. 03/10/25 - Change Dycem (a non-slip material used for sliding in chairs) to a one-way slide. On 11/18/25 at 01:49 PM, R61 laid on her bed on her back, R61's fall mat was in place, and the bed was in a low position. R61's call light laid at the top of her bed under her pillow. R61's call light was out of her reach. R61's wheelchair was on her right side next to her bed. R61 did not have a Dycem in her wheelchair. On 11/19/25 11:48 AM, Certified Nurse's Aide (CNA) N stated call lights should always be within a resident's reach. She stated therapy took care of all the Dycem and ensured that Dycem was in each resident's wheelchair as ordered. On 11/19/25 at 11:58 AM, Licensed Nurse (LN) K stated therapy was responsible for putting the Dycem in the resident's chair; she was unsure who was responsible for ensuring the Dycem remained in the resident's chair. LN K stated that a resident's call light should always be within a resident's reach. On 11/19/25 at 12:04 PM, Administrative Nurse D stated it was the therapy department that put the Dycem in the wheelchair. She stated it would be any staff member's responsibility that put R61 in her wheelchair to check that the Dycem was in the chair. Administrative Nurse D stated the call light should be placed where the resident could reach it to use it. The facility's "Fall Management System" policy, dated 06/2018, documented that the facility was committed to promoting resident autonomy by providing an environment that remained as free of accident hazards as possible. Each resident was assisted in attaining or maintaining their highest practicable level of function through providing the resident with adequate supervision, assistive devices, and functional programs as appropriate to prevent accidents. The facility provides each resident with appropriate assessment and intervention to prevent falls and to minimize complications if a fall occurs. The resident's care plan would be updated. - The Electronic Medical Record (EMR) for R67 documented diagnoses of unsteadiness, chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing),	F0689		

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F0689 SS = E	Continued from page 6 history of falls, and muscle weakness. The “Quarterly Minimum Data Set” (MDS) dated 07/21/25 documented R67 had intact cognition. R67 required supervision from staff for showers, dressing, mobility, transfers, and did not ambulate. The assessment documented R67 had no functional impairment and had no falls. R67’s “Quarterly MDS” dated 10/21/25 documented R67 had intact cognition. R67 required supervision with showers, dressing, mobility, transfers, and ambulation. The assessment documented R67 had no functional impairment and had one fall with injury. R67's 10/15/25 “Care Plan” included the following fall interventions: 01/12/24 – Supervision assistance with transfers. Be sure her call light was within reach and encourage her to use it to call for assistance as needed. 01/29/24 – Staff educated that R67 was not allowed to be in the shower room alone. 05/03/24 - Supervision assistance with her front-wheeled walker. 09/29/25 – Staff educated to assist R67 with placing her oxygen tank in proper bags on her wheelchair or walker for ambulation purposes. R67’s “Fall Assessments” dated 07/11/25 documented R67 was a medium risk for falls. The “Fall Investigation” dated 09/29/25 documented on 09/29/25 at 07:23 PM, R67 had a witnessed fall while coming back into the facility from a smoke break. R67 pushed her walker and oxygen tank. When the tank tipped, she fell. R67 complained of neck and right knee pain. R67 sustained an abrasion (scrape) to her right knee. The investigation documented R67 had a gait imbalance and was educated to ask for assistance and for her oxygen tank to be placed in the bag on her walker. The investigation further documented that staff were educated to assist R67 with placing the oxygen tank into the proper bag on her walker or wheelchair. On 11/18/25 at 11:00 AM, R67 ambulated down the hall with unidentified therapy staff. R67 used a walker and had a small oxygen tank in a pouch on the front of her walker. On 11/18/25 at 02:30 PM, Certified Nurse Aide (CNA) M	F0689		

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F0689 SS = E	Continued from page 7 stated R67 was independent with ambulation except when going to the shower, and staff are to supervise her. CNA M further stated that she was unaware of any falls that R67 might have had. On 11/18/25 at 08:30 AM, Licensed Nurse (LN) J stated R67 used a walker and supervised when she ambulated. LN J further stated that she was unaware of any falls for the resident. On 11/19/25 at 09:45 AM, Administrative Nurse D stated staff should make sure R67's oxygen tank was in the pouch of the walker and supervise her when ambulating. The facility's "Fall Management System" policy, dated 06/2018, documented the facility was committed to promoting resident autonomy by providing an environment that remained as free of accident hazards as possible. Each resident was assisted in attaining or maintaining their highest practicable level of function through providing the resident adequate supervision, assistive devices, and functional programs as appropriate to prevent accidents. The facility provides each resident with appropriate assessment and intervention to prevent falls and to minimize complications if a fall occurs. The resident's care plan would be updated.	F0689		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 123 residents. The sample included 25 residents. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 67 had a physician's order and was assessed for the ability to safely self-administer an inhaler medication. Findings included: - The Electronic Medical Record (EMR) for R67 documented diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), acute and chronic respiratory failure with hypercapnia (when the body can't effectively get rid of carbon dioxide	F0554		

