

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255156		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/17/2026	
NAME OF PROVIDER OR SUPPLIER GRENADA REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1966 HILL DRIVE , GRENADA, Mississippi, 38901			
(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 State Agency (SA) conducted an annual re-certification survey with three (3) complaint investigations (CI MS #3004335, CI MS #3146420 and CI MS #3167239) at the facility from 9/14/26-9/17/26. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA identified non-compliance and cited F584 for CI MS #3167239 related to Clean, Home-Like Environment, cited F677 for CI MS #3004335 and CI MS #3167239 related to Activities of Daily Living (ADL) care. There were no deficiencies cited for CI MS# 3146420. The SA also cited F550, F558, F561, F568, F585, F641, F656, F688, F690, F698, F699, F755, F761, F842 and F880. The census at the time of the survey was 99 and the facility is licensed for 116 beds.			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			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 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interviews, record review and facility policy review, the facility failed to treat one (1) of 26 sampled residents with dignity and respect when staff instructed the resident to urinate in her brief rather than providing a bedpan when requested. Resident #36 Findings include: Review of facility policy titled "Nursing Facility Resident Rights," dated 3/6/2026, revealed, "...The following rights are guaranteed to residents...to be treated with dignity, courtesy, and respect...to receive care necessary to achieve the highest practicable physical, mental, and psychosocial well-being..." During an initial interview on 9/14/2026 at 12:56 PM, Resident #36 stated nurses and Certified Nursing Assistants (CNAs) had instructed her to urinate in her brief instead of providing a bedpan when she requested one. Resident #36's roommate was present during the interview and stated she personally heard staff instruct Resident #36 to urinate in her brief rather than provide the requested bedpan. During an interview on 9/15/2026 at 2:20 PM, the Director of Nursing (DON) stated that if a resident requested a bedpan, the resident should be provided with one. When questioned about staff instructing residents to "pee in their diaper," the DON stated, "No way should they ever be told that by the staff."	F0550					

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F0550 SS = D	Continued from page 2 Record review of a facility in-service document titled "Infection Control-Survey Readiness," dated 5/19/26, revealed, "Do not tell a resident to "just go in your diaper" when they ask to use the restroom. Assist them to the bathroom or offer bedpan/bedside commode." During an interview on 9/16/2026 at 12:06 PM, the Certified Occupational Therapy Assistant (COTA) stated Resident #36 currently required a bedpan for toileting and would continue to require one for the foreseeable future. The COTA stated it would be unsafe for staff to transfer Resident #36 to the toilet but confirmed that use of a bedpan was safe for the resident. Record review of Resident #36's Admission Record revealed the resident was admitted to the facility on 8/12/26 with medical diagnoses that included Unspecified Severe Protein-Calorie Malnutrition, Adult Failure to Thrive, Foot Drop, Right Foot and Foot Drop, Left Foot. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/31/26, revealed a Brief Interview for Mental Status (BIMS) summary score of 13 under Section C, which indicated Resident #36 was cognitively intact.			F0550			
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, resident interview, staff interviews, record review and facility policy review, the facility failed to ensure a call light was within reach for two (2) of 26 sampled residents. Residents #38 and Resident #50 Findings Include: Record review of facility policy titled "Answering the Call Light," revised 9/2022, revealed, "...5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor..."			F0558			

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F0558 SS = D	Continued from page 3 Resident #38 Observation on 9/14/2026 at 11:18 AM revealed Resident #38 was seated in his wheelchair beside the bed, and the call light was lying on the nightstand behind him and was not within his reach. A follow-up observation on 9/14/2026 at 2:59 PM revealed Resident #38 remained in his wheelchair beside the bed, and the call light remained on the nightstand out of his reach. A subsequent observation on 9/14/2026 at 4:24 PM revealed Resident #38 was lying in bed and the call light remained on the nightstand and was not within the resident's reach. During an interview on 9/14/2026 at 4:28 PM, Licensed Practical Nurse (LPN) #6, confirmed Resident #38's call light was out of the resident's reach, and she stated the call light should always be within the resident's reach. Record review of "Admission Record" revealed Resident #38 was admitted to the facility on 3/14/2023 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominate side. Record review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/14/2026 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 13, indicating Resident #38 was cognitively intact. Resident #50 During observation and interview on 9/14/2026 at 4:12 PM revealed Resident #50 was seated in his wheelchair beside the bed, and his call light was lying on the nightstand behind him and was not within reach. Observation further revealed Resident #50 had limited ability to move his fingers. Resident #50 stated he was unable to reach his call light and the last person who had been in the room closed the door when leaving the room, and he was unable to open the door independently and had been waiting for someone to enter the room so he could ask for assistance. During an interview on 9/14/2026 at 4:30 PM, LPN #6 confirmed Resident #50's call light was lying on the nightstand behind the resident and was not			F0558			

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F0558 SS = D	Continued from page 4 within his reach. LPN #6 stated the call light should have been left within the resident's reach and confirmed Resident #50 was unable to open the door independently to obtain assistance if needed. Record review of "Admission Record" revealed Resident #50 was admitted to the facility on 3/25/2024 with diagnoses of Fusion of Spine, Cervical Region and Spinal Stenosis, Cervical Region. Record review of MDS with ARD of 9/3/2026 revealed under Section C, a BIMS summary score of 15, indicating Resident #50 was cognitively intact. During an interview on 9/16/2026 at 3:16 PM, the Director of Nursing (DON) stated residents' call lights should always be within reach. She stated that even when a resident was able to independently enter and exit the room, staff should leave the call light positioned so it would be within the resident's reach upon returning to the room. The DON stated that "essentially everybody" was responsible for ensuring residents' call lights were within reach and that staff should verify the call light was accessible before leaving a resident's room. The DON confirmed Resident #38 was able to use the call light to call for assistance when it was within reach. She also confirmed Resident #50 was able to use his soft-bulb call light when it was within reach and was unable to independently open his room door. The DON confirmed the call lights for Residents #38 and #50 should have been left within their reach.	F0558					
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F0561					

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F0561 SS = D	Continued from page 5 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to honor residents' choices and preferences by failing to consistently assist Resident #62 to attend church services and to serve her meals in individual bowls, and by failing to provide Resident #85 with requested coffee, for two (2) of 26 sampled resident. Resident #62 and Resident #85 Findings Include: Review of the facility policy titled "Nursing Facility Resident Rights," which was undated, revealed under "Quality of care and participation in care: To receive care necessary to achieve the highest practicable physical, mental, and psychosocial well-being." The policy also revealed under, "Freedom of choice and autonomy: To make choices about daily life, schedules, clothing, and activities... To participate in activities inside and outside the facility." Resident #62 An observation and interview with Resident #62 on 9/15/26 at 8:30 AM revealed she was lying in bed. She stated she loved attending activities, especially church services, but staff did not get her up because there were not enough staff available. Resident #62 stated she required a lift for transfers, which required two staff members. She stated church services were held on Wednesday mornings. Because staff had to get her up for dialysis, she had asked them to get her up earlier so she could attend church services, but they did not. Resident #62 stated church services were the most important activity she requested to attend. Further observation revealed the resident had difficulty locating the food			F0561			

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F0561 SS = D	Continued from page 6 items while attempting to eat breakfast from a regular dining plate. She was served grits and chopped sausage with gravy. The food was mixed together and placed on the back half of the plate. The resident had consumed approximately one-half of the breakfast meal but stated she had consumed all of it. When asked about her vision, the resident stated she was blind. Resident #62 stated she had requested that her food items be served in individual bowls because it was easier for her to scoop out the food. She stated whether the kitchen sent her meal in bowls depended on who was working and said, "Sometimes they do and sometimes they do not." An observation and interview with Certified Nurse Aide (CNA) #2 on 9/15/26 at 8:47 AM confirmed Resident #62 was not served her breakfast in individual bowls according to her preference. CNA #2 stated the resident had made her request known a long time ago and the kitchen was aware of it. She stated the kitchen did not always provide the bowls. CNA #2 stated the bowls made it easier for the resident to feed herself and feel more independent. An interview with the Activity Assistant on 9/15/26 at 4:10 PM revealed Resident #62 loved attending church services but did not attend very often. She stated that, during the previous month, the resident attended approximately five minutes at the end of one program. She stated she had spoken with all staff on the floor, including nurses and aides, and asked them to get the resident up, but staff continued to ignore the resident's request. She stated it was important for residents to make choices about their care and that the facility should try to honor those preferences. Record review of Resident #62's August through September 2026 "Group Activity Log" revealed the resident was documented as attending church services on 8/5/26 and 8/19/26 and a music performance on 8/20/26. An interview with the Assistant Dietary Account Manager on 9/16/26 at 3:10 PM confirmed the dietary department was aware that Resident #62 had requested that her food items be served in individual bowls. She stated the cook knew to prepare the food in bowls. However, the preference was not listed on the meal ticket to inform the staff member preparing the meal tray. She confirmed the resident's preference for bowls should be honored. An interview with Licensed Practical Nurse (LPN) #3 on 9/17/26 at 8:15 AM revealed staff tried to honor Resident #62's preference to get up for activities.			F0561			

