STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175445	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD , LAWRENCE, Kansas, 66049

(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
F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations in 2675868 and 2599012. The 2567 was sent electronically on 12/15/25.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F0550		

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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F0550 SS = D	Continued from page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 62 residents. The Sample included 17, with two residents reviewed for dignity. Based on observations, record review, and interviews, the facility failed to ensure a dignified care environment for Resident (R) 1 and R21 during meal service. Findings Included: - On 12/02/25 at 12:22 PM, an observation was completed in the main dining room for meal service. R1 (a cognitively impaired resident who was physically dependent on staff assistance) sat in his Broda chair (specialized wheelchair with the ability to tilt and recline) at the table closest to the kitchen entry door. R1 had a Foley catheter (an indwelling urinary catheter with a tube inserted into the bladder to drain urine into a collection bag). R1's urinary collection bag was hung directly under his wheelchair. R1's urinary collection bag was visible and was one-third full with bright yellow urine. R1 had no privacy cover on his urinary collection bag. R21 (a cognitively intact resident who was physically dependent on staff for assistance) sat at the dining room table closest to the kitchen serving window. R21 sat in her wheelchair with her Foley catheter tubing and collection bag attached to the bottom right side of her wheelchair. R21's urinary collection was half full of yellow urine with bag had no privacy barrier in place. On 12/03/25 at 02:15 PM, Certified Nurse's Aide (CNA) M stated all the wheelchairs had bags in the bottom to place the urinary collection bags. She stated urine in the bag should not be visible. On 12/03/25 at 01:55 PM, Licensed Nurse (LN) G stated all the residents had dignity/privacy bags for the Foley catheters. She stated staff were expected to place them in the bags when transferring the residents to their wheelchairs.	F0550		

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F0550 SS = D	Continued from page 2 On 12/03/25 at 02:43 PM, Administrative Nurse D stated the resident's urine collection bags were to never be placed directly on the wheelchairs without having a dignity bag in place. He stated it was the staff's responsibility to ensure resident dignity. The facility's "Urinary Catheter Usage" policy, revised 11/2017, indicated staff were to ensure the appropriate placement and functionality of the catheters each shift. The policy indicated staff were responsible for maintaining the catheters with placement below the resident's bladder and ensuring sanitary practices. The policy noted that staff were to provide privacy barriers or covers. The facility's "Resident Rights" policy, revised 11/2017, indicated the facility was to ensure all residents were treated in a dignified manner. The policy indicated the facility was to provide ongoing education and In-service.	F0550		
F0577 SS = C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and	F0577		

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F0577 SS = C	Continued from page 3 accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 62 residents. The sample included 17 residents. Based on interviews, observation, and record review, the facility failed to post the previous state inspection information in a location accessible to residents and visitors. Findings included: - On 12/02/25 at 03:30 PM, review of the state agency results book that was available in the lobby area lacked the Statement of Deficiencies, which included citations from a complaint survey conducted on 10/25/25. On 12/03/25 at 10:21 AM, Administrative Staff A stated the survey binder that was available for the residents, families, and visitors did not contain the previous state inspection results. The facility's "Resident Rights" policy, dated 04/27/18, documented the resident had the right to self-determination.	F0577		
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other	F0583		

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F0583 SS = D	Continued from page 4 letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 62 residents. The sample included 17 residents, with one reviewed for privacy. Based on observation, record review, and interviews, the facility failed to secure protected health information (PHI) for Resident (R) 62. Findings Included: On 12/01/25 at 07:15 AM, an inspection of the Red Hall revealed an unsecured and unsupervised treatment cart outside R62's room. The cart contained stock medications, treatment supplies, and insulin for residents on the hall. The cart laptop was open and contained R62's picture and protected health information (PHI) within direct view. On 12/01/25 at 07:18 AM, Licensed Nurse (LN) J opened R62's door and exited the room into the hallway. LN J stated she was not sure if the medication carts were supposed to be locked, but would lock them during the survey inspection. She stated the PHI should not be left open on the computers when not in use. On 12/03/25 at 02:43 PM, Administrative Nurse D stated that staff have been educated to ensure the computers were locked or placed in "hidden mode" when staff walk away from them to protect the resident's PHI. The facility's "Resident Rights" policy, revised 11/2017, indicated the facility would ensure each resident's privacy and ensure all residents were educated and informed of their rights.	F0583		
F0602 SS = D	Free from Misappropriation/Exploitation	F0602		

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F0602 SS = D	Continued from page 5 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: The facility identified a census of 62 residents. The sample included 17 residents, with five reviewed for abuse and/or neglect. Based on the record review and interview, the facility failed to ensure Resident (R) 37, R58, R61, R67, and R73 were free from abuse when their medication was misappropriated from the facility's medication cart. Findings included: - The “Facility Incident Report 2599012” completed on 08/27/25 indicated R37, R58, R61, R67, and R73’s pain medication showed errors in medication that occurred at the times when Licensed Nurse (LN) K worked and had possession of the narcotic keys. A record review of R37 (resident with intact cognition) documented R37 had had pain from a fracture. R37 was a long-term care resident who recently suffered a left femur fracture and underwent surgery for fixation. R37 had documented decline in her functional mobility and decline in her ability to assist in her self-care tasks. A record review of R58 (resident with moderately impaired cognition) documented R58 needed moderately/maximal assistance with activities of daily living (ADL). A record review of R61 (a resident with moderately impaired cognition) documented R61 needed staff assistance with functional abilities and balance impairments, a history of falls, and takes pain medication. A record review of R67 (resident with intact cognition) documented R67 had a subarachnoid hemorrhage (a life-threatening type of stroke caused by bleeding into the space between the brain and the thin tissues	F0602		

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F0602 SS = D	Continued from page 6 (meninges) that cover it) and a T12 compression fracture (fracture of the last vertebra in the lower back). A record review of R73 (a resident who was severely impaired) documented R73 needed partial/moderate assistance with ADLS. R73 was on hospice and received pain medication. Review of the “Complaint Investigation Witness Statement” dated 08/23/25, while checking for medications to reorder, a pattern was noticed on the Red Hall that had multiple oxycodone 2.5 milligram (mg) and 5 mg notations that did not appear on the Electronic Medical Record but were logged out on the medical paper "Medication Administration Record" (MAR). The review found several residents' MARs that were checked had inconsistencies. A Review of the “Corrective Actions taken in response to the incident” dated 08/23/25 documented that LN K was immediately suspended and has since been terminated. Re-education of all nurses on documentation of administration of pain and other as-needed (PRN) medications, including narcotics. One-on-one re-education of the same nurses identified as having errors in the documentation of PRN medication. The facility would conduct an audit of all PRN-controlled medications weekly over a four-week period and would present the findings in the Quarterly Quality Assurance report. A review of training presented and signed by all nursing staff documented immediately upon the discovery or suspicion of discrepancy, suspected loss, or diversion, the Director of Nursing and Pharmacist were consulted, and an investigation was conducted. If any discrepancy was found, the pharmacy and the Director of Nursing were to be contacted. On 12/03/25 at 10:45 AM, Administrative Nurse D stated that it was brought to his attention from a floor nurse that there were discrepancies in the MAR for missing narcotics. An immediate investigation was conducted with the Pharmacy Consultant. Administrative Nurse D stated that all narcotics that were discontinued, or the resident had left the facility, should be given to the Director of Nursing, who would lock them up in a two-key lock and be destroyed with the pharmacist's consultation and the Director of Nursing. Administrative Nurse D stated that training on discrepancies of medication and narcotic counts was done with all nursing staff, as a group and one-on-one. Administrative Nurse D stated he felt the breakdown in	F0602		

