STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA ARROWHEAD	2500 ARROWHEAD DR , RAPID CITY, South Dakota, 57702

(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 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/9/25 through 9/11/25. Avantara Arrowhead was found not in compliance with the following requirements: F554, F578, F583, F641, F645, F657, F686, F689, F695, F697, F699, F745, F759, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/9/25 through 9/11/25. Areas surveyed included fall prevention, potential staff-to-resident abuse, skin and pressure ulcer prevention, and potential resident neglect. Avantara Arrowhead was found not in compliance with the following requirement: F684.	F0000		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (31) observed with medications at her bedside were securely stored, had a physician's order for self-administration, and were not outdated according to the provider's policy. Findings include: 1. Observation and interview on 9/9/25 at 9:51 a.m. and 3:24 p.m. with resident 31 in her room revealed: *Resident 31 had a Lubrifresh P.M. eye ointment (a medication used to treat the inflammation that results from dry eyes) box and a bottle of saline nasal spray (a medication used to moisturize and clear nasal passages) on her over-the-bed table.	F0554	1. The Director of Nursing (DON) observed resident 31's room and checked for any medication at bedside that is self-administered and interviewed for preferences on self-administering medication on 10/1/25. The DON evaluated resident 31 to determine her ability to self-administer her medication, reviewed care plan, and orders obtained on 10/1/25. A lock box was provided to resident 31 on 10/7/25. All residents have the potential to be affected. DON or designee evaluated all resident rooms for medications at bedside and any residents expressing the desire to self-administer medication were evaluated for the ability to self-administer medication by 10/15/25. 2.Nursing Home Administrator (NHA) or Designee completed education with all staff on the Self-Administration of Medications policy and to report any medications left at bedside to the charge nurse if observed. Education will occur no later than October 15, 2025. Those not at the education session will be educated prior to their first shift worked.	10/15/25

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
Sharon Martin	Administrator	10/07/25

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F0554 SS = D	Continued from page 1 *She stated she self-administered those medications. *The saline nasal spray had a hospital label on it that stated it was issued on 8/23/25. *Resident 31 stated she used the saline nasal spray as needed for a dry nose. *The Lubrifresh P.M. box contained, -A tube of Lubrifresh P.M eye ointment, which did not have a pharmacy label on it to indicate how the medication was to be administered, and it outdated in July 2020. -A tube of Stye (a red, painful, eyelid bump) sterile lubricant ointment (a medication used to relieve burning, stinging, and itching related to a Stye), which did not have a pharmacy label on it to indicate how the medication was to be administered. -A bottle of Refresh Liquid Gel eye drops (for dry eyes), which did not have a pharmacy label on it to indicate how the medication was to be administered, and it outdated in July 2024. *Resident 31 stated she self-administered the Lubrifresh P.M. eye ointment every night and the Refresh Liquid Gel eye drops as needed for her dry eyes. -She stated the last time she had self-administered both the Lubrifresh eye ointment, and the Refresh Liquid Gel eye drops had been the evening of 9/8/25. -She stated she self-administered the Stye sterile lubricant ointment and the Lubrifresh P.M. eye ointment interchangeably. *There was a unit dose of albuterol sulfate 2.5 mg (milligram) /3 ml (milliliter) (a medication used to treat shortness of breath related to conditions such as asthma or chronic obstructive lung diseases). *There was no nebulizer machine (device that converts liquid medication into an inhalable mist) in resident 31’s room. *Resident 31 stated she had not been administered a nebulizer medication in “a long time”. 2. Review of resident 31’s electronic medical record (EMR) revealed:	F0554	3.The DON or designee will audit 10 random resident rooms for medication at bedside to ensure residents have self-administration orders in place, a medication self-administration evaluation in the last quarter and medications are securely stored. The audit will be weekly for 4 weeks then monthly for 2 months. Results of the audits will be discussed by the DON or designee at the monthly Quality Assessment Process Improvement (QAPI) meeting with IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on findings.	