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F0554 SS = D	Continued from page 8 because of persistent lung disease). The" Quarterly Minimum Data Set" (MDS) dated 10/21/25 documented R67 had intact cognition. R67 required supervision with showers, dressing, mobility, transfers, and ambulation. The assessment documented R67 received an antianxiety (a class of medications that calm and relax people), antidepressant (a class of medications used to treat mood disorders), diuretic (a medication to promote the formation and excretion of urine), and hypoglycemic (a medication to treat low blood sugars) medication. R67's 10/16/25 "Care Plan" included the following interventions for COPD: 01/12/24 – Administer nebulizer treatments as ordered, give oxygen therapy as ordered by the physician, and monitor for signs and symptoms of acute respiratory insufficiency. 06/16/25 – Administer inhalers as ordered. The "Physician's Order" dated 07/11/25 directed staff to administer fluticasone-umeclidinium-vilant (used to help control the symptoms of asthma and improve lung function) 100-62.5-25 micrograms (mcg)/act, one inhalation, orally, daily for COPD. The EMR documented that the inhaler was scheduled for 07:00 AM daily. On 11/18/25 at 08:10 AM, Licensed Nurse (LN) I handed R67 the inhaler, did not provide instructions on how to use it, turned and went out to the cart to get applesauce to mix into R67's medication. R67 tried to inhale and found that the inhaler was empty. LN I came back into the room, and R67 handed her the inhaler and stated it was empty. LN I had R67's medication for her breathing treatment and told R67 that she was going to put the medication in the nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) and to make sure that she took it after she ate. As LN, I started to put the medication into the nebulizer machine, she asked me if it was ok that she leave it. This surveyor told her that I did not know and asked what the facility policy was. LN I stated, she would return after R67 finished her meal to administer her breathing treatment. On 11/18/25 at 08:20 AM, LN I stated that she would contact the physician to tell her that R67 had not received her inhaler as scheduled. LN I stated staff should have seen that the inhaler was almost empty and should have reordered it. LN I stated that she was not sure if R67 had an assessment to make sure she was able	F0554		

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F0554 SS = D	Continued from page 9 to administer her inhaler independently, but felt she could since R67 was cognitively intact. LN I further stated that they leave her breathing treatment medication at her bedside all the time, and she always took it. On 11/19/25 at 09:43 AM, Administrative Nurse D stated staff should have reordered the inhaler, and she would not have missed her scheduled dose. Administrative Nurse D verified that R67 did not have an assessment for self-administration of medications and should not have been given the inhaler to self-medicate. The facility's "Self-Medication of Medications" policy, dated 01/2025, documented the clinician would provide an opportunity for the patient to administer his/her own medications. The medications listed at the time of admission and recertification would be considered part of the plan of care. Staff assess the patient's ability to self-administer medications correctly and document the patient's response and understanding to teaching.	F0554		
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate	F0561		

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F0561 SS = D	Continued from page 10 in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 123 residents. The sample included 25 residents. Based on observation, interview, and record review, the facility failed, due to her posttraumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), to provide only female caregivers that were requested, for Resident (R) 82. Findings included: - The Electronic Medical Record (EMR) for R82 documented diagnoses of PTSD and insomnia (inability to sleep). The “Quarterly Minimum Data Set” (MDS) dated 10/03/25 documented R82 had intact cognition. R82 was independent with dressing, personal hygiene, mobility, transfers, and ambulation. The assessment documented R82 had no behaviors and did not receive psychotropic medications. R82's “Care Plan” dated 09/27/25, initiated on 06/27/25, documented social services to provide psychosocial support as needed. The care plan lacked documentation R82 requested no male caregivers. The “Social Services Assessment” dated 07/06/25 documented R82 had a diagnosis of PTSD and had been abused by her ex-husband, and stated the abuse was primarily emotional, mental, and financial. The assessment documented R82 preferred no male caregivers, and her trigger was loud noises. The assessment documented R82 refused psychiatric services at that time. The “Social Services Assessment” dated 10/06/25 documented R82’s trauma had been identified in the previous assessment and had not changed, and to refer to her care plan. The assessment documented R82 understood the importance of having social interaction, and no new needs were identified. The assessment lacked documentation R82 was offered psychiatric services. On 11/18/25 at 07:45 AM, R82 in bed working on her computer. R82 stated she did not have concerns with her care and liked to be in her room on her computer.	F0561		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175298	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0561 SS = D	Continued from page 11 On 11/18/25 at 01:00 PM, Licensed Nurse (LN) J stated she was unaware R82 had PTSD or of any residents on the first floor that had PTSD. LN J further stated she was unaware that R82 preferred not to have male caregivers. On 11/18/25 at 03:30 PM, Social Service X stated she had been unaware that the resident's request for no male caregivers was not on the care plan. On 11/19/25 at 08:20 AM, CNA O stated he had just been made aware R82 did not want any male caregivers and had assisted her many times in the past. On 11/18/25 at 03:45 PM, Administrative Nurse E stated that R82's request for no male caregivers should be on the care plan, and verified it was not. On 11/19/25 at 09:45 AM, Administrative Nurse D stated R82's PTSD and triggers should have been on the care plan before yesterday. Staff should have been made aware that the resident had PTSD and that she preferred female caregivers. The facility's "Resident Rights" policy, dated 10/04/23, documented that as a resident of the nursing facility, you have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The resident had the right to exercise their rights without interference, coercion, discrimination, or reprisal from the facility. The resident had the right to be treated with respect and dignity and receive services in the facility with reasonable accommodation of the need and preferences, except when to do so would endanger the resident or other residents.	F0561		
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:	F0628		

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F0628 SS = D	Continued from page 12 (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with 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	F0628		

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F0628 SS = D	Continued from page 13 section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and 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	F0628		