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F0561 SS = D	Continued from page 7 However, the facility was sometimes short-staffed and were not always able to get her up. Record review of the "Admission Record" revealed Resident #62 was admitted to the facility on 5/24/25 with diagnoses that included End Stage Renal Disease, Dependence on Renal Dialysis, Paraplegia, and Unspecified Visual Loss. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/29/26, revealed under Section C a Brief Interview for Mental Status (BIMS) summary score of 13, which indicated Resident #62 was cognitively intact. Section GG documented that the resident was dependent for chair/bed-to-chair transfers (helper does all the effort). Resident #85 An observation outside Resident #85's door on 9/15/2026 at 8:30 AM revealed Resident #85 stating, "Can I please get a cup of coffee?" Certified Nurse Aide (CNA) #1 stated, "No, you know you can't have any coffee." Resident #85 once again stated, "Please, I just want a cup of coffee." CNA #1 stated, "She's always asking for a cup, and she knows she can't have it." CNA #1 abruptly left the room. During an interview on 9/15/2026 at 8:35 AM, the Assistant Director of Nursing (ADON) stated, "Yeah, she can't have any coffee because it makes her bowels run off." The ADON further acknowledged I guess we could give her something for diarrhea when it happens. She acknowledged that the residents' wishes were not honored and they should have been. During an interview on 9/16/2026 at 9:45 AM, the Director of Nurses (DON) revealed it is our expectation that all of our residents are treated with dignity and respect. She confirmed Resident #85 should have been given a cup of coffee, and if it was harsh on her stomach, it could have been explained to her, and she could have been given the choice of whether she wanted the coffee or not. She confirmed Resident #85 was able to make her own decisions. During an interview on 9/16/2026 at 3:45 PM, the Administrator revealed that Resident #85's wishes should have been honored. If the coffee doesn't agree with her stomach, then it should be explained to her, and then she should be allowed to make that decision. It's not our decision to make for her.	F0561			

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F0561 SS = D	Continued from page 8 Record review of the "Admission Record" revealed Resident #85 was admitted to the facility on 1/25/19 with diagnoses that included Systolic Congestive Heart Failure and Unspecified protein-calorie malnutrition. A record review of the MDS, with an ARD of July 15, 2026, revealed a BIMS summary score of 13 under Section C, indicating Resident #85 was cognitively intact.	F0561					
F0568 SS = D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to provide quarterly trust fund account statements to one (1) of two (2) residents reviewed for personal funds. Resident #46 Findings Include: Record review of the facility policy from the Business Office Policy and Procedure Manual revised 3/26 revealed, "...3. The resident or legal representative must be provided with an individual accounting of all transactions on a quarterly basis. A signed and witnessed document must be kept on file of the date the statements were mailed/sent and the quarter statement period..." An interview with Resident #46 on 9/14/26 at 11:12 AM revealed he had a trust fund account with the facility but had not received a quarterly account statement. He stated his daughter was his Responsible Representative (RR) and that he knew	F0568					

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F0568 SS = D	Continued from page 9 she had not received a statement in the mail. Record review of Resident #46's "Resident Trust Fund Account Statement" revealed the account was opened on 12/18/25. A telephone interview with Resident #46's Resident Representative (RR) on 9/16/26 at 9:31 AM revealed she had never received a statement for the resident's trust fund account from the facility. An interview with the Business Office Manager on 9/16/26 at 9:41 AM revealed trust fund account statements were required to be mailed quarterly to the RR so the RR would be aware of the account transactions. She confirmed the facility had not mailed account statements for any residents since the previous business office staff member left the position in 7/2025. Record review of the "Admission Record" revealed Resident #46 was admitted to the facility on 11/01/25 with a diagnosis that included Malignant Neoplasm of the Prostate. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/05/26, revealed under Section C a Brief Interview for Mental Status (BIMS) summary score of 10, which indicated Resident #46 was moderately cognitively impaired.	F0568					
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or	F0584					

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F0584 SS = D	Continued from page 10 theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations, resident interviews, staff interviews, and record review, the facility failed to ensure residents were provided a safe, clean, comfortable, and homelike environment by failing to ensure soiled bed linens were changed timely for two (2) of ninety-nine (99) residents reviewed for clean bed linens. Residents #9 and Resident #34 Findings Include: Review of a statement on facility letterhead dated September 16, 2026, and signed by the Administrator revealed the facility does not have a policy on homelike environment. Resident #9 On 9/14/2026 at 3:45 PM, an observation revealed Resident #20s bed sheets were visibly soiled with coffee stains. During an interview, Resident #9 stated his daughter had asked a staff member to change his sheets the previous Thursday (09/10/2026); however, the sheets had not been changed. On 9/15/2026 at 9:00 AM, a follow up observation			F0584			

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F0584 SS = D	Continued from page 11 and interview revealed the same coffee stains remained on Resident #9's sheets and he stated the sheets had not been changed. During an observation and interview on 9/15/2026 at 3:05 PM with the Director of Nursing (DON), the DON confirmed the sheets were dirty and should have been changed. The DON stated bed linens should be changed three times per week and as needed and stated she would have someone change Resident #9's sheets. On 9/15/2026 at 9:45 PM, a follow-up observation revealed Resident #9's sheets remained soiled with the same coffee-stain pattern observed on Monday and Tuesday. During an interview, Resident #9 stated, "No, I thought I was going to have my sheets changed after y'all came in, but they are still dirty." During an interview with the Administrator on 9/16/2026 at 9:00 AM, she stated Resident #9's sheets should have been changed and does not know why they haven't been changed. Record review of Resident #9's "Admission Record" revealed the resident was admitted to the facility on 1/05/2026 with diagnosis that included Post-Traumatic Stress Disorder (PTSD). Record review of Resident #9's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/09/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. Resident #34 On 9/14/2026 at 4:00 PM, an observation revealed Resident #34's bed sheets were visibly soiled. A large area on the left side of the sheet contained a large area of dried brown liquid substance and a colored liquid substance and soilage. On 9/15/2026 at 9:00 AM, a follow-up observation revealed the same soilage pattern remained on Resident #34's sheets, with additional spillage noted on the left side of the bed. Resident #34 was unable to communicate. On 9/15/2026 at 9:50 PM, a follow-up observation revealed the same stains and soilage remained on Resident #34's sheets, including feeding residue and pink-colored medication spillage. During an interview with the Administrator on 9/16/2026 at 9:00 AM, she stated Resident #34's			F0584			

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F0584 SS = D	Continued from page 12 sheets should have been changed timely. The Administrator stated it was the facility's expectation to keep the resident and the resident's linens clean and if they are visibly soiled then the staff should change the sheets. Record review of Resident #34's "Admission Record" revealed the resident was admitted to the facility on 8/08/2026 with diagnosis that included Cerebral Infarction. Record review of Resident #34's MDS revealed under Section C of the BIMS section was blank. Resident #34 was nonverbal and unable to participate in an interview.			F0584			
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with			F0585			

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F0585 SS = D	Continued from page 13 whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and			F0585			

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F0585 SS = D	Continued from page 14 (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to promptly resolve a resident grievance regarding a missing wallet for one (1) of 26 sampled residents. Resident #46 Findings Include: Review of the facility policy titled "Filing Grievances/Complaints" latest review 4/3/26, revealed under "Policy Interpretation and Implementation: ...7. Upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a written report of such findings to the Administrator within 72 hours of receiving the grievance and/or complaint.... 11. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed verbally and in writing (if requested) of the findings of the investigation and the actions that will be taken to correct any identified problems." An interview with Resident #46 on 9/14/26 at 11:12 AM stated that his wallet had been missing for months. He stated the wallet contained \$30, his photo identification, and a credit card. He stated he knew the wallet contained a \$20 bill but was unsure whether the remaining \$10 consisted of one \$10 bill or two \$5 bills. Resident #46 stated staff knew the wallet was missing but did nothing to locate it. Record review of Resident #46's "Grievance" dated 5/29/26 revealed, "On 5/28/26, Mr. (Proper last name of the resident) states that his wallet was missing, he says that he went to take a shower and left his wallet in his wheelchair. When he returned the wheelchair was gone and he was not able to find his wallet. He also states that the wallet contained maybe \$10 (dollars) and a credit card. A summary of the pertinent findings and conclusions revealed the Administrator has spoken with the resident on two different occasions regarding his misplaced item. The room has been searched, and clothes have been looked through. The wallet and the \$10.00 will be replaced." The Administrator marked the grievance as resolved on 6/03/26. Record review of Resident #46's Resident Trust Fund Account Statement with transaction dates from 6/1/26 through 9/15/26 revealed no evidence that			F0585			

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F0585 SS = D	Continued from page 15 the promised replacement money was credited to his account. An interview with the Administrator (ADM) on 9/16/26 at 8:48 AM revealed she had spoken with Resident #46 and filed a grievance regarding his missing wallet. The ADM stated the resident reported the wallet contained \$10 and a credit card. She stated she thought they (the facility) had replaced the money and the wallet but confirmed neither had been replaced. She stated grievances should be resolved timely and that this grievance was overlooked. Record review of the "Admission Record" revealed Resident #46 was admitted to the facility on 11/01/25 with a diagnosis that included Malignant Neoplasm of the Prostate. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/05/26, revealed under Section C a Brief Interview for Mental Status (BIMS) summary score of 10, which indicated Resident #46 was moderately cognitively impaired.			F0585			
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a			F0641			

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F0641 SS = D	Continued from page 16 resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure four (4) Minimum Data Set (MDS) assessments accurately reflected Resident #61's status, including the State Level II Pre-Admission Screening and Review (PASRR) determination and an active diagnosis of schizoaffective disorder, for one (1) of 26 residents reviewed. Resident #61 Findings include: Review of facility policy titled "MDS Coding Policy" reviewed 7/16/2026, revealed, "(Proper Name) affiliated facilities utilize the most up to date Resident Assessment Instrument (RAI) manual for determination of coding each section of the Resident Assessment, timely and accurately..." Record review of Resident #61's Level II PASRR "Summary of Findings Report" dated 12/29/2025, revealed, "...The individual meets criteria for having a diagnosis of mental illness as defined by PASRR. Axis I primary: Schizoaffective Disorder – 295.70...Axis I secondary: Bipolar I most recent episode depressive unspecified – 296.50..." Record review of Resident #61's MDS Admission/Medicare 5-day assessment with an Assessment Reference Date (ARD) of 2/25/2026 revealed Section A1500, Preadmission Screening and Resident Review (PASRR), was coded "0, No," indicating Resident #61 was not currently considered by the State Level II PASRR process to have a serious mental illness, intellectual disability, or related condition. Record review of Resident #61's Progress Note dated 4/6/2026 revealed, "...Assessment and Plan...7. Bipolar disorder...Monitor mood stability, behavioral symptoms, and medication tolerance...continue psychiatric medication monitoring...8. Schizoaffective disorder...monitor for hallucinations, delusions, or			F0641			