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F0554 SS = D	Continued from page 2 *She was admitted on 11/5/24. *She had a 7/24/25 Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated her cognition was intact. *She had a 9/2/25 physician's order for "Artificial Tears Opthalmic Ointment 83-15 % (White Petrolatum-Mineral Oil) Instill 1 application in both eyes at bedtime for dry eyes BOTH EYES" and "Carboxymethylcellulose Sodium Opthalamic Solution (Carboxymethylcellulose Sodium (Opthth)) Instill 1 drop in both eyes four times a day for dry eyes". *There was no physician's order for the albuterol sulfate nebulizer solution, the saline nasal spray, the Stye sterile lubricant, or the Refresh Liquid Gel eye drops. *Resident 31's 8/12/25 Medication Self-Administration Evaluation did not include, the Lubrifresh P.M. eye ointment, Stye sterile lubricant, Refresh Liquid Gel eye drops, saline nasal spray, or the albuterol nebulizer solution as medications resident 31 had been assessed to safely self-administer. *Resident 31's 8/12/25 Medication Self-Administration Evaluation indicated: -There was no physician's order to keep her medications at bedside. -Her medications were to be stored in the medication cart. 3. Interview on 9/10/25 at 1:37 p.m. with certified medication aide (CMA) O revealed he: *Knew which residents were assessed to self-administer medications by a list that was in a binder on the medication cart. *Reviewed the list and stated resident 31 was not on the list. *Did not know who was responsible for updating the list or when it was last updated. *Did not know that resident 31 had medications on her over-the-bed table that she was self-administering. 4. Interview on 9/11/25 at 9:58 a.m. with licensed practical nurse (LPN) K revealed:	F0554		

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F0554 SS = D	Continued from page 3 *There were no residents in the facility who had a physician's order to store medications in their room. *If she found a medication in a resident room, she would talk to the resident about the safety risk of keeping medication unsecured in their room due to wandering residents and then remove the medication from the resident's room. *A physician's order was required prior to the administration of a medication to a resident. *She knew which residents were able to self-administer their own medications, after being set up by the nursing staff, because it was indicated on the resident's care plan. *Medications that were outdated were to be destroyed and could not be administered to residents. 5. Interview on 9/11/25 at 4:46 p.m. with director of nursing (DON) B revealed: *After a resident expressed interest in self-administering medication the care team would determine if the resident had the mental capacity to self-administer medication. If the resident was found to have the mental capacity to self-administer medications an assessment would be completed to determine if it was safe for the resident to self-administer medications. *Once that assessment was completed and the resident was deemed safe to self-administer medications, a physician's order would need to be obtained for a resident to self-administer medications. *If medications were to be stored in a resident's room those medications would need to be stored in a secure location and the physician's order would need to indicate that those medications could be stored in the resident's room. *The list of residents who were assessed as safe to self-administer medication was to be maintained by nursing management and kept on the medication cart. *Expired medications were not to be administered to residents. 6. Review of the provider's 11/19/24 Self-Administration of Medications policy revealed:	F0554		

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F0554 SS = D	Continued from page 4 *"Each resident has a right to self-administer medications should they desire, unless practice is determined unsafe." *"If the resident is deemed capable to self-administer medications, then the drugs will be stored in a locked box in the resident's room, unless otherwise determined by the interdisciplinary team." *"Nursing is to get an order from the clinician for self-administration of medications." *"Nursing staff will be responsible for recording self-administration doses in the resident's medical administration record, unless otherwise determined by the interdisciplinary team. To accomplish this, a licensed nurse, at the end of each shift, is to ask the resident if medications were taken as ordered by the physician and recorded on eMAR [electronic medication administration record]." Review of the provider's September 2018 Medication Administration policy revealed: *"Medications are administered in accordance with written orders of the prescriber." *"No expired medications will be administered to a resident."	F0554		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option,	F0578	1.Resident 8's advance directive status was reviewed on 9/10/2025 with Business Office Manager (BOM), order obtained by Unit Manger (UM) on 9/15/25, and care plan updated by DON on 10/7/25. All residents have the potential to be affected. NHA or designee audited all residents' code status to verify it is their current wishes, that it is entered into the electronic medical record, and care planned by 10/15/25. 2.NHA or Designee completed education with all nurses on the Advance Directive Policy, as well as procedures should a resident's advanced directive change upon return from hospital. Education will occur no later than October 15, 2025. Those not at the education session will be educated prior to their first shift worked.	10/15/25