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F0628 SS = D	Continued from page 14 for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (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	F0628		

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F0628 SS = D	Continued from page 15 the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 123 residents. The sample included 25 residents, with one resident reviewed for the discharge process. Based on record review and interviews, the facility failed to provide a final summary of Resident (R) 128's status at discharge. Findings included: - R128s “Electronic Medical Records” (EMR) documented diagnoses of unsteadiness on feet, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), weakness, major depressive disorder (major mood disorder that causes persistent feelings of sadness), dependence on renal dialysis (a procedure where impurities or wastes are removed from the blood), acquired absence of left great toe, blindness right eye muscle, and dysphagia (swallowing difficulty). R128's "Entry Minimum Data Set (MDS)" completed 09/18/25. R128's “Care Plan” dated 09/18/25 documented:	F0628		

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F0628 SS = D	Continued from page 16 - R128 wanted to be discharged home after his skilled stay in the facility. - R128's plan of care dated 10/03/25 documented a pre-discharge plan would be held with the resident, family caregivers, to evaluate progress and revise the discharge plan as needed. R128's EMR under the "Assessment" tab for the Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition R128's EMR under "Fall Committee "Interdisciplinary Team (IDT) dated 09/22/25 documented post-fall investigation for the fall that occurred on 09/21/25. R128 fell out of bed. R128 was sent to the Emergency Room (ER) due to being on Heparin (blood thinner) for evaluation and treatment post fall. Staff would provide a falling star outside of R128's room for intervention. R128's EMR under "Social Services" dated 0/22/25 documented R128's spouse declined a bed hold. R128's spouse stated he would not be coming back to the facility because bed rails were not allowed. On 11/19/25 at 11:58 AM, Licensed Nurse (LN) K stated she was unsure whose responsibility it would be to do a discharge summary for a resident who was an unplanned discharge. On 11/19/25 at 12:04 PM, Administrative Nurse D stated that for an unplanned discharge, the social services did a portion of the discharge summary. Administrative Nurse D stated the remainder of the unplanned discharge would be her responsibility. On 11/19/25 at 10:44 AM, Administrative Staff A stated the facility was unable to locate a discharge summary or recompilation of R128's care as requested. The facility's "Admission, Transfer, and Discharge" policy dated 11/16 documented that it was the policy of the facility that each resident would remain in the facility and not be transferred or discharged unless the discharge or transfer was appropriate as per the existing criteria. When the facility transfers or discharges a resident, the facility would ensure that the transfer or discharge was documented in the resident's medical record and appropriate information was communicated to the receiving health care institution or provider.	F0628		
F0656 SS = D	Develop/Implement Comprehensive Care Plan	F0656		

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F0656 SS = D	Continued from page 17 CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.	F0656		

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F0656 SS = D	Continued from page 18 This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 123 residents. The sample included 25 residents. Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for two residents, Resident (R) 67 for smoking, and for R82 for posttraumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress). Findings included: - The Electronic Medical Record (EMR) for R67 documented diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), acute and chronic respiratory failure with hypercapnia (when the body can't effectively get rid of carbon dioxide because of persistent lung disease). The" Quarterly Minimum Data Set" (MDS) dated 10/21/25 documented R67 had intact cognition. R67 required R67 supervision with showers, dressing, mobility, transfers, and ambulation. The assessment documented R67 received oxygen therapy. R67's 10/15/25 "Care Plan" lacked documentation a care plan for smoking was developed. The "Smoking Assessment" dated 04/25/25 documented R67 had no visual deficits, no cognitive loss, and no falls. The assessment documented R67 smoked zero times per day, could light her own cigarette, and used oxygen. The assessment further documented R67 had been educated on safe smoking practices and education of the risks of smoking. On 11/19/25 at 09:30 AM, R67 sat in a wheelchair outside smoking. On 11/18/25 at 02:45 PM, Certified Nurse Aide (CNA) M stated R67 went outside several times a day with supervision to smoke. On 11/18/25 at 08:30 AM, Licensed Nurse (LN) J stated R67 smoked and was able to go outside with staff assistance. On 11/19/25 at 09:40 AM, Administrative Nurse D verified there was not a smoking care plan for R67, and she should have one.	F0656		

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F0656 SS = D	Continued from page 19 The facility's "Care Plans-Initial/Baseline and Comprehensive" policy, dated 02/22, documented the facility's development and implementation of a baseline or initial, and a comprehensive care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident. The care plan must meet professional standards of quality care, Care. Treatment and services are planned to ensure that they are appropriate to the residents' needs and provide an individualized, interdisciplinary plan of care for residents that is appropriate to the residents' needs, strengths, limitations, and goals. - The Electronic Medical Record (EMR) for F82 documented diagnoses of PTSD and insomnia (inability to sleep). The "Quarterly Minimum Data Set" (MDS) dated 10/03/25 documented R82 had intact cognition. R82 was independent with dressing, personal hygiene, mobility, transfers, and ambulation. The assessment documented R82 had no behaviors and did not receive psychotropic medications. R82's "Care Plan" dated 09/27/25 initiated on 06/27/25, documented social services to provide psychosocial support as needed. The EMR lacked documentation of a care plan for R82's PTSD that was developed. The "Social Services Assessment" dated 07/06/25 documented R82 had a diagnosis of PTSD and had been abused by her ex-husband, and stated the abuse was primarily emotional, mental, and financial. The assessment documented R82 preferred no male caregivers, and her trigger was loud noises. The assessment documented R82 refused psychiatric services at that time. The "Social Services Assessment" dated 10/06/25 documented R82's trauma had been identified in the previous assessment, had not changed, and to refer to her care plan. The assessment documented R82 understood the importance of having social interaction, and no new needs were identified. The assessment lacked documentation. R82 was offered psychiatric services. On 11/18/25 at 07:45 AM, R82 in bed working on her computer. R82 stated she did not have concerns with her care and liked to be in her room on her computer. On 11/18/25 at 02:45 PM, Certified Nurse Aide (CNA) M stated she was not aware R82 had a diagnosis of PTSD and did not know what her triggers would be.	F0656		