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F0602 SS = D	Continued from page 7 the medication misappropriation was that narcotics were not taken out of the cart immediately after the medication had been discontinued. On 12/03/25 at 01:52 PM, LN I stated it required two nurses at the end of the shift and the start of the shift to verify narcotics. LN I stated the facility does in-services on misappropriation of narcotics and the importance of narcotic counts. The facility's "Abuse, Neglect, and Exploitation" policy, revised 11/28/17, documented misappropriation of a resident meant the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. The resident has a right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involutory seclusion, neglect, exploitation, misappropriation of resident property, and injury of unknown origin.	F0602		
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 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	F0628		

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F0628 SS = D	Continued from page 8 §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 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.	F0628		

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F0628 SS = D	Continued from page 9 §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. §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	F0628		

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F0628 SS = D	Continued from page 10 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 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.	F0628		

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F0628 SS = D	Continued from page 11 (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 62 residents. The sample included 17 residents, with one resident reviewed for hospitalization. Based on observation, record review, and interviews, the facility failed to provide a written notice of transfer/discharge as soon as practicable, and the facility also failed to provide a bed hold notice with the required information for Resident (R) 50. Findings included: - R50's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of hypotension (low blood pressure) and Parkinson’s disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). The “Admission Minimum Data Set (MDS)” dated 11/17/25 documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. R50's "Falls Care Area Assessment (CAA)” dated 11/25/25 documented she triggered for falls related to impaired balance and history of falls. R50's “Care Plan” dated 10/31/25 documented: 10/31/25 - R50 planned to return home. On 11/03/25 at 08:00 AM a “Communication Note” documented R50 was found on the floor by her bed. R50 was transferred by ambulance to the hospital. On 12/02/25 at 08:33 AM, R50 sat upright in her wheelchair at the dining room table. R50 visited with other residents at the dining room table. R50’s hair was combed. On 12/03/25 at 10:21 AM, Administrative Staff A stated there was no written notification or bed hold provided	F0628		

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F0628 SS = D	Continued from page 12 to R50 or her legal representative for her facility-initiated transfer to the hospital on 11/03/25. She stated was to provide the bed hold information to the resident or their legal representative at the time of transfer. Administrative Staff A stated the nursing staff would notify the social service of the transfer. She stated that social services was responsible for providing the written notification and follow-up on the bed hold. The facility's "Discharge Criteria" policy dated 11/28/17 documented residents were permitted to remain in the facility and not be transferred or discharge unless appropriate discharge criteria was met.	F0628		
F0656 SS = D	Develop/Implement Comprehensive Care Plan 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.	F0656		

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F0656 SS = D	Continued from page 13 (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. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 62 residents. The sample included 17 residents with five reviewed for care plan. Based on observation, record review, and interviews, the facility failed to implement a comprehensive care plan for Resident (R) 54 related to his activities of daily living (ADL). Findings Included: - R54's Electronic Medical Records (EMR) noted diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), benign prostatic hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), dysphagia (difficulty swallowing), and dementia (a progressive mental disorder characterized by failing memory and confusion). R54's "Quarterly Minimum Data Set" (MDS) dated 10/02/25 documented a Brief Interview for Mental Status (BIMS) score of six, indicating severe cognitive impairment. The MDS noted he had impairments in both legs. The MDS noted he required supervision during meals but was dependent on staff for toileting, dressing, oral hygiene, bathing, bed mobility, and transfers. The MDS noted he was frequently incontinent of bladder and always incontinent of bowel. The MDS noted he was at risk for falls but had none since his admission. R54's "Dementia Care Area Assessment" (CAA) completed 07/09/25 indicated he usually would understand others, but instructed staff to anticipate his needs. The CAA	F0656		

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F0656 SS = D	Continued from page 14 noted he worked with speech therapy services to improve cognition. R54's "Urinary Incontinence CAA" completed 07/09/25 indicated he was at risk for skin breakdown and incontinence related to his cognitive impairment and limited mobility. The CAA noted he worked with occupational and physical therapy services to improve his functional abilities. The CAA instructed staff to anticipate his needs and assist with toileting as indicated. R54's CAA did not trigger for his functional abilities. R54's "Care Plan" initiated 06/30/25 indicated the following interventions: 06/30/25 - The facility was to follow his advanced directives and indicated he was a "Full Code" (term used to indicate the desire to receive resuscitative measures in the event of cardiac arrest). 06/30/25 – He took medications with Black Box Warnings (BBW- the highest safety-related warning that medications can have assigned by the Food and Drug Administration) 10/31/25 – He had nutritional concerns, and staff were expected to offer feeding assistance during mealtimes. R54's "Care Plan" did not acknowledge his identified incontinence needs, his activities of daily living preferences or required level of assistance, and that he required a Hoyer lift (total body mechanical lift) with two staff member assistance for transfers. On 12/02/25 at 11:03 AM, R54 sat in his Broda Chair (specialized wheelchair with the ability to tilt and recline) in his room. R54's Hoyer lift sling was underneath him. R54's resident representative sat next to him. She stated the facility continually lacked communication between the management and direct care staff related to how and when cares were performed on the residents. She stated she attended the care plan meetings and felt the care was not being completed as discussed in the meetings. She stated she continually had to remind the facility to provide bathing and toileting care. On 12/03/25 at 01:55 PM, Licensed Nurse (LN) G stated that the nurses used report sheets but had access to the care plans for review. She stated R54 required full assistance from staff and was transferred with a Hoyer lift. She stated the care plans should reflect the	F0656		