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F0578 SS = D	Continued from page 5 formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the provider failed to ensure one of one sampled resident's (8) advance directive wishes after he returned to the facility following a hospital stay was accurately identified and documented to ensure the resident's directives were followed if an event that may have prompted life-sustaining measures occurred. Findings include: 1. Record review of resident 8's electronic medical record (EMR) revealed: *His code status (specifies the type of emergent treatment a person wishes to receive if their heart or breathing would stop) was entered on 4/10/25 as "Intubate (a tube inserted into the lungs to control breathing) Only" in the EMR. *He had two signed documents that were checked "Do Not Resuscitate" (no life-sustaining measures) (DNR) in his EMR and in his paper chart. -One DNR was signed by resident 8 on 3/28/24. -The other DNR was signed by him on 7/23/24. -Those two documents had a provider's signature and a	F0578	3.Nursing Home Administrator or designee will review all residents who return from a hospitalization to ensure that their Advanced Directives are reviewed upon readmission and any changes in their wishes are addressed through physician order and care planned are correctly. Audits will be weekly for three months. Results of the audits will be discussed by the Administrator or designee at the monthly QAPI meeting with IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on findings.	

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F0578 SS = D	Continued from page 6 signature of the facility's authorized agent. *His care plan included a focus area of "I have elected DNR status. CPR (cardiopulmonary resuscitation; an emergency procedure used to restart a person's heartbeat) measures ARE NOT to be performed". -The goal for that focus area stated, "staff will respect my decisions to be DNR". 2. Interview on 9/10/25 at 11:38 a.m. with resident 8 revealed: *He thought his code status was DNR. *He had to be intubated once during a surgical procedure and stated, "I never want to go through that again". 3. Interview on 9/10/25 at 2:55 p.m. with licensed practical nurse (LPN) E revealed: *The resident's code status was kept in the paper chart on orange paper so it "stands out easily". *She confirmed that resident 8's code status in his paper chart was a DNR and his code status in his EMR was Intubate Only. *She looked at his Intubate Only code status in the EMR and identified it was changed by nurse supervisor LPN M on 4/10/25. *She stated that if the resident code (stop breathing or if his heart stop beating) then she would have to follow the highest level of care that was listed in his records which was to intubate only. 4. Interview with nurse supervisor LPN M on 9/10/25 at 3:06 p.m. revealed: *The residents receive admission paperwork when they arrive at the facility, which included code status wishes for the resident to fill out and sign. -The code status was to be signed by the provider and a witness from the facility. *Resident 8 was admitted to the hospital on 4/8/25 and returned to the facility on 4/10/25. -She noticed his code status changed to Intubate Only when he was in the hospital. She updated his EMR with that new code status after he returned to the facility	F0578		

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F0578 SS = D	Continued from page 7 on 4/10/25. -She confirmed that she did not discuss that code change with the resident before she updated his code status in the EMR. 5. Interview with director of nursing (DON) B on 9/11/35 at 4:46 p.m. revealed: *She would expect that if there was a question about a code status change after a resident's hospitalization, the facility would need to confirm the resident's code statis wishes with the resident. *Code status were to be reviewed at the residents' care conferences.	F0578		
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws.	F0583	1.No immediate correction could occur for resident 12 displayed protected health information. LPN K was provided written education by DON on protection of resident data on 10/01/25. On 10/01/25, NHA reported unsecured (electronic medical record) EMR to corporate compliance officer. All residents are at risk for failures of unsecured displayed EMR. 2. The DON or designee will educate all nurses and medication aides in facility on HIPPA and how to secure the laptop to ensure resident information is unviewable when not at the nurses cart. Education will occur no later than October 15, 2025. Those not at the education session will be educated prior to their first shift worked. 3.The DON or designee will conduct 5 random observations of nurses or medication aides per week to verify their laptops are secure when not at medication cart viewing the record. The audit will be weekly for 4 weeks then monthly for 2 months. Results of the audits will be discussed by the DON or designee at the monthly QAPI meeting with IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	10/15/25