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F0641 SS = D	Continued from page 17 behavioral changes. Continue structured behavioral monitoring in Skilled Nursing Facility (SNF) setting..." Record review of Resident #61's MDS Medicare five-day Assessment with an ARD of 4/7/2026 revealed Section I6000, Schizophrenia, was not checked; therefore, the assessment did not identify schizoaffective disorder as an active diagnosis. Record review of Resident #61's Progress Note dated 5/4/2026 revealed, "...Assessment and Plan 1. Paranoid behavior with schizoaffective disorder...2. Bipolar disorder with mood instability..." Record review of Resident #61's Medication Administration Record (MAR) for May 2026 revealed aripiprazole 30 milligrams (mg) daily, lumateperone (Caplyta) 42 mg daily, cariprazine 1.5 mg daily, and quetiapine 400 mg twice daily were ordered on 2/19/2026 for diagnoses that included schizoaffective disorder. The medications were administered during the seven-day look-back period of 5/21/2026 through 5/27/2026. The MAR further revealed antipsychotic behavior monitoring was ordered every shift and documented during the seven-day look-back period. Record review of Resident #61's MDS Quarterly Assessment with an ARD of 5/27/2026 revealed Section I6000, Schizophrenia, was not checked; therefore, the assessment did not identify schizoaffective disorder as an active diagnosis. Record review of Resident #61's "Status Note" dated 8/24/2026 revealed, "...History of Present Illness 64-year-old woman with a history of schizoaffective disorder, bipolar disorder...who presents with an acute psychotic/behavioral episode..." Record review of Resident #61's MDS Quarterly Assessment with an ARD of 8/25/2026 revealed Section I6000, Schizophrenia, was not checked; therefore, the assessment did not identify schizoaffective disorder as an active diagnosis. During an interview with the MDS Coordinator on 9/16/2026 at 3:05 PM, she stated she was unaware Resident #61 had a Level II PASRR. The MDS Coordinator reviewed Section A1500 of the MDS assessment with an ARD of 2/25/2026 and confirmed the section was coded incorrectly. The MDS Coordinator also reviewed Section I of the MDS assessments with ARDs of 4/7/2026, 5/27/2026, and 8/25/2026 and confirmed schizoaffective disorder			F0641			

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F0641 SS = D	Continued from page 18 should have been coded under I6000. She stated, "I left off the Schizophrenia diagnosis because our company warned against coding for Schizophrenia." Record review of Resident #61's Admission Record revealed the resident was admitted to the facility on 2/19/26 with medical diagnoses that included schizoaffective disorder, unspecified, Undifferentiated Schizophrenia, and bipolar disorder, unspecified. Record review of the MDS, with an ARD of 8/25/26, revealed a Brief Interview for Mental Status (BIMS) summary score of 15 under Section C, which indicated Resident #61 was cognitively intact.	F0641					
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 19 (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: Based on observations, interviews, and record review, the facility failed to develop and implement comprehensive, person-centered care plans that accurately reflected residents' assessed needs, diagnoses, preferences, and required services, and that included individualized goals and interventions, for eight (8) of 26 residents reviewed for comprehensive care planning (Residents #4, #6, #9, #35, #36, #50, #61, and #72). Specifically, care plans failed to address or accurately reflect Resident #9's PTSD triggers; Resident #35's indwelling urinary catheter and associated care and monitoring needs; Resident #36's expressed preference and need for a bedpan; and Resident #61's documented mental-health diagnoses and related behavioral needs. In addition, staff failed to implement established care-plan interventions for Residents #4, #6, #50, and #72, including personal hygiene, hand orthosis use, scheduled incontinence care, and grooming and toileting. These failures resulted in care plans that did not consistently provide staff with accurate, individualized direction for meeting residents' assessed needs and placed residents at risk for receiving care that was inconsistent with their needs, diagnoses, preferences, and planned interventions. Findings include: Review of the facility policy titled "Care Plans-Comprehensive Person-Centered" reviewed 01/2023 revealed, "A comprehensive... person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident."	F0656					

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F0656 SS = D	Continued from page 20 Resident #4 Review of Resident #4's "Care Plan Report" revealed under, "Focus: The resident has activity of daily living (ADL) self-care performance deficit r/t (related to) Cerebral Infarction due to Unspecified Occlusion or Stenosis of right Carotid Arteries & (and) L (left) sided Hemiparesis." Also revealed under, "Interventions: Bathing/Showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse..." During an observation of Resident #4 on 9/14/26 at 10:48 AM, he was lying in bed wearing a hospital gown with three to four dark brown, circular stains of various sizes on the chest area of the gown. His fingernails on both hands were approximately five-eighths (5/8) inches long and had a dark brown substance underneath them. During an observation and interview with Licensed Practical Nurse (LPN) #5 on 9/15/26 at 3:15 PM confirmed Resident #4 was wearing a soiled gown and had long fingernails with a dark substance underneath them and stated that he needs to be cleaned up. An interview with the Minimum Data Set (MDS) Nurse on 9/17/26 at 11:28 AM revealed the purpose of the care plan was to ensure the staff knew how to care for the residents. She confirmed Resident #4's care plan was not followed for nail care or ADL care. Record review of the "Admission Record" revealed the facility admitted Resident #4 on 1/14/25 with a medical diagnosis of Alzheimer's Disease. Record review of the MDS with an Assessment Reference Date (ARD) of 8/05/26, revealed under Section C a Brief Interview for Mental Status (BIMS) summary score of 9, which indicated Resident #4 was moderately cognitively impaired. Resident #6 Record review of Resident #6's "Care Plan Detail" revealed under, "Focus: The resident has an ADL self-care performance deficit r/t (related to) Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side." Also revealed under, "Interventions: Resident to have Left WHFO (wrist-hand-finger orthosis) to treat contractures to be worn for eight (8) hours daily or to resident tolerance. To be applied by nursing after breakfast and removed before supper.			F0656			

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F0656 SS = D	Continued from page 21 Nursing to check skin and report any changes..." During an observation and interview with Resident #6 on 9/14/26 at 11:25 AM, he was sitting in his motorized wheelchair in his room. His left fingers were contracted and bent inward toward his palm. Resident #6 stated he had a hand splint in his dresser drawer that he was supposed to wear, but staff did not apply it. On 9/15/26 at 3:31 PM an interview with the Director of Nursing (DON) revealed she expected the aides to apply the splints and the nurses to ensure this was completed. An interview with the MDS Nurse on 9/17/26 at 11:28 AM confirmed the care plan was not followed for the splint application. Record review of the "Admission Record" revealed Resident #6 was admitted to the facility on 9/04/25 with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side, Muscle Wasting and Atrophy, and Contracture, Left Hand. Record review of the MDS, with an ARD of 6/9/26, revealed under Section C a BIMS summary score of 14, which indicated Resident #6 was cognitively intact. Resident # 9 Record review of Resident #9's Care Plan Detail with review start date of 7/22/26 revealed "Focus: I have a history of, or known incidence to, one or more traumatic event(s) Dx (diagnosis) of PTSD (Post-Traumatic Stress Disorder), Goals: Resident will inform staff of any increased levels of anxiety/depression or exposure to identified triggers." No identified triggers were listed on the care plan. On 9/14/2026 at 4:24 PM during an interview Resident #9 stated he had PTSD related to his previous employment as a Chief of Police. Resident #9 stated that most of the time he did not experience problems with triggers; however, there were times when certain things bothered him. On 9/17/2026 at 1:00 PM, during an interview, Minimum Data Set (MDS) Coordinator #2 confirmed			F0656			

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F0656 SS = D	Continued from page 22 the care plan for Resident #9's PTSD triggers had not been developed. Record review of Resident #9's "Admission Record" revealed the resident was admitted to the facility on 1/05/2026 with a diagnosis that included PTSD. Record review of Resident #9's MDS, with an ARD of 7/09/2026, revealed under Section C a BIMS score of 14, indicating the resident was cognitively intact. Resident #35 Review of Resident #35's comprehensive care plan, initiated 8/21/2026 and revised through 9/8/2026, revealed no identified problem, measurable objective, timeframe, or individualized interventions addressing the indwelling urinary catheter, the clinical indication for continued catheter use, catheter care, monitoring of urine output, or monitoring for signs and symptoms of catheter-related complications. On 9/14/2026 at 12:31 PM, during an initial observation Resident #35 was observed in bed with an indwelling urinary catheter drainage bag attached to the bed rail. When questioned about the catheter, Resident #35 stated that he received it while he was in the hospital. Record review of Resident #35's History and Physical dated 8/28/2026 revealed, "He was sent from (proper name of hospital) for urinary obstruction due to urinary retention. Outside Emergency Room (ER) placed with Foley and had a total of four (4) liters (L) of urine output." Record review of Resident #35's Order Summary Report of active orders as of 9/15/2026 revealed no physician order for the indwelling urinary catheter, catheter care, catheter monitoring, or urine-output monitoring. On 9/15/2026 at 3:58 PM, during an interview and concurrent record review the Director of Nursing (DON) stated that she was unaware Resident #35 had returned from the hospital on 9/7/2026 with an indwelling urinary catheter. During an interview on 9/16/2026 at 9:31 AM, the MDS Coordinator stated that she was not aware Resident #35 had an indwelling urinary catheter. She			F0656			