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F0656 SS = D	Continued from page 15 resident's current or changing needs. She stated R54 was incontinent and required frequent checks and care. On 12/03/25 at 02:15 PM, Certified Nurse's Aide (CNA) M stated that only the nurse had access to the care plans. She stated that direct care staff received their instructions from the nurses during daily meetings. On 12/03/25 at 02:43 PM, Administrative Nurse D stated that the direct care staff and nurses relied more on the report sheets than the care plans. He stated the plans should reflect the resident's needs or care requirements. He stated the report sheet information was pulled directly from the care plans. He stated the care plans were reviewed quarterly, annually, and when changes occurred by the interdisciplinary team. The facility's "Comprehensive Care plan" policy, revised 03/2024, indicated each resident was to have a comprehensive assessment and provided individualized interventions to reflect their treatment needs. The policy indicated that the care plans were reviewed and updated to reflect changes that may occur with the resident's goals and care needs.	F0656		
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		

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F0657 SS = D	Continued from page 16 (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: The facility identified a census of 62 residents. The sample included 17 residents with five reviewed for care plan revisions. Based on observation, record review, and interviews, the facility failed to revise Resident (R) 38 and R27's care plans to reflate changes in their care. Findings Included: - R38's Electronic Medical Records (EMR) noted diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), limited mobility, muscle weakness, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R38's "Quarterly Minimum Data Set" (MDS) dated 08/28/25 documented a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. The MDS noted she could independently complete bathing, dressing, bed mobility, and transfers. The MDS noted she was at risk for developing pressure ulcers but had no current injuries. The MDS noted she had pressure-reducing devices in place for her bed and wheelchair. R38's "Pressure Injuries Care Area Assessment" (CAA) completed 06/06/25 indicated she was at risk for skin breakdown and pressure injuries. The CAA noted she had pressure-reducing devices for her wheelchair and bed. The CAA indicated she was taken off hospice services on 05/25/25. R38's "Care Plan" initiated 06/05/24 indicated the following interventions: 06/06/24 – The plan indicated she needed prompts and stand-by assistance to complete personal hygiene, oral hygiene, dressing, showering, and toileting. 06/17/24 - The plan noted she was at risk for skin breakdown. The plan noted she had a pressure-relieving mattress in place. The plan indicated she had low	F0657		

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F0657 SS = D	Continued from page 17 air-loss (specialized air mattress used to prevent pressure-related injuries) mattress and instructed staff to ensure the correct settings according to her weight. 10/30/24 - The plan instructed staff to perform weekly skin checks. On 12/02/25 at 07:30 AM, R38 sat up in her bed and ate her breakfast. Her bed was in the medium height (waist high) position. She had a pressure-reducing mattress, but it was not a low air-loss mattress. She stated her bed changed once she came off hospice service because she didn't need the air mattress. On 12/03/25 at 01:55 PM, Licensed Nurse (LN) G stated she had a pressure-reducing bed but didn't think she had a low air-loss mattress. She stated the care plan should be updated once the resident's needs changed, and old interventions should be removed. On 12/03/25 at 02:43 PM, Administrative Nurse D stated the care plans were reviewed quarterly and updated as needed. He stated R38 was on hospice services, and the bed was changed out once she was taken off hospice. He stated the plan was not updated. The facility's "Care plan" policy, revised 03/2024, indicated each resident was to have a comprehensive assessment and provided individualized interventions to reflect their treatment needs. The policy indicated that the care plans were reviewed and updated to reflect changes that may occur with the resident's goals and care needs. - R27's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The "Quarterly Minimum Data Set (MDS)" dated 10/09/25 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented that R27 had received respiratory treatment during the observation period. R27's "Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA)" dated 04/29/25 documented he required staff assistance with his functional abilities. Other risk factors included limitations in	F0657		

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F0657 SS = D	Continued from page 18 mobility, incontinence, and a diagnosis of dementia. R27's “Care Plan” dated 07/07/25 documented the following interventions: 07/07/25 - Staff would assist him with repositioning at least every two hours. R27's plan of care lacked direction to the nursing staff for oxygen therapy. R27‘s EMR under the “Orders” tab revealed the following physician orders: Oxygen per nasal cannula as needed daily. Monitor oxygen saturation and notify physician if below 90 percent, dated 04/16/25. The physician order lacked a diagnosis for administration. On 12/02/25 at 08:30 AM, R27 sat upright at the dining room table asleep his wheelchair. There was an empty medication cup and a plastic drinking cup on the table in front of him. R27’s lower extremities were on his wheelchair pedals. On 12/03/25 at 02:15 PM, Certified Nurse’s Aide (CNA) M stated that only the nurse had access to the care plans. She stated that direct care staff received their instructions from the nurses during daily meetings. She stated direction for oxygen administration should be included on the resident’s care plan. She stated usually the nurse would tell the CNAs how many liters per minute to set the oxygen at. On 12/03/25 at 01:55 PM, Licensed Nurse (LN) G stated that the nurses used report sheets but had access to the care plans for review. She stated a resident‘s care plan should include directions to staff for oxygen administration and monitoring. She stated she would modify a resident care plan when needed. She stated everyone had access to the resident plan of care, but did not have the time to review or read them. On 12/03/25 at 02:43 PM, Administrative Nurse D stated that the direct care staff and nurses relied more on the report sheets than the care plans. He stated the plans should reflect the resident's needs or care requirements. He stated the report sheet information was pulled directly from the care plans. He stated the care plans were reviewed quarterly, annually, and when changes occurred by the interdisciplinary team. He stated only the administrative staff could modify the resident’s care plans, and the CNAs did not have access to review the resident’s plan of care.	F0657		

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F0657 SS = D	Continued from page 19 The facility's "Care Plan" policy, revised 03/2024, indicated each resident was to have a comprehensive assessment and provided individualized interventions to reflect their treatment needs. The policy indicated that the care plans were reviewed and updated to reflect changes that may occur with the resident's goals and care needs.	F0657		
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: The facility identified a census of 62 residents. The sample included 17 residents, with one reviewed for quality of care. Based on observation, record review, and interviews, the facility failed to ensure the physician order was followed for a daily weight for R45 to monitor for congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid). Findings included: - R45's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of hypotension (low blood pressure), CHF, and atrial fibrillation (rapid, irregular heartbeat). The "Admission Minimum Data Set (MDS)" dated 11/10/25 documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated intact moderately impaired cognition. The MDS documented R45 had received diuretic (a medication to promote the formation and excretion of urine) medication during the observation period. R45's "Dehydration Care Area Assessment (CAA)" dated 11/16/25 documented he had triggered for dehydration related to constipation. The nursing staff would monitor for signs or symptoms of dehydration. R45's "Care Plan" dated 11/14/25 documented:	F0684		