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F0583 SS = D	Continued from page 8 (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure one of one sampled resident's (12) protected health information in the resident's electronic medical record (EMR) was secured and was not displayed and accessible to other residents and staff in the west hall by one of one observed licensed practical nurse (LPN) (K). Findings include: 1. Observation and interview on 9/11/25 at 1:13 p.m. with licensed practical nurse (LPN) K in the west hall revealed: *LPN K was away from the medication cart, administering medications to resident 12. *The computer screen on the medication cart was unlocked and displayed resident 12's EMR information. *Multiple staff members and residents were in the west hall and walked past that unlocked computer screen that displayed resident 12's EMR information. *LPN K agreed that the computer screen should have been locked. 2. Interview on 9/11/25 at 1:36 p.m. with director of nursing (DON) B revealed: *The EMR system used by the provider had a "lock screen" feature to secure the residents' EMR information from being viewed. *She would expect the screen to be locked anytime a staff member walked away from it. 3. Review of the provider's 12/20/19 HIPAA [Health Insurance Portability and Accountability Act] Fundamentals policy revealed: *"HIPAA is a federal regulation comprised, in part, of the Privacy Rule, Security Rule, Enforcement Rule, and Breach Notification Rule. As an employee of a healthcare facility, you are required to comply with	F0583		

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F0583 SS = D	Continued from page 9 HIPAA regulations in performing your job duties to protect the integrity and privacy of residents' Protected Health Information (PHI). PHI is any individually identifiable information that the facility creates, receives or maintains related to the treatment of residents or payment for residents' care. PHI can be in any form or media, whether electronic, paper, or oral." *"HIPAA Do: -Log off of computers/terminals when not in use." *"HIPAA Don't: -Leave charts or paper PHI in areas accessible by the public." *"HIPAA Breaches -A breach is an unauthorized use or disclosure of PHI that compromises the integrity of a resident's PHI."	F0583		
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-	F0645	1.Resident 8's PASRR was reviewed by Social Services Designee (SSD) on 10/3/25. All residents at risk for failure to review PASRR accuracy and provide associated mental health needs. NHA or designee will audit all residents to verify accuracy of their PASRR and to ensure mental health needs are addressed by 10/15/25. 2. Licensed Social Worker will provide education to SSD no later than 10/7/2025 on reviewing PASRR for accuracy and ensuring mental health needs are offered/provided. 3. The NHA or Designee will conduct audits on all newly admitted residents to ensure their PASRR has been reviewed and is accurate and any mental health needs requested/ recommended in PASRR are in place. Audits weekly for three months. Results of the audits will be discussed by the NHA or designee at the monthly QAPI meeting with IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on findings.	10/15/25

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F0645 SS = D	Continued from page 10 (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of two	F0645		