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F0656 SS = D	Continued from page 23 confirmed that a care plan addressing the catheter and associated care needs had not been developed. Record review of Resident #35's Admission Record revealed that the resident was originally admitted to the facility on 8/20/2026 with diagnoses that included age-related osteoporosis with current pathological vertebral fracture, subsequent encounter for fracture with routine healing. Record review of the MDS, with an ARD of 9/13/2026, revealed a BIMS summary score of 14 under Section C, which indicated Resident #35 was cognitively intact. Resident #36 Review of Resident #36's comprehensive care plan, initiated 8/13/2026 and current as of 9/16/2026, revealed an identified problem of bladder incontinence related to a history of urinary tract infection, impaired mobility, and the presence of a neurostimulator. The care plan included a goal that the resident's risk for septicemia would be minimized or prevented through prompt recognition and treatment of signs and symptoms of a urinary tract infection through the review date of 11/24/2026. The care-plan interventions included cleaning the resident's perineal area after each incontinent episode; providing or assisting with incontinent care during daily care and as needed; changing the resident's clothing as needed after incontinent episodes; monitoring for signs and symptoms of a urinary tract infection; monitoring for possible causes of incontinence; and providing the resident with an adult brief or incontinent pads as needed. The comprehensive care plan contained no documentation of Resident #36's expressed preference to use a bedpan rather than void in an incontinent brief. It contained no measurable objective, timeframe, or individualized interventions directing staff to offer or provide Resident #36 with a bedpan when requested, although the resident was dependent on staff for toileting hygiene. On 9/14/2026 at 12:56 PM, during an initial interview Resident #36 stated that nurses and Certified Nursing Assistants (CNAs) had instructed her to urinate in her brief instead of providing a bedpan when she requested one. Resident #36's roommate was present during the interview and stated that she personally heard staff instruct Resident #36 to urinate in her brief rather than provide the requested bedpan. On 9/16/2026 at 12:06 PM, during an interview the			F0656			

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F0656 SS = D	Continued from page 24 Certified Occupational Therapy Assistant (COTA) stated that Resident #36 currently required a bedpan for toileting and would continue to require one for the foreseeable future. The COTA stated that it would be unsafe for staff to transfer Resident #36 to the toilet but confirmed that use of a bedpan was safe for the resident. During an interview on 9/16/2026 at 9:35 AM, the MDS Coordinator stated that she was not aware Resident #36 preferred a bed pan and she had not implemented that into her care plan. Record review of Resident #36's Admission Record revealed that the resident was admitted to the facility on 8/12/2026 with diagnoses that included Unspecified Severe Protein-Calorie Malnutrition, Adult Failure to Thrive, Foot Drop, Right Foot, and Foot Drop, Left Foot. Record review of the MDS, with an ARD of 8/31/2026, revealed a BIMS summary score of 13 under Section C, which indicated Resident #36 was cognitively intact. Section GG0130C, Toileting Hygiene, coded Resident #36 as "01. Dependent." Resident #50 Record review of Resident #50's "Care Plan Report" revealed under, "Focus: The resident has bowel incontinence r/t immobility, Spinal Fusion." Also, revealed under, "Interventions: Check resident every two hours and assist with toileting as needed." Record review of Resident #50's "Care Plan Report" revealed under, "Focus: The resident has an ADL self-care performance deficit r/t Fusion of Spine, Cervical Region." Also, revealed under, "Interventions: Toilet Use: The resident requires total assistance by (2) staff for toileting." Record review of MDS with an ARD of 9/3/2026 revealed under, Section GG, Resident #50 was dependent for toileting hygiene. On 9/14/2026 at 4:12 PM, during an interview Resident #50 stated he had not received incontinent care since getting up at approximately 11:00 AM that morning. During a follow-up observation at 4:30 PM, Resident #50 was sitting outside his room door and a staff member asked if he was ready to go to bed. Resident #50 responded, "Yes ma'am." On 9/15/2026 at 9:00 AM, during an interview Resident #50 stated he was not assisted to bed until approximately 8:20 PM and did not receive			F0656			

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F0656 SS = D	Continued from page 25 incontinent care until that time. He stated he did not receive incontinent care again until approximately 2:30 AM. On 9/15/2026 at 9:26 PM, during an interview Resident #50 stated he had not received incontinent care or been changed since approximately 2:30 PM that day. On 9/15/2026 at 9:32 PM, during an observation and interview Licensed Practical Nurse (LPN) #6 pulled back Resident #50's brief and revealed the resident was wearing two briefs, a green brief underneath a white brief. Upon further observation, the green brief was saturated with urine to the top of the brief. LPN #6 confirmed the brief was saturated with urine. During an interview on 9/17/2026 at 11:12 AM, the MDS Coordinator confirmed the resident's care plan provides staff with direction regarding how the resident's care should be provided. She confirmed that failing to check Resident #50 every two hours did not follow the resident's care plan. Record review of "Admission Record" revealed Resident #50 was admitted to facility on 3/25/2024 with diagnoses of Fusion of Spine, Cervical Region and Spinal Stenosis, Cervical Region. Record review of MDS with an ARD of 9/3/2026 revealed under Section C, a BIMS summary score of 15, indicating Resident #50 was cognitively intact. Resident # 61 Review of Resident #61's comprehensive care plan for behaviors, initiated 8/27/2026, revealed the identified problem, "The resident is/has potential to be verbally aggressive (screaming and cursing at staff) related to (r/t) Dementia." The care plan documented the following behaviors: • On 8/24/2026, Resident #61 was noted to be hollering and cursing at staff. • On 8/23/2026, Resident #61 was noted to be screaming and hollering that staff was "messing with her and kept coming into her room messing with her bed and things." The care plan included a goal that Resident #61 would demonstrate effective coping skills through the review date. An additional goal stated that the resident would verbalize an understanding of the need to control verbally abusive behavior through the review date of 10/5/2026. The care-plan interventions included administering medications as ordered and monitoring their effectiveness and side effects; analyzing key times, places, circumstances,			F0656			

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F0656 SS = D	Continued from page 26 triggers, and interventions that de-escalated the behaviors; assessing and anticipating the resident's needs; assessing the resident's coping skills and support system; allowing the resident time to express herself and her feelings; and monitoring the resident's behaviors every shift and as needed. The care plan also identified Resident #61's 8/25/2026 admission to a behavioral-health unit as an intervention. The behavior care plan attributed Resident #61's behaviors to dementia and did not identify schizoaffective disorder or Bipolar I Disorder as factors related to the behaviors. The care plan did not contain individualized goals or interventions specifically addressing the resident's documented mental-health diagnoses or the recommendations for psychosocial rehabilitation and medication evaluation and monitoring would be incorporated into the resident's care. During an interview on 9/16/2026 at 3:30 PM, the MDS Coordinator confirmed that Resident #61's behavior care plan had not been developed accurately. She stated that the resident's behaviors were not related to dementia but were related to the resident's mental-health diagnoses of Schizoaffective Disorder. Record review of Resident #61's Admission Record revealed the resident was admitted to the facility on 2/19/26 with medical diagnoses that included Schizoaffective disorder, unspecified, Undifferentiated Schizophrenia, and Bipolar Disorder, unspecified. Record review of the MDS, with an ARD of 8/25/26, revealed a BIMS summary score of 15 under Section C, which indicated Resident #61 was cognitively intact. Resident #72 Record review of Resident #72's "Care Plan Report" revealed under, "Focus: The resident has an ADL (activity of daily living) self-care performance deficit r/t (related to) Unspecified Dementia, unspecified severity without behavioral disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety, and cerebral infarction due to Unspecified Occlusion or Stenosis of left anterior Cerebral Artery." Date initiated: 8/14/25. Also revealed under "Interventions The resident needs total staff assistance to remove facial hair. ... Toilet Use: The resident requires up to substantial/extensive assistance of one staff for toileting."	F0656					

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F0656 SS = D	Continued from page 27 On 9/14/2026 at 3:25 PM an observation and interview revealed Resident #72 had approximately one-half (1/2) inch long facial hair on her chin and stated, "I don't like this hair on my face." On 9/15/2026 at 8:25 AM an observation and interview revealed, upon entering Resident #72's room, a foul odor was present. Resident #72 was sitting on the side of her bed eating breakfast. An incontinence brief was observed lying on the floor beside the resident's bed. The brief was heavily saturated with urine and soiled with a brown substance. Resident #72 stated, "My diaper was so heavy it fell off of me." Resident #72's facial hair remained unchanged from the previous day. On 9/15/2026 at 8:40 AM, during an interview and observation the Assistant Director of Nurses (ADON) confirmed Resident #72's brief was lying on the floor beside her bed and was heavily saturated with urine and a brown substance. The ADON acknowledged the condition of the brief indicated the resident appeared not to have been changed in a while. An interview on 9/17/26 at 10:35 AM, the MDS Coordinator revealed the purpose of the care plans are to ensure that the resident's individualized needs are developed and that the staff will know how to follow out those individualized needs. She confirmed Resident #72's ADL care plan was not being followed if she was found to not be adequately groomed and toileted. Record review of "Admission Record" revealed Resident #72 was initially admitted to facility on 8/13/2025 with diagnoses which included Major Depressive Disorder, Cerebral Infarction, and unspecified Dementia. Record review of MDS with an ARD of 8/8/2026 revealed under Section C, a BIMS summary score of 09, indicating Resident #72 was moderately cognitively impaired.			F0656			
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;			F0677			

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F0677 SS = D	Continued from page 28 This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, record review and facility policy review the facility failed to provide necessary assistance with activities of daily living (ADLs), including incontinence care and personal grooming, for four (4) of 11 residents reviewed for ADL care. Residents #4, #50, #59, and #72. Findings Include: Review of the facility policy titled, "Activities of Daily Living (ADL), Supporting" with a revised date of March 2018 revealed, "Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene..." Resident #4 An observation of Resident #4 on 9/14/26 at 10:48 AM revealed he was lying in bed wearing a hospital gown with three to four dark brown, circular stains of various sizes on the chest area of his gown. His fingernails on both hands were approximately five-eighths (5/8) inches long and had a dark brown substance underneath them. An observation and interview with Licensed Practical Nurse (LPN) #5 on 9/15/26 at 3:15 PM revealed Resident #4 was wearing a soiled gown and had long fingernails with a dark substance underneath them. LPN #5 stated nurse aides were responsible for providing daily personal hygiene care, including cutting and cleaning the resident's fingernails and changing his gown when it was soiled. LPN #5 stated the resident could scratch himself and sustain a skin injury. An observation and interview with the Director of Nursing (DON) on 9/15/26 at 3:26 PM revealed she expected nurse aides to provide daily personal hygiene care, including changing the resident's gown when it was soiled and cleaning and cutting his fingernails. Record review of the "Admission Record" revealed the facility admitted Resident #4 on 1/14/25 with a medical diagnosis of Alzheimer's Disease.			F0677			