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F0684 SS = D	Continued from page 20 11/14/25 - R45 received medications that had black box warnings, and the nursing staff would monitor for any adverse reaction and notify the physician. R45‘s EMR under the “Orders” tab revealed the following physician orders: Weigh daily to monitor for signs of CHF, dated 11/04/25. Lasix (Furosemide- diuretic) tablet 40 milligram (mg), give one tablet by mouth two times a day for edema (swelling resulting from an excessive accumulation of fluid in the body tissues), dated 11/04/25. Review of R45’s EMR under the “Vitals” tab, the “Medication administration Record (MAR)," the “Progress Notes,” and the “Treatment Administration Record (TAR)” from 11/04/25 to 12/01/25 (27 days) lacked evidence staff measured and recorded R45's weight on following seven dates 11/06/25, 11/10/25, 11/12/25, 11/15/25, 11/16/25, 11/19/25, and 11/20/25. R45’s clinical record lacked documentation of any refusals of any daily weights and any physician notification of daily weights that had not been obtained. On 12/02/25 at 12:56 PM, R45 sat upright on his bed. R45’s bedside table was pulled across his lower extremities, which had three cups of fluid on the table. R45 was awake and watched his TV. On 12/03/25 at 01:45 PM, Licensed Nurse (LN) I stated it was ultimately the nurse’s responsibility to ensure daily weights were obtained and documented. LN I stated if the resident refused to be weighed, she would notify the physician and document the refusal on the TAR and in the progress notes. On 12/03/25 at 02:24 PM, Certified Nurse Aide (CNA) M stated the nurse would write on the report sheet if a resident was a daily weight and the expectation was to obtain their weight before breakfast. CNA M stated she would then notify the nurse of the resident’s weight. CNA M stated if the resident refused to be weighed, she would notify the nurse. On 12/03/25 at 02:45 PM, Administrative Nurse D stated he would expect the physician order to followed. Administrative Nurse D stated if the resident was to refuse be weighed then the nurse would notify the physician and write a progress not in the residents’ EMR.	F0684		

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F0684 SS = D	Continued from page 21 The facility's "Physician Orders" policy dated 09/21/21 documented physician orders would be followed related to the care needs of individual residents.	F0684		
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: The facility identified a census of 62 residents. The sample included 17 residents, with two residents reviewed for treatment/services to prevent/heal 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 observation, record review, and interviews, the facility failed to ensure pressure-reducing measures were placed on Resident (R) 2, and further failed to ensure R2's Low air loss (LAL) mattress (medical device that uses continuous airflow through small holes in the surface to reduce moisture, keep skin cool and dry, and redistribute pressure to prevent and treat pressure ulcers) was set at the proper weight. Findings Included: - R2's Electronic Medical Record (EMR) 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), senile degeneration of brain (a progress degeneration of the brain with age), and dementia (a progressive mental disorder characterized by failing memory and	F0686		

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F0686 SS = D	Continued from page 22 confusion). The “Significant Change Minimum Data Set (MDS)" dated 09/22/25 documented a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R2 was dependent on the staff for bathing and toileting. The MDS documented R2 had one Stage 3 (full-thickness pressure injury extending through the skin into the tissue below), and two unstageable (depth of the wound is unknown due to the wound bed being covered by a thick layer of other tissue and pus) pressure wounds. The MDS documented R2 had a pressure-reducing mattress in her chair and on her bed The “Pressure Ulcer/Injury Care Area Assessment (CAA)” dated 09/22/25 documented R2 triggered CAA due to risk for skin breakdown related to incontinence and impaired bed mobility. The CAA documented multiple pressure injuries were noted, and treatment orders were in place per provider orders. The CAA documented staff would assist R2 with repositioning as needed, and a pressure-relieving mattress and cushion were in use for prevention. R2 was admitted to Hospice services on 09/15/25. R2’s “Care Plan” documented the following: 09/29/23 - staff to apply protective barrier to R2’s skin after incontinence. 12/02/24 - Licensed Nurse (LN) was to check R2’s skin weekly for any injury and report to the physician with any skin injury. R2’s plan of care lacked staff direction and interventions for pressure injuries/ulcers on the heels and coccyx. R2’s plan of care lacked staff direction for monitoring of R2’s LAL mattress. R2’s physicians‘ “Orders” documented the following: Ensure heel protectors are on patients' feet/heels to reduce the risk of pressure sores every shift, dated 1028/25. “Magic Butt” (paste compound formula) two times a day for wound care to the coccyx, dated 10/28/25. Wound care to left heel: cleanse left heel with normal saline, pat dry with gauze, and apply skin-prep (liquid skin protectant) to left heel, dated 11/05/25.	F0686		

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F0686 SS = D	Continued from page 23 Wound care to the right heel, cleanse right heel with normal saline, pat dry with gauze, apply skin-prep to right heel would apply Calcium alginate (a gel-like substance derived from seaweed that is commonly used for medical dressings), to wound bed with ABD (thick dressing) pad then Kerlix (stretchy gauze bandage) and change daily and prn every day shift, dated 11/18/25. R2's EMR lacked direction for staff monitoring of her LAL mattress. R2's EMR under 'Weights and Vitals" documented a weight of 121.2 on 11/17/25. On 12/01/25 at 08:32 AM, R2 laid on her back in her bed with her eyes closed. R2's heels were wrapped with kerlix and laid on a pink chuck directly on the mattress. R2 did not have boots on her heels, and R2's heels were not offloaded. R2's LAL mattress, which was controlled with a dial, was set at 180 pounds. On 12/02/25 at 10:17 AM, R2 laid in her bed with her head elevated and eyes open. R2 did not have boots to her heels. R2's heels were wrapped with kerlix and were offloaded on a pillow covered with a pink chuck. R2's LAL mattress, which was controlled with a dial with pre-set weights, was set at 180 pounds. On12/03/25 at 01:52 PM, LN I stated the facility had a provider that takes care of checking the LAL mattresses, and the settings were set at the correct settings. LN I stated she did believe the facility had requested R2's boots. R2 stated it was the floor nurse and the Certified Nurse Aides' (CNAs)responsibility to ensure boots were applied to a resident's heels, or heels were floated. On 12/02/25 at 12:10 PM, Administrative Nurse D stated he had made calls to R2's hospice provider to request R2's boots. He stated the facility had requested the boots for R2 a couple of times and had not received the boots. He stated staff should be offloading R2's heels while she was in bed. Administrative Nurse D stated, "Breathe" A provider sets the LAL mattress; he stated the mattress dial was set by weight. He stated the only time the staff would touch the mattress was if the mattress was not working. The facility's "Wound Assessment, Prevention and Treatment" policy, revised 11/28/17, documented a resident who enters the facility without pressure ulcers would not develop them unless the individual. The clinical condition demonstrates that they were	F0686		