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F0645 SS = D	Continued from page 11 sampled residents resident (8 and 31) with diagnosed post-traumatic stress disorder had a Preadmission Screening and Resident Review (PASRR) reviewed for accuracy to ensure the resident was evaluated for mental health care needs. Findings include: 1. Review of resident 8's electronic medical record (EMR) revealed: *He was admitted to the facility on 4/2/24. *His care plan dated 4/3/24 had a focus area of "I am at risk for altered thought process due to history of alcohol abuse, PTSD, depression, and anxiety". *He had a Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated his cognition was intact. *Resident 8's diagnoses included: insomnia (trouble falling and staying asleep), alcohol abuse, major depressive disorder, anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), post-traumatic stress disorder, depression, adjustment disorder(a mental health reaction to stressful life events or changes that are considered a maladaptive response to a psychosocial stressor), and hallucinations (to see, hear, smell, taste, or touch something that is not there). *He had a PASRR that was screened at Level 1 (one). - PASRR question box "does the individual have a condition of, or is there any presenting evidence that may indicate the individual may have mental illness?" was marked "no". 2. Observation and interview on 9/10/25 at 11:38 a.m. with resident 8 in his room revealed he: *Resided in a private room. He was sitting in his bed with his laptop on the table in front of him. He was wearing a hospital gown. *Did not usually go to the facility's activities and preferred to stay in his room. *Was a veteran of the United States armed forces. *Had worked in underground mines part-time while he was going to college. He would have to climb up and down a	F0645		

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F0645 SS = D	Continued from page 12 height of 150 feet on ladders. He sometimes had to carry dynamite up and down that ladder. *Said, “I didn’t know they [the facility] knew about that” when he was asked about his diagnosis of post-traumatic stress disorder (PTSD; a mental health condition that can develop after exposure to a traumatic event). *Stated he had a hard time knowing what could trigger him. *Has not been offered any services for his PTSD that he can remember since being in the facility. 3. Interview on 9/10/25 at 1:52 p.m. with social services designee (SSD) D revealed: *She had been in her SSD role at the facility for about a year. *She received resident 8’s PASRR from a branch of the United States Department of Veterans Affairs (VA). *She reviewed resident 8’s PASRR and agreed it was completed incorrectly. *She agreed that a Level II PASARR would have been accurate for resident 8. 4. Interview with administrator A on 9/11/25 at 5:31 p.m. revealed: *She would expect each resident’s PASRR to be completed and accurate. 5. Review of the provider’s 5/14/25 Preadmission Screening and Resident Review (PASRR) policy revealed: *”The Preadmission Screening and Resident Review (PASRR) is a federal requirement to ensure [the] nursing facility residents with serious mental illness (MI) or intellectual and developmental disability (ID/DD) are: -Identified and evaluated; -Placed in the most appropriate and least restrictive setting available; -Transitioned to an appropriate community setting when they no longer meet criteria for nursing facility placement;	F0645		

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F0645 SS = D	Continued from page 13 -Provided with the MI/ID/DD services they need, including specialized services." *"A negative Level 1 screen permits admission to proceed and ends the pre-screening process unless possible serious mental disorder or intellectual disability arises later. A positive Level 1 screen necessitates an in-depth evaluation of the individual, by the state-designated authority, known as Level II [two] PASRR, which must be conducted prior to admission to the facility". *"Failure to pre-screen residents prior to admission to the facility may result in the failure to identify residents who have or may have MD, ID, or a related condition. A record of the prescreening should be retained in the resident's medical record". *"Individuals who have or are suspected to have MD, ID, or a related condition (as indicated by a positive Level 1 screen) may not be admitted to a Medicaid-certified nursing facility unless approved based on Level II [two] PASRR evaluation and determination. Exemptions to this requirement are specified in §483.20 (k)(2) and may be exercised at the discretion of the State, as specified in the State's PASRR process".	F0645		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical	F0657	1.Resident 8 care plan was reviewed on 10/3/25 by SSD to include his trauma exposure and how to manage his trauma. Resident 31 care plan was reviewed on 10/3/25 by SSD to include her trauma exposure and how to manage her trauma. All residents at risk for failure to review and update care plan for past trauma and how to manage their needs. NHA or designee will audit residents for a history of trauma and those identified with a history of trauma were evaluated and care plan updated by 10/15/25. 2. Licensed Social Worker will provide education to the NHA, DON, BOM, UM, SSD, ADON, MDS, Dietary Manager, Human Resource, Maintenance Director, Activities Director, Central Supply, and Transport Coordinator (IDT Team) no later than 10/7/2025 on completing trauma screening and updating of care plan for residents identified with past trauma.	10/15/25