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F0656 SS = D	Continued from page 20 On 11/18/25 at 01:00 PM, Licensed Nurse (LN) J stated she was unaware R82 had PTSD or of any residents on the first floor that had PTSD. LN J further stated she was unaware that R82 preferred not to have male caregivers. On 11/18/25 at 03:30 PM, Social Service X stated she was unaware that there was no care plan for staff to provide the PTSD triggers when providing care for R82. Social Service X further stated she did not talk to R82 about her past trauma because she did not want to bring up past trauma and upset her. On 11/18/25 at 03:45 PM, Administrative Nurse E stated that she had just put a PTSD care plan in place for R82 and verified that it should have been on the care plan after the PTSD assessment was completed. On 11/19/25 at 09:45 AM, Administrative Nurse D stated R82's PTSD and triggers should have been on the care plan before yesterday. Staff should have been made aware that the resident had PTSD and that she preferred female caregivers. The facility's "Care Plans-Initial/Baseline and Comprehensive" policy, dated 02/2022, documented the facility's development and implementation of a baseline or initial, and a comprehensive care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident. The care plan must meet professional standards of quality care, Care. Treatment and services are planned to ensure that they are appropriate to the residents' needs and provide an individualized, interdisciplinary plan of care for residents that is appropriate to the residents' needs, strengths, limitations, and goals.	F0656		
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: The facility identified a census of 123 residents. The sample included 25 residents, with two residents reviewed for activities of daily living (ADL) care. Based on observation, record review, and interviews, the facility failed to ensure staff assisted Resident	F0677		

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F0677 SS = D	Continued from page 21 (R) 10 with showers as scheduled. Findings Included: - R10's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of cerebrovascular accident (CVA: stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hypertension (elevated blood pressure), chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing, need for assistance), dysphagia (swallowing difficulty), and contracture (abnormal permanent fixation of a joint). R10's " Annual Minimum Data Set" (MDS) dated 08/16/25 recorded a Brief Interview for Mental Status (BIMS) score of 99, which indicated severely impaired cognition. The MDS documented R10 had an impairment in his upper and lower extremities on one side of his body. The MDS documented R10 required staff assistance for all ADLs. R10's "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 08/16/25 documented R10 had an alteration in cognition related to dementia (a progressive mental disorder characterized by failing memory and confusion). The CAA documented R10 was at risk for complications due to restricted mobility and being unable to communicate. R10's "Care Plan" revised 09/02/25 documented: - R10 would maintain his current level of function. - R10 was in total dependence on staff with activities of daily living (ADL), bed mobility, transfers, eating, dressing, grooming, and toilet use. R10's EMR under "Progress Notes" documented the following note by social services on 11/04/25. A care plan meeting was held with R10's spouse, and the assistant director of nursing stated she was monitoring that showers were being given. R10's spouse stated she would like full showers, not bed baths, and had requested showers be moved to the evening shift. The assistant director of nursing stated R10's chart had been updated with the new request for R10. R10's EMR under "Task" documented R10 received a shower on 11/01/25, 11/04/25, a sponge bath on 11/10/25, a shower on 11/13/25, and a shower on 11/17/25.	F0677		

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F0677 SS = D	Continued from page 22 On 11/17/25 at 07:55, R10 laid in his bed on his back with his eyes closed. R10's hair appeared greasy. On 11/19/25 08:35 AM, Administrative Nurse F stated she oversaw ensuring all residents received their showers or baths, whichever the resident requested. Administrative Nurse F stated she picked up shower sheets daily. If a resident did not get a shower as scheduled, she talked to the Certified Nurse's Aides (CNA), and the process was that the resident would get a shower the next day. Administrative Nurse F stated it was the request of R10's spouse that he received a full shower and not a bed bath. On 11/19/25 at 11:48 AM, CNA N stated it was the CNA who was responsible for ensuring R10 received his shower. She stated CNAs have a bath schedule every day they are responsible for. She stated bath sheets were filled out every day, and if a resident did not get his bath that day, it was expected that staff would pass that information on to the next shift to do. On 11/19/25 at 12:04 PM, Administrative Nurse D stated that all CNAs have a shower schedule for each day. She stated it was expected that the showers would be done on the day they were scheduled. Administrative Nurse D stated that Administrative Nurse F was responsible for following up with the staff if a resident did not get their shower as scheduled. The facility's "Quality of Care" policy dated 10/2023 documented that it was the policy of the facility that residents were given the appropriate treatment and services to improve his or her abilities. Residents who were unable to carry out ADLs would receive necessary services to maintain good nutrition, grooming, personal hygiene, and oral hygiene.	F0677		
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	F0686		