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F0677 SS = D	Continued from page 29 Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/05/26, revealed under Section C a Brief Interview for Mental Status (BIMS) summary score of 9, which indicated Resident #4 was moderately cognitively impaired. Section GG revealed the resident was dependent on staff for personal hygiene. Resident #50 Record review of the MDS with an ARD of 9/3/2026 revealed under, Section GG, Resident #50 was dependent on staff for toileting hygiene. During an interview on 9/14/2026 at 4:12 PM, Resident #50 stated he had not received incontinent care since getting up at approximately 11:00 AM that morning. During a follow-up observation at 4:30 PM, Resident #50 was sitting outside his room door and a staff member asked if he was ready to go to bed. Resident #50 responded, "Yes ma'am." During an interview on 9/15/2026 at 9:00 AM, Resident #50 stated he was not assisted to bed until approximately 8:20 PM last night and did not receive incontinent care until that time. He stated he did not receive incontinent care again until approximately 2:30 AM. During an interview on 9/15/2026 at 9:26 PM, Resident #50 stated he had not received incontinent care or been changed since approximately 2:30 PM that day. During an observation and interview on 9/15/2026 at 9:32 PM, LPN #6 pulled back Resident #50's brief and revealed the resident was wearing two briefs, a green brief underneath a white brief. Upon further observation, the green brief was saturated with urine to the top of the brief. LPN #6 confirmed the brief was saturated with urine. During an observation and interview on 9/15/2026 at 9:44 PM, Certified Nursing Assistant (CNA) #3 removed Resident #50's briefs. Observation revealed the green brief was fully saturated with urine from front to back, and the white brief contained a small amount of urine in the center. Observation of Resident #50's buttocks revealed no skin concerns. CNA #3 stated that after receiving her assignment at the beginning of her shift, she asked Resident #50 if he was wet, and the resident stated he was not. CNA #3 stated she had not provided incontinent care to Resident #50 at any time during her shift. She stated residents should be checked during rounds every two hours and confirmed she had not completed the			F0677			

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F0677 SS = D	Continued from page 30 required two-hour rounds for Resident #50 during her shift. During an interview on 9/16/2026 at 3:20 PM, the Director of Nursing (DON) stated her expectation was for residents to be checked at least every two hours and as needed. She stated it was unacceptable for Resident #50 to have been left unchecked for the reported length of time and he should not have had two briefs on. The DON stated she had previously received complaints from Resident #50 regarding not being changed timely and had provided staff in-services regarding checking residents and providing care every two hours. Record review of "Admission Record" revealed Resident #50 was admitted to the facility on 3/25/2024 with diagnoses of Fusion of Spine, Cervical Region and Spinal Stenosis, Cervical Region. Record review of MDS with an ARD of 9/3/2026 revealed under Section C, a BIMS summary score of 15, indicating Resident #50 was cognitively intact. Resident #59 An observation on 9/14/26 at 11:06 AM revealed Resident #59 was lying in bed and did not respond to verbal stimuli. He appeared unkempt, with uncombed, oily hair and long gray facial hair measuring approximately five-eighths (5/8) inches in length. An observation and interview with LPN #5 on 9/15/26 at 3:18 PM revealed Resident #59 was scheduled to receive a bath during the day shift on Tuesday, Thursday, and Saturday. LPN #5 confirmed the resident had not been bathed or shaved, and his hair had not been washed in awhile it appeared. An interview with the DON on 9/15/26 at 3:30 PM revealed she expected Resident #59 to receive all personal hygiene care on his scheduled bath days. She confirmed residents should be clean and well groomed. Record review of the "Admission Record" revealed the facility admitted Resident #59 on 2/25/26 with medical diagnoses that included Cerebral Infarction due to Embolism of Left Carotid Artery. Record review of the MDS with an ARD of 9/08/26 revealed under Section C, a BIMS summary score of 6, which indicated Resident #59 was severely cognitively impaired. Section GG revealed the			F0677			

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F0677 SS = D	Continued from page 31 resident was dependent on staff for bathing and personal hygiene. Resident #72 An observation and interview on 9/14/2026 at 3:25 PM revealed Resident #72 had approximately one-half (1/2) inch long facial hair on her chin and she stated, "I don't like this hair on my face." An observation and interview on 9/15/2026 at 8:25 AM revealed, upon entering Resident #72's room, a foul odor was present. Resident #72 was sitting on the side of her bed eating breakfast. An incontinence brief was observed lying on the floor beside the resident's bed. The brief was heavily saturated with urine and soiled with a brown substance. Resident #72 stated, "My diaper was so heavy it fell off of me." Resident #72's facial hair remained unchanged from the previous day. During an interview and observation on 9/15/2026 at 8:40 AM, the Assistant Director of Nurses (ADON) confirmed Resident #72's brief was lying on the floor beside her bed and was heavily saturated with urine and a brown substance. The ADON acknowledged the condition of the brief indicated the resident appeared not to have been changed in a while. During an interview on 9/15/2026 at 2:15 PM, the DON stated the ADON had informed her that Resident #72's brief was found on the floor. The DON stated that if the brief was so saturated that it fell off the resident, then the resident had obviously not been changed as she should have been during the night. The DON further stated she had received complaints from day-shift staff on a few occasions regarding residents being found heavily soiled at the beginning of the shift. The DON stated the nurse aides were responsible for providing residents' ADL care, including bathing, toileting, and shaving facial hair according to residents' preferences. An observation and interview on 9/15/2026 at 2:35 PM revealed Resident #72 continued to have approximately one-half (1/2) inch long facial hair on her chin and stated, "Yeah, they haven't taken care of my shaving." During an observation and interview on 9/15/2026 at 4:35 PM, Resident #72 was observed sitting in the designated smoking area with approximately one-half (1/2) inch long facial hair remaining on her	F0677					

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F0677 SS = D	Continued from page 32 chin. The Administrator observed Resident #72 and confirmed the presence of the facial hair. The Administrator stated, "She is not adequately groomed, and this is not acceptable." Record review of "Admission Record" revealed Resident #72 was initially admitted to facility on 8/13/2025 with diagnoses which included Major Depressive Disorder, Cerebral Infarction, and unspecified Dementia. Record review of MDS with an ARD of 8/8/2026 revealed under Section C, a BIMS summary score of 09, indicating Resident #72 was moderately cognitively impaired.	F0677					
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to provide services to maintain or improve residents' range of motion and mobility as evidenced by failure to apply a hand splint as ordered (Resident #6) and failure to provide needed assistance for a resident's use of a motorized wheelchair for two (2) of three (3) residents reviewed for range of motion and mobility. Resident #6 and Resident #21.	F0688					

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F0688 SS = D	Continued from page 33 Findings Include: Review of the facility policy titled "Contracture Management Program" revised 3/4/26 revealed, "Intent: To have a program within the facility geared towards the prevention of new contractures and maintenance or improvement of range of motion..." Resident #6 Record review of Resident #6's "Order Summary Report" revealed an order dated 5/26/26, "Resident to have left WHFO (wrist-hand-finger orthosis) to treat contracture to be worn 8 (eight) hours daily or to resident tolerance. To be applied by nursing after breakfast and removed before supper. Nursing to check skin and report any changes." An observation and interview with Resident #6 on 9/14/26 at 11:25 AM revealed he was sitting in his motorized wheelchair in his room. His left fingers were contracted and bent inward toward his palm. Resident #6 stated he had a hand splint in his dresser drawer that he was supposed to wear, but staff did not apply it. Record review of Resident #6's "Occupational Therapy (OT) Discharge Summary" dated 11/13/25 revealed under "Functional Maintenance: Pt (patient) to have L (left) WHFO (wrist-hand-finger orthosis) to treat contractures to be worn up to 8 (eight) hrs. (hours) per pt (patient) tolerance and applied by nsg (nursing)." An interview with the Director of Nursing (DON) on 9/15/26 at 3:31 PM revealed she expected the aides to apply the splints and the nurses to ensure this was completed. The DON stated the splint was listed in the task section/Kardex so the aides would know when to apply it. She confirmed the resident's contractures could worsen if the splint was not applied as ordered. Record review of Resident #6's September 2026 "Task" revealed the left-hand splint was listed as PRN (as needed), which did not match the order for daily use. The record contained no documentation or staff initials showing the splint was applied any during September 2026. Record review of the "Admission Record" revealed Resident #6 was admitted to the facility on 9/04/25 with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side, Muscle Wasting and Atrophy, and Contracture, Left Hand."			F0688			

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F0688 SS = D	Continued from page 34 Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/9/26, revealed under Section C a Brief Interview for Mental Status (BIMS) summary score of 14, which indicated Resident #6 was cognitively intact. Resident #21 During observation and interview on 9/14/2026 at 3:02 PM, Resident #21 stated staff had broken the charging port on her wheelchair headset. She stated the headset allowed her to independently operate her motorized wheelchair, and, without it, she relied on staff to operate the controls located on the back of the wheelchair to take her where she wanted to go. Observation revealed the wheelchair controls were located on the back of the chair and were completely out of Resident #21's reach. Resident #21 stated there were times when she wanted to go outside and staff told her no. She stated that if her headset were working, she would be able to independently operate her wheelchair and go outside without staff assistance. During an interview on 9/15/2026 at 4:38 PM, Resident #21 stated she had reported her broken wheelchair headset to the Administrator, therapy staff, and the wheelchair company representative. Observation of the headset revealed the charging port was pushed inward. Resident #21 stated she believed the damage occurred when staff plugged the charger into the headset too forcefully. Resident #21 stated, "I'm tired of sitting in one spot all day, I want to be able to go where I want to go." She stated that the previous day, while attending an activity, she was ready to return to her room and asked Certified Nursing Assistant (CNA) #4, who was walking by, to assist her. Resident #21 stated CNA #4 shook her head "no" and did not assist her back to her room. Resident #21 further stated that today she asked staff to assist her outside for 4:30 PM smoke break but was told she would have to wait. During an interview on 9/15/2026 at 4:42 PM, CNA #3 confirmed Resident #21 asked for assistance going outside for a smoke break and she did not assist the resident. CNA #3 stated she intended to find another staff member to assist Resident #21 but had not done so. CNA #3 confirmed Resident #21 was unable to independently operate her motorized wheelchair and acknowledged that she should have assisted the resident outside. During an interview on 9/16/2026 at 9:18 AM, the			F0688			