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F0686 SS = D	Continued from page 24 unavoidable. A comprehensive, individualized care plan would be developed to address prevention of development of pressure ulcers, management of risk factors, and treatment strategies for residents with pressure ulcers. The strategies would be developed through collaboration between the resident, the representative, the physician, the dietitian, and the clinical staff.	F0686		
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 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 identified a census of 62 residents. The sample included 17 residents, four residents were sampled for accidents and hazards. Based on observation, record review, and interviews, the facility failed to provide Resident (R) 2's fall interventions as directed by her care plan. Findings included: - R2's Electronic Medical Record (EMR) 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), senile degeneration of brain (a progress degeneration of the brain with age) and dementia (a progressive mental disorder characterized by failing memory and confusion). The "Significant Change Minimum Data Set (MDS)" dated 09/22/25 documented a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R2 was dependent on the staff for bathing and toileting. The MDS documented R2 had falls since admission or reentry or the prior assessment. The MDS documented R2 had two or more falls with injury during the observation period. The "Falls Care Area Assessment (CAA)" dated 09/22/25	F0689		

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F0689 SS = D	Continued from page 25 documented R2 triggered for falls CAA due to the risk for falls related to impaired balance. The CAA documented other risk factors, including cognitive (impaired thought process) impairments, incontinence, limitations in mobility, opioid (use for pain), dementia, and senile degeneration of the brain. The CAA documented R2 had clear speech and was often able to understand others. The CAA documented R2 was admitted to hospice on 09/15/25. R2's "Care Plan" documented the following fall interventions: 06/24/2025 - nonskid strips placed in front of the recliner to help keep my feet from sliding out from under me. 06/24/25 - Place call light within reach. 09/22/25 - Place a fall mat next to the bed. 09/22/25 - Bed in the lowest position. 08/25/25 - Staff to check R2 every 2 hours. 10/03/25 - Staff to provide non-slip socks. On 12/03/25 at 02:22 PM, Certified Nurse's Aide (CNA) M stated she did not have access to the care plan. CNA M stated she would know who needed a fall mat by the daily CNA report and the nursing report. CNA M stated the fall mats should be placed on the side of the bed, and if the resident was a fall risk, the bed should be in a low position. On 12/03/25 at 01:52 PM, Licensed Nurse (LN) I stated she was unsure if everyone had access to the care plan. LN I stated the expectation was that the CNA would put the fall mat down when putting the resident to bed. She stated she was unsure if beds should be in a low position, as it was different for each resident. On 12/02/25 at 10:22 AM, Administrative Nurse D stated that fall mats should be on the side of the bed that R2 would roll out of bed on. Administrative Nurse D stated the fall mat should not be under the bed. He stated the last staff member to leave a resident's room should ensure the fall mat was in place, and the bed was in the lowest position. Administrative Nurse D stated that all staff would know if a resident needed a fall mat or bed, which should be in the lowest position on the daily report sheet. Administrative Nurse D removed R2's fall under her bed and placed it on the side of her bed.	F0689		

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F0689 SS = D	Continued from page 26 The facility's "Falls" policy, revised 04/27/18, documented the facility would implement systems to reduce the risk of falls based on resident assessment. An individualized care plan intervention would be developed for residents identified through assessment as being at risk of falls. The interventions would be reviewed and updated on a regular basis when a fall occurred.	F0689		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 62 residents. The sample included 17 residents, with one resident reviewed for respiratory care. Based on interviews, observation, and record review, the facility failed to ensure there was physician indication for oxygen administration for Resident (R) 27. Findings included: - R27's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The "Quarterly Minimum Data Set (MDS)" dated 10/09/25 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented that R27 had received respiratory treatment during the observation period. R27's "Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA)" dated 04/29/25 documented R27 required staff assistance with his functional abilities. Other risk factors included limitations in	F0695		

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F0695 SS = D	Continued from page 27 mobility, incontinence, and a diagnosis of dementia. R27's "Care Plan" dated 07/07/25 documented the following interventions: 07/07/25 - Staff would assist him with repositioning at least every two hours. The plan of care lacked direction for the nursing staff related to R27's oxygen therapy. R27's EMR under the "Orders" tab revealed the following physician orders: Oxygen per nasal cannula as needed daily. Monitor oxygen saturation and notify the physician if below 90 percent dated 04/16/25. The physician's order lacked a diagnosis for administration. On 12/02/25 at 08:30 AM, R27 sat upright at the dining room table, asleep in his wheelchair. There was an empty medication cup and a plastic drinking cup on the table in front of him. R27's lower extremities were on his wheelchair pedals. On 12/03/25 at 01:45 PM, Licensed Nurse (LN) I stated oxygen was a medication and required a diagnosis for any medication. LN I stated she would call the physician to obtain a diagnosis. On 12/03/25 at 02:45 PM, Administrative Nurse D stated he would expect that all medication would have an indication for administration. He stated he would expect the nurse to call and get a diagnosis. The facility's "Oxygen Safety and Management" policy dated 03/22/19 documented oxygen would be administered in a safe manner to residents who require it. Oxygen would be provided to residents based on their physician's orders. Concentrators and oxygen tanks would be available for resident use. Physician orders for oxygen use would include the rate of oxygen flow (liters/minute), the route of administration, the mask, and the frequency of administration.	F0695		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive	F0698		

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F0698 SS = D	Continued from page 28 person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 62 residents. The sample included 17 residents, with one resident reviewed for dialysis (a procedure where impurities or wastes are removed from the blood), and end-stage renal disease (ESRD- a terminal disease of the kidneys). Based on observation, record review, and interviews, the facility failed to provide standards of care related to Resident (R) 7's dialysis. Findings included: - R7's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid) and end stage renal disease (the final stage of chronic kidney disease, where the kidneys have permanently stopped working and can no longer function at a level needed to sustain life). The "Quarterly Minimum Data Set" (MDS) dated 11/16/25 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R7 was impaired on one side of his body. The MDS documented R7 required dialysis during the observation period. R7's "Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) dated 08/14/25 documented R7 admitted to the facility following hospitalization. The CAA documented R7 was admitted for therapy services. The CAA documented R7 required additional assistance with his activities of daily living (ADL). The CAA documented R7 received dialysis on Monday, Wednesday, and Friday. R7's "Care Plan" documented the following: 08/12/25 - R7 wanted to remain safe during his stay in the facility. 08/12/25 - R7 planned to return home after therapy. 08/12/25 - R7 needed help obtaining the services and resources to be able to go home. R7's plan of care lacked direction for staff to care for his dialysis treatments.	F0698		