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F0686 SS = D	Continued from page 23 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: The facility identified a census of 123 residents. The sample included 25 residents, with five reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on interviews, observations, and record reviews, the facility failed to ensure Resident (R) 84's pressure-reducing interventions were implemented correctly when R84's low air-loss mattress (specialized air mattress used to prevent pressure related wounds) was not set within his current weight range. The facility additionally failed to float R10's heels as directed by wound treatment. heels Findings included: - R84's Electronic Medical Records (EMR) included diagnoses of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), heart disease, and a stage-three (full-thickness pressure injury extending through the skin into the tissue below) pressure injury. R84's "Admission Minimum Data Set (MDS)" dated 10/26/25 noted a Brief Interview for Mental Status (BIMS) score of six, indicating severe cognitive impairment. The MDS noted he had no upper or lower extremity mobility impairments. The MDS noted he was dependent on staff assistance for bathing, dressing, personal hygiene, and oral hygiene. The MDS noted he required substantial to maximal assistance for bed mobility and transfers. The MDS noted he had one stage-three pressure ulcer and was at risk for further pressure ulcer development. The MDS noted he had pressure-reducing devices for his bed and wheelchair. R84's "Care Area Assessment (CAA)" within his MDS triggered for functional abilities on 10/28/25. The CAA noted he required staff assistance for his activities of daily living (ADL). The CAA noted his care plan was implemented to minimize the risks related to his ADL decline. R84's "CAA" triggered for pressure ulcers on 10/28/25.	F0686		

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F0686 SS = D	Continued from page 24 The CAA noted he admitted to the facility with a stage-three pressure injury. The CAA noted his care plan was implemented to minimize the risks related to pressure ulcers. R84's "Care Plan" initiated 10/20/25 indicated the following interventions: 10/20/25- He was dependent on staff assistance for bathing, toileting, oral hygiene, and dressing. 10/20/25- He required substantial assistance from staff for transfers and bed mobility. 10/20/25- He was at risk for pressure ulcers and had an air mattress. The intervention instructed staff to check the placement and function of the mattress. The plan lacked instructions related to the low-air-loss mattress settings. R84's EMR under "Assessments" indicated he admitted to the facility on 10/20/25 with a stage-two pressure injury on his left heel. The EMR indicated no decline or further development of new wounds during his stay at the facility. R84's EMR under "Vitals" indicated he weighed 132.1 pounds (lbs.) on 11/07/25. R84's EMR under "Physician Orders" dated 10/20/25 indicated he had a low-air-loss mattress and instructed staff to check placement and functioning. A review of the low-air-loss mattress manufacturer's operation (Drive) manual indicated the mattress system was intended to reduce the incidence of pressure ulcers while optimizing comfort. The manual indicated the mattress pump's pressure levels and firmness were preset based on the weight range selected. The manual revealed that using the mattress while deflated puts the resident at risk for injuries. On 11/17/25 at 07:57 AM, R84 lay in his bed. R84's low-air-loss mattress was set to 200 lbs. The mattress pump had fixed weight settings of 50lbs, 75lbs, 125lbs, 150lbs, 175lbs, 200lbs, 250lbs, 275lbs, 300lbs, and 350lbs. On 11/18/25 at 08:55 AM, R84 sat in his bed with his bedside table over him. He stated he was done with his breakfast tray and needed staff to assist him. R84's call light was placed inside the dresser next to his bed and out of his reach. R84's low-air-loss mattress was set to 200lbs.	F0686		

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F0686 SS = D	Continued from page 25 On 11/19/25 at 10:00 AM, Licensed Nurse (LN) G stated the low-air-loss mattress was set based on what the care plan indicated. She stated the bed was set by the resident's current weight. On 11/19/25 at 12:05 PM, Administrative Nurse D stated staff were expected to check the bed settings each shift. She stated the bed was to be set by the weight of the residents. She stated the care plans were to identify the correct settings of each mattress. The facility's "Skin and Wound Monitoring and Management" policy, reviewed 04/2025, indicated the facility would provide preventative wound management practices to include skin assessments, pressure-reducing devices, wound care services to management, and prevent wounds. - R10's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of cerebrovascular accident (CVA: stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hypertension (elevated blood pressure), chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing, need for assistance, dysphagia- swallowing difficulty), and contracture (abnormal permanent fixation of a joint). The " Annual Minimum Data Set" (MDS) for R10 dated 08/16/25 recorded a Brief Interview for Mental Status (BIMS) score of 99, which indicated severely impaired cognition. The MDS documented R10 was at risk for pressure injury. The MDS documented R10 had a pressure-reducing device in his wheelchair and a pressure-reducing device in his chair. The MDS documented R10 had a turning/repositioning program and nutrition or hydration interventions. The MDS documented R10 had no pressure wounds. R10's "Pressure Ulcer/Injury Care Area Assessment" (CAA) dated 08/16/25 documented R10 was at risk for skin/pressure injury related to bowel and bladder incontinence. The CAA documented R10 required assistance with activities of daily living (ADL). R10's "Care Plan" dated 08/06/25 documented the following: - R10 required a low air loss mattress to bed, and a pressure reducing cushion to wheelchair, nursing staff	F0686		