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F0688 SS = D	Continued from page 35 CNA #4 confirmed Resident #21 asked her for assistance returning to her room. CNA #4 stated she was returning from taking out the trash when the resident made the request. She stated she intended to get the resident's assigned CNA to assist her back to her room. CNA #4 acknowledged that she could understand how the interaction may have made Resident #21 feel that she was unwilling to assist her. During an interview on 9/17/2026 at 11:30 AM, the Activity Assistant stated that during Bingo on 9/14/2026, Resident #21 was finished with the activity and wanted to return to her room. She stated CNA #4 was walking past the activity room toward the nurse's station when Resident #21 asked, "Hey [CNA #4], can you take me back to my room really quick?" The Activity Assistant stated CNA #4 looked directly at Resident #21 and shook her head "no". She confirmed CNA #4 was not carrying anything that would have prevented her from assisting the resident. The Activity Assistant stated she then decided to assist Resident #21 back to her room so she could return and finish the activity. She stated that as they approached the nurse's station, nurses and CNAs were standing at the desk and blocking the way. The Activity Assistant stated Resident #21 became frustrated with the situation. During an interview on 9/17/2026 at 12:40 PM, the Administrator confirmed Resident #21 had reported the broken wheelchair headset to her. She confirmed Resident #21 was unable to independently operate her motorized wheelchair without the headset and was dependent on staff for assistance with locomotion. The Administrator stated staff should have assisted Resident #21 when she requested help going where she wanted to go. Record review of "Admission Record" revealed Resident #21 was admitted to facility on 9/26/2025 with diagnoses of Unspecified Injury at C4 Level of Cervical Spinal Cord, Subsequent Encounter and Unspecified Injury at C5 level of Cervical Spinal Cord, Subsequent Encounter. Record review of MDS with an ARD of 6/25/2026 revealed under, Section C, a BIMS summary score of 15, indicating Resident #21 was cognitively intact.			F0688			
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence.			F0690			

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F0690 SS = D	Continued from page 36 §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to identify and assess an indwelling urinary catheter following a resident's return from the hospital, clarify the catheter's continued clinical necessity and obtain appropriate orders, and provide catheter care and monitoring for eight (8) days for one (1) of 10 residents with an indwelling urinary catheter. (Resident #35). Findings include: Review of the facility policy titled "Catheter Care, Urinary," revised 3/3/2026, revealed, "...Documentation: The following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given...3. All assessment data obtained when giving catheter	F0690					

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F0690 SS = D	Continued from page 37 care...4. Character of urine...5. Any problems noted at the catheter/urethral junction..." During an initial observation on 9/14/2026 at 12:31 PM, Resident #35 was observed in bed with an indwelling urinary catheter drainage bag attached to the bed rail. Resident #35 stated he got it while he was in the hospital recently. Record review of Resident #35's History and Physical dated 8/28/2026 revealed, "He was sent from (proper name of hospital) for urinary obstruction due to urinary retention. Outside Emergency Room (ER) placed with Foley and had a total of four (4) liters (L) of urine output." Record review of Resident #35's Order Summary Report of active orders as of 9/15/2026 revealed no physician order for the indwelling urinary catheter, catheter care, catheter monitoring, or urine-output monitoring. Record review of Resident #35's Treatment Administration Records, Medication Administration Records, progress notes, and care plan from 9/7/2026 through 9/15/2026 revealed no documented catheter care or catheter assessment. The only documentation related to output during the eight-day period was a General Progress Note dated 9/9/2026 at 11:01 PM, which documented, "Output-450." The note did not identify the source of the output, the unit of measurement, or include an assessment of the catheter, urine characteristics, catheter patency, tubing, drainage bag, insertion site, or signs and symptoms of urinary tract infection. During an interview and concurrent record review on 9/15/2026 at 3:58 PM, the Director of Nursing (DON) stated she was unaware that Resident #35 had returned from the hospital on 9/7/2026 with an indwelling urinary catheter. The DON confirmed that the admitting nurse documented the presence of the catheter but did not enter orders for the catheter or catheter care. The DON further confirmed that, because no orders had been entered, Resident #35 had not received catheter care or monitoring from 9/7/2026 through 9/15/2026. The DON stated she expected the admitting nurse to contact the physician to determine whether the catheter should be continued and obtain appropriate orders, or to verify that the hospital discharge documentation contained a diagnosis or clinical indication supporting continued catheter use. During an interview and concurrent record review on 9/15/2026 at 4:04 PM, the DON identified a			F0690			

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F0690 SS = D	Continued from page 38 follow-up appointment scheduled for 9/22/2026 in Resident #35's hospital discharge paperwork. The DON confirmed that the appointment had not been entered into the resident's orders or appointment schedule. The Assistant Director of Nursing (ADON) stated that Resident #35 had an appointment with (proper name of facility) but acknowledged that she had not entered an order for the appointment and had not been aware of the appointment before the record review. Record review of Resident #35's Admission Record revealed the resident was originally admitted to the facility on 8/20/2026 with diagnoses that included age-related osteoporosis with current pathological vertebral fracture, subsequent encounter for fracture with routine healing. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/13/26, revealed a Brief Interview for Mental Status (BIMS) summary score of 14 under Section C, which indicated Resident #35 was cognitively intact.	F0690					
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 person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure that dialysis-related services were provided consistent with professional standards of practice by failing to implement and monitor a physician-ordered fluid restriction and failing to monitor the resident's condition before and after dialysis treatments for one (1) of seven (7) residents receiving dialysis services, Resident #1. Findings include: Review of facility policy titled "Dialysis Management Policy," revised 3/12/2026, revealed, "...The facility will ensure that residents requiring dialysis receive appropriate clinical oversight...the facility will ensure coordination regarding...fluid status monitoring...Dietary recommendations and	F0698					

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F0698 SS = D	Continued from page 39 restrictions..." During the initial tour of Resident #1's room on 9/14/2026 at 11:41 AM, Resident #1's nightstand had a water pitcher labeled with the resident's name and it was observed as Resident #1 was at dialysis. Review of Resident #1's Order Summary Report revealed, "...Resident to have 1000 cubic centimeter (cc)/milliliter (ml) fluid per 24 hours. Dietary to give 480cc/24hr: 240cc/ml- breakfast; 120cc/ml- lunch; 120cc/ml- dinner. Nursing to give 520cc: 120 cc/ml- night shift; 200 cc/ml- day; 200cc- evening shifts...Active 7/22/2026...Resident to receive dialysis 3 days a week on Monday, Wednesday, Friday (M/W/F) at (proper name of facility) dialysis center under the care of (proper name) ...Chair Time 12:10 PM." During an observation and interview on 9/15/2026 at 8:43 AM, Resident #1's breakfast tray was observed on his bedside table. The tray card listed six ounces of coffee, four ounces of milk, four ounces of orange juice, and eight ounces of Nepro, totaling 22 ounces, or approximately 660 milliliters, of fluid. The 660 milliliters listed on the tray card exceeded the physician-ordered breakfast allotment of 240 milliliters by approximately 420 milliliters and exceeded the resident's entire daily dietary fluid allotment of 480 milliliters by approximately 180 milliliters. Resident #1 also had a water pitcher at his bedside. He stated that staff "keep it full." Resident #1 stated that he was unsure whether he was on a fluid restriction. Record review of Resident #1's Medication Administration Records (MAR) for July 2026, August 2026, and September 2026, and nursing progress notes from 7/14/2026 through 9/14/2026 revealed that nursing staff documented fluids provided during medication passes on the MAR; however, fluids provided by dietary staff were not documented or included in the resident's daily fluid-intake totals. The records contained no documentation showing that the fluids provided by dietary and nursing staff were totaled and reconciled with the physician-ordered 1,000-milliliter daily fluid restriction. Record review of the dialysis communication forms from 8/31/2026 through 9/11/2026 and nursing progress notes from 7/14/2026 through 9/14/2026 revealed the records contained no documentation of Resident #1's vital signs before departure for dialysis or upon return to the facility on dialysis treatment days.			F0698			

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F0698 SS = D	Continued from page 40 During an interview and concurrent record review on 9/17/2026 at 10:22 AM, the Director of Nursing (DON) confirmed that staff were not documenting or monitoring all of Resident #1's daily fluid intake. She stated that only fluids administered during medication passes were documented on the Medication Administration Record and that fluids provided by dietary staff were not recorded. The DON also confirmed that Resident #1 should not have had a water pitcher at his bedside because he was on a physician-ordered fluid restriction. She stated that monitoring Resident #1's total fluid intake was important to determine compliance with the prescribed fluid restriction and reduce the risk of fluid overload. The DON further confirmed that nursing staff did not obtain or document Resident #1's vital signs before departure for dialysis or upon return to the facility on dialysis treatment days. Review of Resident #1's Admission Record revealed that the resident was originally admitted to the facility on 7/14/2026 with diagnoses that included End Stage Renal Disease and Dependence on Renal Dialysis. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/20/2026, revealed a Brief Interview for Mental Status (BIMS) summary score of 12 under Section C, which indicated Resident #1 had moderate cognitive impairment.			F0698			
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on resident interview, staff interviews, facility policy review, and record review, the facility failed to accurately assess one (1) of 1 resident reviewed for Post-Traumatic Stress Disorder (PTSD) to identify potential triggers and ensure trauma informed care was provided. Resident #9			F0699			