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F0698 SS = D	Continued from page 29 R7's EMR under the physicians' "Orders" tab lacked direction for nursing to care for R7, who needed dialysis. The EMR lacked a physician order for R7's dialysis. The EMR lacked direction for staff to access R7's dialysis shunt (tube or device implanted in the body to redirect a body fluid from one cavity to another) in his left arm. The EMR lacked direction for staff for R7's dialysis location, transportation provider, and the date and times that R7 received dialysis. On 12/03/25 at 02:22 PM, Licensed Nurse (LN) I stated the process to ensure a resident's standard of care for dialysis would be to check the "Treatment Administration Record" (TAR), nursing report, and the care plan for specific orders for dialysis. LN I stated nursing staff do not check the residents' shunt, she stated dialysis takes care of the residents' dialysis needs. LN I stated the facility ensured residents had a lunch to take with them to dialysis. On 12/03/25 at 02:43 PM, Administrative Nurse D stated the nurses would know a resident was on dialysis by the nursing report sheet and nurse-to-nurse communication. Administrative Nurse D stated he did not know who had access to the care plans; he thought just the administrative staff. He stated he could see where having direction for nursing in the TAR, and the care plan would be good, along with the nursing report sheet. The facility's "Dialysis" policy, revised 11/28/17, documented dialysis services would be provided for residents with end-stage renal disease. A physician's order would be obtained at the time of admission for the provision of dialysis treatment. The facility would arrange for dialysis services and transportation to and from the dialysis unit for any resident who required them.	F0698		
F0730 SS = F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(e)(7) §483.35(e)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must	F0730		

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F0730 SS = F	Continued from page 30 comply with the requirements of §483.95(g). This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 62 residents. The sample included 17 residents. Five Certified Nurse Aides (CNA) were reviewed for yearly performance evaluations and in-service training. Based on record review and interview, the facility failed to ensure one of the five reviewed CNA staff had the required yearly performance evaluations completed. This placed the residents at risk for inadequate care. Findings included: - Review of the facility's performance evaluation and in-service records revealed the following: CNA N, hired 09/30/23, had no yearly performance evaluations provided upon request. On 12/03/25 at 09:30 AM, Administrator A stated the facility did not have a performance evaluation for CNA N. On 12/03/25 at 02:43 PM, Administrative Nurse D stated that yearly evaluations were completed on all direct care staff. He stated the evaluations were used to gauge performance and identify areas of needed improvement for direct care staff. The facility's "Staffing" policy, dated 06/2017, indicated performance reviews will be conducted on each employee at least annually to identify employee strengths and goals. The policy noted that the evaluation would be utilized to determine training needs for the employee.	F0730		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F0761		

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F0761 SS = E	Continued from page 31 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 62 residents. The Sample included 17 residents. Based on observations, record review, and interviews, the facility failed to ensure safe medication storage of three of its six medication carts. Findings Included: - On 12/01/25 at 07:08 AM, an inspection of the Blue Hall revealed an unlocked and unsupervised medication cart next to the medication storage room. The cart contained prescription medications, stock medications, insulin (a hormone that lowers the level of glucose in the blood), and treatment supplies for the residents on the hall. An inspection of the Blue Hall also revealed an unsecured, smaller treatment cart that contained stock medication and treatment supplies next to the medication cart. At 07:11 AM, Certified Medication Aide (CMA) M entered the hallway and secured both carts. She stated staff were expected to lock the carts when not directly supervising them. On 12/01/25 at 07:15 AM, an inspection of the Red Hall revealed an unsecured and unsupervised treatment cart outside Resident (R) 62's room. The cart contained stock medications, treatment supplies, and insulin for residents on the hall. The cart laptop was open and contained R62's picture and protected health information (PHI) within direct view. At 07:18 AM, Licensed Nurse (LN) J opened R62's door and exited the room into the hallway. LN J stated she was not sure if the medication carts were supposed to be locked, but would lock them during the survey inspection. She stated the PHI should not be left open on the computers when not in use.	F0761		

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F0761 SS = E	Continued from page 32 On 12/03/25 at 02:43 PM, Administrative Nurse D expected the medication carts to be supervised or locked when not in use. He stated that staff received annual training related to resident safety and medication storage expectations. The facility's "Storage of Medications" policy, revised 01/2021, indicated that drugs and biological agents were expected to always be stored in a locked compartment or area. The Policy indicated staff were expected to supervise all medications and biologicals during times of administration or use.	F0761		
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. (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: The facility identified a census of 62 residents. The facility had one main kitchen and two dining areas. Based on observation, interview, and record review, the facility failed to ensure that staff members properly tested the dishwashing sanitization chemicals documented freezer and refrigerate temperatures. The facility also failed to staff donned hairnets and beard guards and maintain dairy food at the appropriate temperature.	F0812		

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F0812 SS = F	Continued from page 33 Findings included: - During the initial tour of the kitchen and dining room area on 12/01/25 at 07:10 AM, an open undated gallon of milk sat in a brown tub without ice. Dietary Staff EE tempted the open milk, which was 46 degrees. The Milk was discarded. Dietary Staff EE lacked a hairnet when setting up the breakfast serving line. Dietary Staff CC carried two juice glasses, touching the tops of the glasses where the resident would drink from. On 12/01/25 at 07:45 AM, review of the “Low Temperature Sanitizing Dish Machine Log,” “Refrigerator Temperature Log,” and the “Freezer Temperature Log” for November 2025 revealed the following ten days lacked documentation on 11/21/25, 11/22/25, 11/26/25, 11/27/25, 11/28/25, 11/29/25, and 11/30/25. On 12/02/25 at 12:45 PM, Dietary Staff DD failed to don (put on) a beard guard as he worked in the food prep area. On 12/03/25 at 10:01 AM, Dietary Staff BB stated staff should always wear a hairnet and facial hair net when in the kitchen food prep area. She stated that staff should hold the glasses at the base of the cup and not touch the part of the glasses where the resident would drink from. Dietary Staff BB stated the temperatures for the dishwashing machine, refrigerators, and freezers should be recorded daily. Dietary Staff BB stated dairy products should always be kept on ice to ensure they do not spoil. The facility’s “Food Storage” policy, revised 04/06/20, documented food would be stored on shelves in a clean, dry area, free from contaminants. Food would be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety. Check refrigerator temperature regularly. Conduct random temperature checks of food items.	F0812		
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	F0849		

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F0849 SS = D	Continued from page 34 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 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.	F0849		

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F0849 SS = D	Continued from page 35 (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. (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	F0849		

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F0849 SS = D	Continued from page 36 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 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.	F0849		

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F0849 SS = D	Continued from page 37 §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 identified a census of 62 residents. The sample included 17 residents, with two residents reviewed for hospice services. Based on observation, record review, and interviews, the facility failed to ensure collaboration between the nursing home and hospice services to identify hospice-supplied services, supplies, medication, and equipment for Resident (R) 3 and R1. Findings included: - R3's Electronic Medical Records (EMR) noted diagnoses of heart failure, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), overactive bladder, and morbid obesity (severely overweight). R3's "Significant Change Minimum Data Set" (MDS) dated 09/03/25 documented a Brief Interview for Mental Status (BIMS) score of 12, indicating mild cognitive impairment. The MDS noted she could independently complete bathing, transfers, showering, dressing, personal hygiene, toileting, and footwear. The MDS noted she reported she had little interest in doing things and had feelings of hopelessness. The MDS indicated she was on hospice services. R3's "Functional Abilities Care Area Assessment" (CAA) completed 09/12/25 indicated she required assistance with her functional abilities and impaired balance. The plan instructed staff to anticipate her needs. The plan noted she was admitted to hospice services on 08/27/25. R3's "Care Plan" initiated 11/11/24 indicated the following interventions: 12/10/24 - The plan indicated she was often independent with her activities of daily living but may need help from staff. The plan indicated she could dress herself, perform oral hygiene, and personal hygiene with set-up assistance. The plan indicated she wanted to bathe twice a week and needed assistance washing her back.	F0849		