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F0686 SS = D	Continued from page 26 were to monitor for functioning and settings. - R10's plan of care documented nursing was to do a head-to-toe skin assessment weekly. - R10's plan of care documented R10 was at risk for skin/pressure injury related to bowel and bladder incontinence and requires assistance with ADLs. R10's "Braden Scale for Prediction Pressure Sore Risk" dated 10/06/2025 documented a score of 11, indicating a high risk for pressure ulcers. R10's "Weekly Wound Assessment" dated 11/14/25 documented no new skin issues. R10's EMR under the "Orders" tab revealed the following physician orders: Offload heels while in bed as the resident tolerates every shift, dated 10/01/25. On 11/17/25 at 07:55 AM, R10 laid in his bed on his back with his eyes closed. R10 heels laid directly on the mattress. On 11/17/25 at 01:30 PM, R10 laid on his back in his bed. R10 had a hand towel laid on his shoulder, around his neck. R10's heels laid directly on the mattress. On 11/19/25 at 11:48 AM, Certified Nurse's Aide (CNA) N stated it was anyone who went into R10's room's responsibility that ensure that his heels were not floated, to ensure they were elevated off the mattress. On 11/19/25 at 11:58 AM, Licensed Nurse (LN) K stated it was the nurse's job to sign off that heels were floated. She stated any staff member who had worked with R10 was responsible for ensuring heels were floated when they leave his room. On 11/19/25 at 12:04 PM, Administrative Nurse D stated it was the responsibility of all nursing staff and therapy to ensure R10's heels were floated before leaving his room. She stated the nurse does sign off that heels were floated while the nurse was in the room doing cares. The facility's "Skin and Wound Monitoring and Management" policy reviewed 04/25 documented it was the policy of the facility that a resident who enters the facility without pressure injury does not develop pressure injury unless the individuals clinical condition or other factors demonstrates that a developed pressure injury was unavoidable and a resident having pressure injury receives necessary	F0686		

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F0686 SS = D	Continued from page 27 treatment and services to promoted healing, prevent infection , and prevent new, avoidable pressure injury from developing.	F0686		
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 123 residents. The sample included 25 residents. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 82 received trauma-informed care to eliminate or mitigate triggers that may cause traumatization related to a diagnosis of post-traumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress). Findings included: - The Electronic Medical Record (EMR) for R82 documented diagnoses of PTSD and insomnia (inability to sleep). The “Quarterly Minimum Data Set” (MDS) dated 10/03/25 documented R82 had intact cognition. R82 was independent with dressing, personal hygiene, mobility, transfers, and ambulation. The assessment documented R82 had no behaviors and did not receive psychotropic medications. R82’s “Care Plan” dated 09/27/25, initiated on 06/27/25, documented social services to provide psychosocial support as needed. The EMR lacked documentation of a care plan for R82’s PTSD that was developed. The “Social Services Assessment” dated 07/06/25 documented R82 had a diagnosis of PTSD and had been abused by her ex-husband, and stated the abuse was primarily emotional, mental, and financial. The assessment documented R82 preferred no male caregivers, and her trigger was loud noises. The assessment	F0699		

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F0699 SS = D	Continued from page 28 documented R82 refused psychiatric services at that time. The “Social Services Assessment” dated 10/06/25 documented R82’s trauma had been identified in the previous assessment and had not changed, and to refer to her care plan. The assessment documented R82 understood the importance of having social interaction, and no new needs were identified. The assessment lacked documentation. R82 was offered psychiatric services. On 11/18/25 at 07:45 AM, R82 in bed working on her computer. R82 stated she did not have concerns with her care and liked to be in her room on her computer. On 11/18/25 at 02:45 PM, Certified Nurse Aide (CNA) M stated she was not aware R82 had a diagnosis of PTSD and did not know what her triggers would be. On 11/19/25 at 08:20 AM, CNA O stated he had just been made aware R82 did not want any male caregivers and had assisted her many times in the past. On 11/18/25 at 01:00 PM, Licensed Nurse (LN) J stated she was unaware R82 had PTSD or of any residents on the first floor that had PTSD. LN J further stated she was unaware that R82 preferred not to have male caregivers. On 11/18/25 at 03:30 PM, Social Service X stated she had been unaware that there was no care plan for staff to provide the PTSD triggers for staff when providing care for R82. Social Service X further stated she did not talk to R82 about her past trauma because she did not want to bring up past trauma and upset her. On 11/18/25 at 03:45 PM, Administrative Nurse E stated that she had just put a PTSD care plan in place for R82 and verified that it should have been on the care plan after the PTSD assessment was completed. On 11/19/25 at 09:45 AM, Administrative Nurse D stated R82’s PTSD and triggers should have been on the care plan before yesterday. Staff should have been made aware that the resident had PTSD and that she preferred female caregivers. The facility’s “Behavioral Health Services” policy, dated 08/2017, documented trauma survivors would receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents’ experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. The plan of care would include non-pharmacological interventions and	F0699		

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F0699 SS = D	Continued from page 29 individualized, person-centered care approaches as well as trauma-informed approaches in accordance with the resident's customary routines, with collaboration and input from the resident and/or resident representative. The care plan would identify specific interventions to avoid, minimize, or decrease the effect/impact of the trigger(s) on the resident. The facility would provide appropriate training to staff to ensure skills and competence for caring for residents with mental and psychosocial disorders, implementing non-pharmacological interventions, and trauma-informed care. Social Services would make the appropriate professional services referral, if needed, following agreement from the resident and/or resident representative.	F0699		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 123 residents. The sample included 25 residents, with seven residents reviewed for unnecessary medications. Based on observation,	F0757		