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F0699 SS = D	Continued from page 41 Findings Include: Record review of the facility policy "Trauma-Informed and Culturally Competent Care" with a review date of 3/3/2026 stated, "Purpose: To guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice." Record review of Resident #9's "Admission Record" revealed the resident was admitted to the facility on 1/05/2026 with a diagnosis that included Post-Traumatic Stress Disorder (PTSD). Record review of Resident #9's Social History dated 1/11/26 revealed, "...G. Trauma Informed Care...2. Does the resident have a diagnosis of Post-Traumatic Stress Disorder? b. no...6b. (Proper Name) states that he witnessed many frightening situations in the line of duty..." No potential trauma triggers were documented. During an interview on 9/14/2026 at 4:24 PM, Resident #9 stated he had PTSD related to his previous employment as a Chief of Police. Resident #9 stated that most of the time he did not experience problems; however, there were times when certain things triggered him and bothered him. On 9/16/2026 at 4:31 PM, during an interview with Social Worker (SW) #1, she stated Resident #9's PTSD was probably missed during the admission process and stated the resident had been admitted once before this admission. During an interview on 9/16/2026 at 5:10 PM, SW #2 stated she would reassess Resident #9 and correct the assessment. SW #2 stated the failure to identify the resident's PTSD was an oversight. On 9/16/2026 at 9:40 AM, an interview with the Director of Nursing (DON) stated it was the facility's expectation that the Trauma Informed Assessment be completed accurately. Record review of Resident #9's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/09/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact.	F0699			
F0755 SS = D	Pharmacy Svcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F0755			

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F0755 SS = D	Continued from page 42 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interviews and facility policy review, the facility failed to provide pharmaceutical services to assure the accurate acquiring, receiving, and administering of all drugs and biologicals to meet the needs of each resident for two (2) of 36 medication administrations. Resident #26 and Resident #53. Findings Include: Review of the facility policy titled, "Medication Administration" with a revised date of 3/5/2026 revealed, "Purpose, To ensure medications are prepared, administered, and documented safely, accurately, and in accordance with prescriber orders and accepted nursing standards of practice. ... 4. Medications are administered according to prescriber orders and within the ordered time frames..." Resident #26 On 9/16/26 at 8:10 AM, a medication administration observation and interview with Licensed Practical Nurse (LPN) #1 revealed LPN #1 administered five (5) medications to Resident #26: Zonisamide oral capsule 100 mg (milligrams), Clobazam oral tablet 10 mg, Sennosides-Docusate Sodium tablet 8.6-50 mg, Glycopyrrolate oral solution 0.5 mg/2.5 mL	F0755					

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F0755 SS = D	Continued from page 43 (milliliter), and Valproate Sodium oral solution 250 mg/5 mL, with 375 mg (7.5 mL) administered. LPN #1 revealed Resident #26 was also ordered Children's Zyrtec Allergy oral solution 5 mg/mL and Saccharomyces boulardii oral packet 250 mg; however, both medications were unavailable. LPN #1 stated Resident #26 was supposed to receive seven (7) medications, but the facility was out of the other two (2) medications. LPN #1 stated the charge nurse was notified when medications needed to be reordered. LPN #1 stated that the Children's Zyrtec Allergy oral solution and Saccharomyces boulardii 250 mg were not administered to Resident #26 as ordered because they were not available to give and had not been reordered. Record review of the September 2026 "Medication Administration Record (MAR)" revealed at the "0900" medication pass, Resident #26 was to receive seven (7) medications including Children's Zyrtec Allergy oral solution and Saccharomyces boulardii 250 mg which were not given. A record review of the facility "Admission Record" revealed Resident #26 was admitted to the facility on 06/25/2026 with diagnoses that included Spastic Quadriplegic Cerebral Palsy, Gastrostomy Status, and unspecified Convulsions. A record review of the Minimum Data Set Section C with an Assessment Reference Date (ARD) of 07/07/26, revealed a Brief Interview of Mental Status (BIMS) score of 99 which indicated Resident #26 was unable to complete the interview. Resident #53 On 9/16/26 at 8:55 AM, a medication administration observation and interview revealed that LPN #3 administered medications to Resident #53 through the resident's Percutaneous Endoscopic Gastrostomy (PEG) tube. The medications administered were Docusate Sodium capsule 100 mg, Potassium chloride liquid 20 meq/15 ml, and Valproic Acid oral solution 500 mg/10 ml. LPN #3 stated that Resident #53 was also supposed to receive Keppra oral solution 100mg/ml however, the medication was unavailable. LPN #3 searched the medication room and stated, "We are out of the Keppra. I will have to order more." Record review of the September 2026 MAR revealed that at the 0900-medication pass, Resident #53 was to receive four (4) medications including Keppra oral solution 100mg/ml .			F0755			

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F0755 SS = D	Continued from page 44 During medication reconciliation, a record review of the MAR revealed that Resident #53's Keppra Oral Solution 100mg/ml 5ml was documented as administered. During an interview and observation on 9/16/26 at 11:08 AM, LPN #3 confirmed she did not administer Resident #53's Keppra because the medication was not available on the medication cart. LPN #3 stated she called the pharmacy and ordered the medication. An observation of the MAR with LPN #3 showed the Keppra was documented as administered. LPN #3 stated, "I, in error, clicked that the medication had been given and should never document that it's given when it is not." LPN #3 further stated, "I honestly think my screen timed out and that's what caused the error." A record review of the facility "Admission Record" revealed Resident #53 was admitted to the facility on 04/11/2025 with diagnoses that included Cerebral Infarction, Encounter for attention to Gastrostomy, and Dysphagia. A record review of the MDS Section C with an ARD of 08/04/26, revealed a BIMS score of 06, which indicated Resident #53 had severe cognitive impairment. During an interview on 9/16/26 at 11:15 AM, the Assistant Director of Nursing (ADON) stated that when medication nurses identified medications running low, they were to be reordered; medication nurses notified the charge nurse when narcotics needed to be reordered and notified central supply when over-the-counter medications needed to be reordered. The ADON revealed that Resident #26's two (2) omitted medications were last ordered on 8/19/26, and the records showed they had been on order but had not been received. The ADON acknowledged that all medications should be readily available for administration and stated, "There's no reason under these circumstances that both residents are lacking medications." During an interview on 9/16/26 at 11:25 AM, the Director of Nursing (DON) stated she contacted the pharmacy regarding Resident #53's Keppra and the pharmacy reported the facility should have had eight (8) remaining doses. The DON stated, "I told the pharmacy, I guess maybe the nurses had a spill or something." The DON further revealed that when medications were administered, nurses were expected to check the physician's orders on the MAR and the			F0755			

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F0755 SS = D	Continued from page 45 dispensed medication to ensure medications were administered as ordered.	F0755					
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and facility policy review, the facility failed to ensure medications were stored in a locked and secured medication cart to prevent unauthorized access for one (1) of four (4) medication carts observed for medication storage. C hall medication cart Findings Include: Review of the facility's policy, "Storage of Medications", reviewed 6/24/25, revealed under "Policy Interpretation and Implementation: 1. Drugs and biologicals used in the facility are stored in locked compartments..." On 09/16/2026 at 1:40 PM, observation revealed that a medication cart on the C Long/C Trach Hall was unlocked and unattended. Residents were present in	F0761					

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F0761 SS = D	Continued from page 46 the hallway, and no nursing staff were observed on the hall supervising the medication cart. On 09/16/2026 at 1:45 PM, Licensed Practical Nurse (LPN) #1 exited the break room and confirmed the medication cart belonged to her. When asked whether the medication cart should have been locked, LPN #1 stated it should have been locked to ensure residents did not access the cart and take medications and confirmed that she had failed to do that. During an interview on 09/16/2026 at 1:50 PM, the Administrator confirmed the medication cart should have been secured to prevent residents from accessing the cart.	F0761					
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative	F0842					

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F0842 SS = D	Continued from page 47 where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on resident interview, staff interviews, record	F0842					

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F0842 SS = D	Continued from page 48 review and facility policy review, the facility failed to maintain a complete and accurately documented clinical record for administration of a prescribed physicians order one (1) of twenty-six (26) sampled residents reviewed for clinical records. Resident #9 Findings Include: Review of facility policy titled, "Medication Administration," dated 03/05/26, stated, "To ensure medications are prepared, administered, and documented safely, accurately, and in accordance with prescriber orders and accepted nursing standards of practice." Record review revealed a physician's order dated 9/09/2026 at 3:00 PM for Sodium Chloride Solution 0.9% intravenously (IV) at 50 milliliters (mL) per hour every shift for low sodium for one day. Record review of the September 2026 Medication Administration Record (MAR) revealed the IV therapy was documented by nursing for 9/09/2026 on the evening shift. The MAR contained no documentation of administration/continuation of the ordered IV therapy for the night shift on 9/09/26 and the day shift 9/10/26. Further review of the clinical record revealed no documentation to verify the ordered IV infusion continued at 50 mL/hr. throughout the prescribed treatment period. During an interview on 9/15/2026 at 9:05 AM, Resident #9 stated he thought he received the sodium IV on all three shifts. On 9/16/2026 at 2:00 PM, the Assistant Director of Nursing (ADON), stated she initiated the IV infusion and that the charge nurses were to document the subsequent shifts. During an interview on 9/16/2026 at 2:05 PM, the Administrator stated that if the care was not documented, it was considered not done and it is the expectation of the facility for nurses to sign the MAR when IV medication is administered to accurately reflect what medication Resident #9 received. Record review of Resident #9's "Admission Record" revealed the resident was admitted to the facility on 1/05/2026 with diagnosis that included Post-Traumatic Stress Disorder (PTSD). Record review of Resident #9's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/09/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact.			F0842			
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection			F0880			