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F0849 SS = D	Continued from page 38 12/10/24 - The plan indicated she was at risk for skin breakdown. The plan indicated she had a pressure reducing mattress and her wheelchair. A review of R3's "Care Plan" revealed no entries related to her hospice services that she admitted to on 08/27/25. On 12/01/25 at 07:00 AM, R3 sat in her bed in her room. Her bed had a pressure-reducing mattress. Her call light was within reach. R3 stated she had not felt well for the last few days and had been on hospice services. She stated that hospice comes in twice weekly to see her. On 12/03/25 at 01:55 PM, Licensed Nurse (LN) G stated the facility's care plan should have indicated which hospice service provider, what services were provided, and what equipment hospice covered. She stated staff should be able to review this information if needed for care. On 12/03/25 at 02:43 PM, Administrative Staff A stated the facility's care plan should identify hospice and the services provided. The facility's "Hospice" policy, revised 11/2017, noted the facility would ensure coordination between the resident, representative, and hospice services providers to ensure effective end-of-life care. The policy indicated that the facility would identify the responsibilities of each party and engage in ongoing communication. - R1's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of hemiparesis (muscular weakness of one half of the body), and hemiplegia (paralysis of one side of the body) following cerebral infarction (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), cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), and dysphagia (swallowing difficulty). The "Significant Change Minimum Data Set" (MDS) dated 11/06/25 documented R1 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R1 had an impairment on one side of his upper and lower body. The MDS documented R1 needed the assistance of staff for	F0849		

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F0849 SS = D	Continued from page 39 all activities of daily living (ADL). The MDS documented R1 received hospice services during the observation period. R1's "Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) dated 11/06/25 documented R1 triggered for the CAA due to his requiring assistance with functional abilities. R1's CAA documented other risk factors for R1 were incontinence, limitations in mobility, and impaired cognition (impaired thought process). The CAA documented R1 was admitted to hospice services on 10/30/25. R1's "Care Plan" documented the following interventions: 12/30/21- R1 always needs his palm protector on. 04/23/25 - R1 wanted to receive the proper assistance with my ADLs. 07/11/25 - R1 needs assistance with his showers in the morning and would like a shower two times a week. R1's plan of care lacked an indication of hospice care or hospice provider services. R1's hospice- provided communication binder was unavailable upon request. R1's EMR under physician "Orders" documented: Admit to hospice for late effect 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) with prognosis of less than 6 months, dated 10/31/25. On 12/01/25 at 08:15 AM, R1 sat in his Broda chair (specialized wheelchair with the ability to tilt and recline) in his room, watching TV with his feet elevated. On 12/03/25 at 02:22 PM, Certified Nurse's Aide (CNA) M stated she did not have access to the care plan, but she would know who was on hospice by her nursing report or by asking her nurse. She stated the nurse reported to the CNA's all information about a resident. She stated residents have their hospice supplies in their rooms. CNA M stated if she was unsure, she would be able to look in the resident's binder. On 12/03/25 at 01:52 PM, Licensed Nurse (LN) I stated she would know a resident was on hospice, the resident	F0849		

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F0849 SS = D	Continued from page 40 would have a binder provided by hospice, she would be able to look at the facility's care plan. LN I was unsure if what the provider provided for supplies would be on the care plan. She stated when the hospice nurse or bath aides were in the facility would be documented in the resident's binder. She stated hospice supplies were marked in the resident's room, specifically for that resident. LN I stated if she noticed a resident did not have a binder she would immediately call the hospice provider. On 12/03/25 at 11:11 AM, Administrative Nurse D stated he had just noticed R1 did not have a binder. He stated he had called the hospice provider and requested one. He stated he had a good repour with the hospice provider, and usually he could just text him if the facility saw any changes in the resident. Administrative Nurse D stated staff would know when a resident was on hospice with their nursing report sheet; he stated he put all pertinent information about a resident on the nursing report sheet. Administrative Nurse D was unsure if all hospice information needed to be on the care plan. The facility's "Hospice/End of Life" policy, revised 11/28/17, documented hospice/end of life services would be provided according to resident needs and preferences. Upon the decision to elect hospice services, the physician would be contacted to obtain orders, and social services would coordinate with hospice.	F0849		
F0880 SS = F	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	F0880		

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F0880 SS = F	Continued from page 41 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: (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.	F0880		

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F0880 SS = F	Continued from page 42 §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: The facility identified a census of 62 residents. The facility identified nine residents on Enhanced Barrier Precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high contact care). The facility failed to identify Resident (R) 74, who had a percutaneous endoscope gastrostomy tube (PEG- a tube inserted through the wall of the abdomen directly into the stomach), and R1, R21, R48, and R6, who had a urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag). Based on record review, observations, and interviews, the facility failed to implement signage or indicators within the physical environment to alert staff and visitors of the required EBP. The facility further failed to store oxygen nasal canula in a sanitary manner, the facility further failed to ensure staff performed adequate hand hygiene, and further failed to ensure Accu-check (blood glucose monitoring test) had a barrier placed prior to being laid down in a resident's room. Findings included: - An initial walkthrough of the facility was completed on 12/01/25 at 07:13 AM. An inspection of the Red hall revealed R6's oxygen nasal cannula laid in her wheelchair. At 07:14 AM, R20's oxygen concentrator sat next to the piano in the main dining room. R20's nasal cannula laid directly on the floor next to the piano bench. On 12/01/25 at 08:25 AM, R47's oxygen nasal cannula and tubing was tightly wrapped around the handles of his wheelchair. On 12/02/25 at 07:44 AM, Licensed Nurse (LN) H gathered supplies for R21's Accu-check monitoring, insulin (a hormone that lowers the level of glucose in the blood) pen, two blue gloves, an insulin pen needle, and an alcohol wipe. LN H read the order in R21's chart, and LN H laid supplies on the counter at the nurse's station. LN H went to the dining room to retrieve R21 and take her to her room to check her glucose reading and give insulin, holding all supplies in her hand. LN H touched R21's hair and glasses and pushed her back to R21's room. LN H laid the Accu-Chek monitor on R21's	F0880		