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F0757 SS = D	Continued from page 30 interview, and record review, the facility failed to hold Midodrine (a medication for low blood pressure) for Resident (R) 26 and R97 and failed to hold insulin (controls the amount of sugar in the blood by moving into the cells) as the physician ordered for R67. Findings included: - The Electronic Medical Record (EMR) for R26 documented diagnoses of hyperlipidemia (condition of elevated blood lipid levels) and hypotension (low blood pressure). The “Annual Minimum Data Set” (MDS) dated 07/08/25 documented R26 had intact cognition. R26 required supervision from staff for toileting hygiene, upper body dressing, personal hygiene, mobility, and transfers. The assessment further documented R26 received insulin, opioid (moderate to severe pain medication), and antiplatelet (medication that prevents platelets from sticking together and decreases your body’s ability to form blood clots) medication. The “Quarterly MDS” dated 09/24/25 documented R26 had intact cognition. R26 required supervision from staff for eating, oral hygiene, upper body dressing, personal hygiene, mobility, transfers, and ambulation. The assessment further documented R26 received insulin and antiplatelet medications. R26's 09/18/25 “Care Plan” included the following hypotension interventions: 04/25/25 - Monitor laboratory reports as ordered and report to the physician as needed. 07/22/25 - Monitor vital signs as ordered and report to the physician as needed. Administer medications as ordered for hypotension and observe for adverse effects. The “Physician’s Order" dated 08/06/25 directed staff to administer Midodrine HCL, 5 milligrams (mg), by mouth twice per day, and hold if systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was over 150 millimeters of mercury (mmHg). This order was discontinued on 09/16/25. The “Treatment Administration Record” (TAR) for September 2025 documented the following days R26 received the medication when the SBP was over the ordered parameter:	F0757		

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F0757 SS = D	Continued from page 31 09/01/25 – 163/57 mmHg The “Physician’s Order,” dated 09/16/25, directed staff to administer Midodrine, 5mg, by mouth, twice per day, and hold is SBP was greater than 150 mmHg. The “TAR,” dated October 2025, documented the following days R26 received the medication when the SBP was over the ordered parameter: 10/01/25 – 154/55 mmHg 10/05/25 – 164/55 mmHg 10/08/25 – 153/63 mmHg On 11/18/25 at 08:10 AM, R26 sat in her wheelchair in her room. On 11/18/25 at 08:30 AM, Licensed Nurse (LN) J stated R26 had already received her morning medications. LN J verified R26 had received her Midodrine medication when her blood pressures were out of the physician-ordered parameters. On 11/18/25 at 02:40 PM, Administrative Nurse D stated the nursing staff should follow the physician's ordered parameters and hold the medication when out of parameters. The facility’s “Medication Administration” policy, dated 09/2014, documented medications were administered as prescribed in accordance with good nursing principles and practices and only person legally authorized to do so. The policy further documented medications were administered in accordance with written orders of the prescriber. - The Electronic Medical Record (EMR) for R97 documented diagnoses of hyperlipidemia (condition of elevated blood lipid levels) and hypotension (low blood pressure). The “Admission Minimum Data Set” (MDS) dated 09/27/25 documented R97 had intact cognition. R97 was independent with eating, oral hygiene, toileting hygiene, personal hygiene, mobility, transfers, and ambulation. The assessment documented R97 received an antibiotic (drugs that kill or inhibit the growth of bacteria). R97's 10/06/25 “Care Plan” directed staff to administer medications as ordered and monitor for side effects and effectiveness.	F0757		

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F0757 SS = D	Continued from page 32 The “Physician’s Order “dated 09/21/25 directed staff to administer Midodrine HCL, 10 milligrams (mg), by mouth twice per day, and hold if systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was over 130 millimeters of mercury (mmHg). The “Treatment Administration Record” (TAR), dated October 2025, documented the following days R97 received the medication when the SBP was over the ordered parameter: 10/01/25 – 131/61 mmHg 10/04/25 – 138/67 mmHg 10/24/25 – 138/74 mmHg 10/26/25 – 132/65 mmHg in AM and 133/59 mmHg in PM 10/28/25 – 134/72 mmHg The “TAR," dated November 2025, documented the following days R97 received the medication when the SBP was over the ordered parameter: 11/04/25 – 137/64 mmHg 11/05/25 – 142/78 mmHg 11/11/25 – 136/71 mmHg 11/14/25 – 132/52 mmHg 11/16/25 – 142/62 mmHg On 11/18/25 at 08:15 AM, R97 was in bed with eyes closed. On 11/18/25 at 02:40 PM, Administrative Nurse D stated the nursing staff should follow the physician's ordered parameters and hold the medication when out of parameters. The facility’s “Medication Administration” policy, dated 09/2014, documented medications were administered as prescribed in accordance with good nursing principles and practices and only person legally authorized to do so. The policy further documented medications were administered in accordance with written orders of the prescriber. - The Electronic Medical Record (EMR) for R67	F0757		