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F0880 SS = D	Continued from page 49 prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (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	F0880					

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F0880 SS = D	Continued from page 50 staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to maintain an effective infection prevention and control program by failing to ensure staff wore gowns in accordance with Enhanced Barrier Precautions (EBP) during the use of indwelling medical devices for (Resident #26 and Resident #53) and maintain sterile technique during tracheostomy care for (Resident #5); and properly contain and handle soiled linen and/or soiled briefs to prevent potential cross-contamination for (Resident #25 and Resident #50) for five (5) of the 26 sampled residents. Findings Include: Review of the facility's policy titled "Enhanced Barrier Precautions," reviewed 3/19/25, revealed, "Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high-contact resident care activities... EBP are indicated for residents with any of the following: ...Wounds and/or indwelling medical devices, even if the resident is not known to be infected or colonized with a multidrug-resistant organism (MDRO) Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies..." Review of facility policy titled "Infection Prevention and Control Program" revised 9/16/2026 revealed, "An infection prevention and control program (IPCP)	F0880					

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F0880 SS = D	Continued from page 51 is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections..." Resident #5 Record review of facility policy titled "Tracheostomy Care" reviewed 6/24/2025 revealed under, "1. Aseptic technique must be used." Record review of "Order Summary Report" revealed an order dated 8/8/24 , "Tracheostomy care every shift and prn (as needed) using aseptic technique. Remove inner cannula, clean with half strength H2O2 (hydrogen peroxide) and sterile H2O (water), dry with sterile gauze and cotton swab. Re-insert inner cannula, turn to lock. Clean outer cannula/stoma with sterile H2O, rinse with sterile H2O, pat dry with sterile gauze. May use split sterile gauze PRN. Two times a day." Observation on 9/15/2026 at 3:01 PM revealed the Certified Respiratory Therapist (CRT), Respiratory Director, performed tracheostomy care for Resident #5. The CRT performed hand hygiene, cleaned the bedside table, placed a red disposal bag at the end of the table, and checked the resident's oxygen saturation. Resident #5 was lying supine in bed with the head of the bed elevated and displayed no signs or symptoms of respiratory distress. The CRT donned regular gloves and disconnected the resident's tubing. The CRT prepared supplies for the procedure. The CRT contaminated the protective sheet when removed from the tracheostomy care kit. He held up the sheet and shook it open making it come in contact with the bedside table. While donning sterile gloves, the CRT contaminated the sterile gloves when the right glove came into contact with the opposite hand and the left glove came into contact with the bedside table. The CRT removed the resident's cannula and gauze dressing, removed his gloves, and performed hand hygiene. The CRT donned regular gloves, obtained peroxide-soaked gauze, and cleansed around the tracheostomy site. No redness, drainage, or other concerns were observed at the tracheostomy site. The CRT removed his gloves, performed hand hygiene, and donned sterile gloves. During application of the sterile gloves, the CRT contaminated the right sterile glove when it came into contact with his left hand. The CRT subsequently used his right hand to insert a new cannula. The CRT removed his gloves, performed hand hygiene, and donned another pair of sterile gloves. During application, the right sterile	F0880					

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F0880 SS = D	Continued from page 52 glove again became contaminated when it came into contact with his left hand. The CRT then placed new gauze around the tracheostomy site. The CRT checked Resident #5's oxygen saturation, which was 95%, and reconnected the resident to the respiratory equipment. The CRT then stated he had forgotten to cleanse the tracheostomy site with saline-soaked gauze. The CRT removed the newly placed dry gauze, cleansed around the tracheostomy site with saline-soaked gauze, removed his gloves, performed hand hygiene, donned sterile gloves, replaced the dry gauze, and reconnected the resident's respiratory equipment. Resident #5 displayed no signs or symptoms of respiratory distress during or immediately following the procedure. During an interview on 9/15/2026 at 3:20 PM, the Certified Respiratory Therapist (CRT), Respiratory Director, confirmed tracheostomy care required sterile technique and stated that a break in sterile technique increased the resident's risk for infection. The CRT stated the available sterile gloves were too small for his hands, making it difficult for him to put on the gloves without contaminating them. During an interview on 9/16/2026 at 2:30 PM, the Infection Preventionist (IP) confirmed tracheostomy care was a sterile procedure. The IP stated that a break in sterile technique during tracheostomy care was an infection-control concern. Record review of "Admission Record" revealed Resident #5 was admitted to facility on 8/7/2024 with a diagnosis of Anoxic Brain Damage, Not Elsewhere Classified. Resident #25 During an observation on 9/14/2026 at 4:24 PM, a soiled flat sheet was observed lying directly on the hallway floor outside Resident #25's room and was not contained in a bag. A red biohazard bag containing Resident #25's personal clothing was observed on top of the soiled sheet. During the observation, multiple staff members, including one Certified Nursing Assistant (CNA) and one nurse, walked past the soiled linen without removing it from the floor. CNA #3 removed linen from a clean linen cart and left the protective cover open, exposing the clean linens. The clean linen cart was approximately one doorway away from the soiled linen on the hallway floor. During an interview on 9/14/2026 at 4:35 PM, Licensed Practical Nurse (LPN) #6 confirmed a soiled			F0880			

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F0880 SS = D	Continued from page 53 sheet was on the hallway floor. LPN #6 stated Resident #25 had told her that his soiled linen needed to be removed. She confirmed she did not remove the linen at that time and then observed Resident #25 place the linen in the hallway. LPN #6 stated the soiled linen should have been removed from the hallway and placed in the appropriate linen barrel immediately. She also confirmed the protective cover on the clean linen cart should remain closed. LPN #6 stated that leaving soiled linen on the floor and leaving the clean linen cart open were infection control concerns. During an interview on 9/16/2026 at 2:13 PM, the Infection Preventionist stated Resident #25 was on EBP due to colonized Candida auris. The IP stated EBP did not require the use of red biohazard bags for Resident #25's linen or trash; however, the facility used the bags to reduce the risk of spreading Candida auris. She stated the biohazard bags alerted staff that the contents were considered contaminated and should be handled accordingly. The IP stated staff should remove trash and soiled linen from Resident #25's room at least once every shift and as needed. She stated soiled linen should never be placed on the floor, and staff should have immediately removed the soiled linen that was observed on the floor. The IP confirmed that placing soiled linen on the floor and failing to remove it immediately were infection control concerns. Record review of "Admission Record" revealed Resident #25 was admitted to facility on 4/24/2025 with a diagnosis of Type 2 Diabetes Mellitus with Diabetic Peripheral Angiopathy without Gangrene. Resident #26 An observation on 9/16/26 at 8:10 AM, revealed LPN #1 administered medications to Resident #26 through the resident's Percutaneous Endoscopic Gastrostomy (PEG) tube. LPN #1 wore gloves but did not wear a gown during the medication administration. During an interview on 9/16/26 at 10:50 AM, LPN #1 confirmed the resident was under EBP due to having the peg tube and a wound. LPN #1 acknowledged she was required to wear a gown while administering the medications through the peg tube and stated, "She had forgotten to put on the gown."	F0880					

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F0880 SS = D	Continued from page 54 A record review of the facility "Admission Record" revealed Resident #26 was admitted to the facility on 06/25/2026 with diagnoses that included Spastic Quadriplegic Cerebral Palsy, Gastrostomy Status, and unspecified Convulsions. A record review of the Minimum Data Set Section C with an Assessment Reference Date (ARD) of 7/7/26 revealed a Brief Interview of Mental Status (BIMS) score of 99 which indicated Resident #26 was unable to complete the interview. Resident #50 During an observation and interview on 9/15/2026 at 9:44 PM, CNA #3 removed two soiled briefs from Resident #50. Observation revealed the green brief was saturated with urine from front to back, and the white brief contained a small amount of urine in the center. CNA #3 placed the soiled briefs directly on the floor and stated she did not know what to do with the soiled briefs because she did not have a bag available. CNA #3 confirmed that placing the soiled briefs on the floor was an infection control concern. During an interview on 9/16/2026 at 2:12 PM, the Infection Preventionist stated CNA #3 should have placed the soiled brief directly into a bag after removing it from the resident. The IP stated placing a soiled brief on the floor was an infection control concern because staff could walk through the area and track contamination to other areas of the facility, increasing the risk of spreading infection. Record review of "Admission Record" revealed Resident #50 was admitted to facility on 3/25/2024 with diagnoses of Fusion of Spine, Cervical Region and Spinal Stenosis, Cervical Region. Resident #53 An observation on 9/16/26 at 8:55 AM, revealed LPN #3 administered medications to Resident #53 through the resident's PEG tube. LPN #3 wore gloves but did not wear a gown during the medication administration. During an interview on 9/16/2026 at 10:55 AM, LPN #3 confirmed Resident #53 had a PEG tube and was under EBP. LPN #3 acknowledged she failed to wear a gown while administering the resident's			F0880			

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F0880 SS = D	Continued from page 55 medications through the PEG tube. A record review of the facility "Admission Record" revealed Resident #53 was admitted to the facility on 04/11/2025 with diagnoses that included Cerebral Infarction, Encounter for attention to Gastrostomy, and Dysphagia. A record review of the MDS Section C with an ARD of 8/4/26 revealed a BIMS score of 06, which indicated Resident #53 had severe cognitive impairment. During an interview on 9/16/2026 at 11:15 AM, the Director of Nursing (DON) confirmed Resident #26 and Resident #53 were under Enhanced Barrier Precautions due to having PEG tubes. The DON stated staff were required to wear gowns and gloves when providing care requiring Enhanced Barrier Precautions to reduce the potential transmission of infection. During an interview on 9/17/2026 at 11:30 AM, the Infection Preventionist stated she had recently provided staff education regarding Enhanced Barrier Precautions and the staff were aware that they should have worn a gown. The IP confirmed that staff were expected to wear gowns and gloves when providing medications through the PEG tube and for residents under Enhanced Barrier Precautions to reduce the potential transmission of infection.			F0880			