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F0880 SS = F	Continued from page 43 bedside table without a barrier, and LN H donned gloves without hand hygiene. LN H took a glucose reading and gave insulin in the abdomen. LN H removed gloves and performed hand washing. An inspection of R74's room revealed no protective equipment (PPE) readily available for EBP. R74 had no signage or indicators R74 was on EBP. R74 had a percutaneous endoscope gastrostomy tube. An inspection of R21's room revealed no PPE readily available for EBP. R21 had no signage or indicators R21 was on EBP. R21 had a urinary catheter. An inspection of R48's room revealed no PPE readily available for EBP. R48 had no signage or indicators R48 was on EBP. R48 had a urinary catheter. An inspection of R66's room revealed no PPE readily available for EBP. R66 had no signage or indicators R66 was on EBP. R66 had a urinary catheter. On 12/02/25 at 08:00 AM, LN H stated she would place a barrier on R21's bedside table before the Accu-check monitor was laid down. She stated she would wash her hands when entering a resident's room, leaving a resident's room, or when her hands were soiled. LN H stated she would sanitize before putting on gloves, after monitoring blood sugar, and giving the insulin. On 12/03/25 at 02:22 PM, Certified Nurse's Aide (CNA) M stated oxygen cannulas not in use should be placed in a bag or just changed if they are found on the floor. CNA M stated she was not aware of enhanced barrier precautions for residents with urinary catheters and peg tubes. She stated there were residents with the enhanced barrier supplies in multiple rooms. On 12/03/25 at 01:52 PM, LN I stated "Breathe" an oxygen provider, checks all oxygen canisters, and changes nasal cannulas. She stated oxygen nasal cannulas should be placed in a bag when not in use. LN I stated the facility uses the standard of practice for urinary catheters and peg tubes On 12/03/25 at 12:05 PM, Administrative Nurse D stated the facility does not need to use enhanced barrier precautions for residents with urinary catheters or ped tubes. He stated the facility used the standard of care and expected residents to wear gloves when doing residents cares. Administrative Nurse D stated oxygen tubing should be kept off the floor, and staff should put oxygen nasal tubing in the bag the tubing came out of if not in use. Administrative Nurse D stated there	F0880		

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F0880 SS = F	Continued from page 44 should be a barrier placed when an Accu-check monitor was laid down in a resident's room. He stated staff should wash their hands when entering a room, leaving a room, or whenever their hands were soiled. He stated hands should be washed or sanitized before applying gloves, and after using the Accu-check monitor, and again before giving residents insulin. The facility's "Oxygen Safety and Management" policy, revised 03/22/19, documented equipment used for oxygen administration (nasal cannula, mask, tubing) would be replaced every two weeks. The equipment should be marked with the name of the resident and the date it was put into use. Oxygen cannulas and masks should not be allowed to come in contact with the floor or other potentially dirty surfaces. If that occurred, they should be replaced. The cannulas or mask should be stored in plastic bags to prevent contamination. The facility's "Enhanced Barrier Precautions" policy, updated 04/06/23, documented EBP refer to an infection control intervention designed to reduce transmission of multi-resident organisms that employs targeted gown and glove use during high-contact resident care activities. EBP was used in conjunction with standard precautions. The facility's "Hand Hygiene" policy dated 11/28/17 documented general guidelines for washing hands with soap and water when hands are visibly soiled, before and after contact with the resident, after contact with blood, or visibly contaminated surfaces or other objects and surfaces in the resident environment.	F0880		
F0881 SS = F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 62 residents. The sample included 17 residents. Based on interviews, observation, and record review, the facility failed to develop and implement the core elements of antibiotic	F0881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175445	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0881 SS = F	Continued from page 45 stewardship to ensure an effective infection prevention and control program including antibiotic stewardship for the residents of the facility. Findings included: - On 12/02/25, requested the infection control log for tracking and trending infections from December 2024 through October 2025. The facility was unable to provide an infection control log for the following months December 2024, June 2025, July 2025, August 2025, September 2025, and October 2025 that included evidence of tracking and identifications of possible infection outbreaks at the facility, lacked consistent identification of infection, the antibiotic administration and the of continent documentation of the infection control surveillance. On 12/02/25 at 02:25 PM, Administrative Nurse D stated he is responsible for tracking and trending for the antibiotic use in the facility. He stated he had not completed the monthly tracking of the antibiotic use since May 2025. He stated he would review if the physician ordered antibiotic had met the criteria for administration at the end of each month to educate himself. The facility's "Antibiotic Stewardship" policy dated 04/27/19 documented the use of antibiotics would be reserved for those conditions that meet clinically approved indications for their use. Education would be provided to nursing staff, clinical providers, residents, and their representative on proper antibiotic use and antibiotic resistance.	F0881		
F0882 SS = F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification;	F0882		

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F0882 SS = F	Continued from page 46 §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 62 residents. The sample included 17 residents. Based on interviews, observation, and record review, the facility failed to designate a staff member with the required qualification and certification as the Infection Preventionist, who was responsible for the facility's Infection Prevention and Control Program. Findings included: - On 12/02/25 at 02:25 PM, Administrative Nurse D stated the nurse listed as the Infection Preventionist was a corporate nurse who would answer questions and give advice as needed, but was not at the facility. Administrative Nurse D stated he was responsible for the Infection Prevention and Control Program. He stated he had not completed a specialized education for the monitoring of the Infection Preventionist. The facility was unable to provide a policy related to the Infection Preventionist as requested on 10/03/25.	F0882		
F0883 SS = E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has	F0883		

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F0883 SS = E	Continued from page 47 the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 62 residents. The sample included 17 residents, with five residents reviewed for immunizations. Based on interviews, observation, and record review, the facility failed offer or obtain informed declinations or a physician-documented contraindication for the Pneumococcal Conjugate Vaccine (PCV20 - vaccination for	F0883		

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F0883 SS = E	Continued from page 48 bacterial infections), and pneumococcal (type of bacterial infection) vaccination for Resident (R) 2, R4, and R8. Findings included: - Review of R2's clinical record lacked documentation of PCV20 being offered, obtained informed declination, or a physician-documented contraindication prior to surveyors entering the facility. Review of R4's medical record lacked documentation of PCV20 being offered, obtained informed declination, or a physician-documented contraindication prior to surveyors entering the facility. Review of R8's clinical record documented not eligible for PCV20; the medical record lacked documentation of PCV20 being offered, obtained informed declination, or a physician-documented contraindication prior to surveyors entering the facility. An Immunization report from the facility documented PVC 13 on 09/28/16 and Pneumococcal Polysaccharide Vaccine (PPSV23) on 08/02/19. On 12/02/25 at 02:25 PM, Administrative Nurse D stated he was responsible for tracking and monitoring the resident's immunizations. He stated that he would have to check the CDC guidelines if the residents were eligible to receive the PCV 20. He stated the facility had not offered the PCV 20 at this time. The facility's "Immunization Pneumococcal" policy, revised 11/28/17, documented pneumococcal vaccinations would be offered to all residents per Centers for Disease Control and Prevention (CDC) guidelines.	F0883		