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F0757 SS = D	Continued from page 33 documented diagnoses of diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin. The “Quarterly Minimum Data Set” (MDS) dated 07/21/25 documented R67 had intact cognition. R67 required setup assistance with eating, oral hygiene, dressing, and personal hygiene. The assessment documented R67 received hypoglycemic (medications used to lower blood sugars) medication. R67’s “Quarterly MDS” dated 10/21/25 documented R67 had intact cognition. R67 required supervision by staff for showers, dressing, mobility, transfers, and ambulation. The assessment documented R67 received hypoglycemic medication. R67's “Care Plan” included the following interventions for diabetes mellitus dated 01/12/24: - Administer medication as ordered by mouth and insulin and monitor for side effects and effectiveness. - Obtain fasting blood sugars as ordered by the physician. - Monitor/document/and report to the physician as needed for signs and symptoms of hypoglycemia (low blood sugar). The “Physician’s Order” dated 07/11/25 directed staff to administer Humalog (a fast-acting insulin), five units, subcutaneous (below the skin), before meals and at bedtime for Diabetes Mellitus. Hold the insulin if the fasting blood sugar is below 100 milligrams (mg) per deciliter (dl). Call the physician if the fasting blood sugar is below 70 mg/dl or over 400 mg/dl. R67’s “Treatment Administration Record” (TAR) for September 2025 documented the following days: R67’s blood sugar was below 100 mg/dl, and the insulin was not held: 09/05/25 at 06:30 AM - 87 mg/dl 09/05/25 at 11:30 AM – 98 mg/dl R67’s “TAR" for October 2025 documented the following days: R67’s blood sugar was below 100 mg/dl, and the insulin was not held: 10/07/25 at 06:30 AM – 87 mg/dl 10/09/25 at 06:30 AM - 95 mg/dl	F0757		

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F0757 SS = D	Continued from page 34 10/11/25 at 06:30 AM – 93 mg/dl R67's "TAR)" for November 2025 documented the following days: R67's blood sugar was below 100 mg/dl, and the insulin was not held: 11/02/25 at 11:30 AM - 91mg/dl 11/05/25 at 06:30 AM – 96 mg/dl 11/06/25 at 06:30 AM – 88 mg/dl On 11/18/25 at 11:30 AM, Licensed Nurse (LN) J obtained R67's blood sugar without concern. LN J verified there were days that R67 received Humalog when her blood sugars were out of parameters. On 11/18/25 at 09:40 AM, Administrative Nurse D stated R67 should not have received her insulin when her blood sugar was out of parameters. The facility's "Medication Administration" policy, dated 09/2014, documented medications were administered as prescribed in accordance with good nursing principles and practices and only person legally authorized to do so. The policy further documented medications were administered in accordance with written orders of the prescriber.	F0757		
F0849 SS = D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC	F0849		

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F0849 SS = D	Continued from page 35 facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.	F0849		

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F0849 SS = D	Continued from page 36 (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and	F0849		

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F0849 SS = D	Continued from page 37 other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 123 residents. The sample	F0849		

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F0849 SS = D	Continued from page 38 included 25 residents, with two reviewed for Hospice (specialized care that mainly aims to provide comfort and dignity to the patients, by providing physical comfort and emotional, social, and spiritual support for people nearing the end of life) services. Based on observation, interview, and record review, the facility failed to ensure a communication process between the hospice provider and the facility for Resident (R) 34, which included a plan of care and a description of the services provided, which included visit frequency for certified nurse aides, chaplain, medications, and medical equipment provided. Findings included: - The Electronic Medical Record (EMR) for R34 documented diagnoses of Huntington's disease (a rare abnormal hereditary condition characterized by progressive mental deterioration, a disabling central nervous system movement disorder), neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and major depressive disorder (major mood disorder that causes persistent feelings of sadness). The "Significant Change Minimum Data Set" (MDS) dated 08/26/25 documented R34 had intact cognition. R34 required supervision of staff for toileting hygiene, dressing, personal hygiene, mobility, transfers, and R34 did not ambulate. The assessment documented R34 received hospice services. R34's 11/17/25 "Care Plan" included the following interventions for hospice services initiated 08/22/25: - Adjust the provision of activities of daily living to compensate for the resident's changing abilities and encourage participation to the extent the resident wishes to participate. - Chaplain would visit. - Consult with the physician and Social Services to have hospice care for the resident in the facility. - Hospice nurse would visit weekly. - Hospice to provide a shower with visits. - Supplies as needed.	F0849		

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F0849 SS = D	Continued from page 39 The “Physician’s Order” dated 08/22/25 directed staff to admit R34 to hospice care. On 11/18/25 at 01:45 PM, staff pushed R34 down the hall in his wheelchair. On 11/18/25 at 02:45 PM, Certified Nurse Aide (CNA) M stated R34 received hospice services, and a hospice CNA provided R34 with his showers. On 11/18/25 at 01:30 PM, Licensed Nurse (LN) J stated R34 received hospice services, and the nurse visited with R34 a couple of times a week. On 11/19/25 at 09:45 AM, Administrative Nurse D stated R34’s care plan should reflect the services and what was provided by Hospice. The facility’s “End of Life Care: Hospice” policy, dated 11/07, documented the facility provided end of life care for dying residents that emphasized prevention and relief of symptoms as well as compassionate attention to the resident’s dignity and preferences. Through continuing interdisciplinary assessment, individualized care plans would be developed and implemented to address the resident’s physical, intellectual, emotional, social, spiritual, and practical needs. Collaboration with Hospice would include processes for orienting staff to facility policies and procedures, which may include residents' rights, documentation, and record-keeping requirements.	F0849		
F0000	INITIAL COMMENTS The following citations represent the findings of a health resurvey and complaint investigations 263182, 2656725, and 2649611. The 2567 was sent electronically on 12/04/25.	F0000		