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F0657 SS = D	Continued from page 14 record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review the provider failed to review and revise the resident's care plan for two of two sampled residents' (8 and 31) care needs related to trauma exposure, and how to manage those needs according to the provider's policy. Findings include: 1. Review of resident 8's electronic medial record (EMR) revealed: *He was admitted to the facility on 4/2/24. *He had a Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated his cognition was intact. *Resident 8's diagnoses included: insomnia (trouble falling and staying asleep), alcohol abuse, major depressive disorder, anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), post-traumatic stress disorder, depression, adjustment disorder(a mental health reaction to stressful life events or changes that are considered a maladaptive response to a psychosocial stressor), and hallucinations (to see, hear, smell, taste, or touch something that is not there). 2. Observation and interview on 9/10/25 at 11:38 a.m. with resident 8 in his room revealed he: *Resided in a private room. He was sitting in his bed with his laptop on the table in front of him. He was wearing a hospital gown. *Does not usually go to the facility's activities and preferred to stay in his room.	F0657	3.The DON or Designee will audit all new admissions to ensure any past trauma and any care needs related to that trauma are included on the plan of care weekly for 3 months. Results of the audits will be discussed by the DON or designee at the monthly QAPI meeting with IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	

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F0657 SS = D	Continued from page 15 *Was a veteran of the United States armed forces. *Had worked in underground mines as while he was going to college. He would have to climb up and down a height of 150 feet on ladders. *Said, “I didn’t know they [the facility] knew about that” when he was asked about his diagnosis of post-traumatic stress disorder (PTSD; a mental health condition that can develop after exposure to a traumatic event). *Had a hard time knowing what would trigger him. *Had not been offered any services for his PTSD that he can remember since being in the facility. 3. Review of resident 8’s care plan revealed: *He had a focus area of “I am at risk for altered thought process due to history of alcohol abuse, PTSD, depression, and anxiety”. -The Interventions listed for this focus area included “Call provider for any changes in cognitive functioning and/or any changes in behavior. Give medications as ordered. Keep the environment uncluttered. Make sure the resident wears eyeglasses and hearing aids, if applicable. Offer cues, direction, and redirection as needed”. -The interventions did not include what would potentially trigger resident 8’s PTSD or what the staff could do to prevent re-triggering the resident’s trauma. -The interventions did not tell staff what kind of behaviors they would need to monitor him for. -The care plan interventions for resident 8 were not specific to what staff would need to do when he would have an altered thought process. 4. Observation and interview on 9/10/25 at 9:01 a.m. with resident 31 in her room revealed: *The room was dark with the only light source coming from the outside window. *She had multiple items situated around her on her over-the-bed tables. *She did not move her legs when she attempted to	F0657		

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F0657 SS = D	Continued from page 16 reposition herself in bed with the use of her side rails (bars attached to the bed). *She stated she used the side rails to reposition herself, but her legs sometimes got “tangled up”. *Resident 31 stated she was a veteran of the armed forces. *Since her admission to the facility, she had not spoken to a staff member about her past traumas or experiences that have been difficult for her. *She felt like she was “talked around” instead of spoken to. *She did not remember if she was offered counseling services since her admission. *Resident 31 stated she had received counseling through the VA (Veterans Affairs) but did not have a good experience. 5. Review of resident 31’s EMR revealed: *She was admitted on 11/5/24. *She had a 7/24/25 Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated her cognition was intact. *Resident 31’s diagnoses included adjustment disorder (a mental health reaction to stressful life events or changes that are considered a maladaptive response to a psychosocial stressor), borderline personality disorder (a mental disorder characterized by unstable moods, behavior, and relationships), major depressive disorder, PTSD, nightmare disorder (repeated intense nightmares), and anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). *She had a 9/2/25 physician’s orders for, “Bupropion HCL ER (XL) Tablet Extended Release 24 Hour [and anti-depressant medication]150 MG [milligrams] Give 1 tablet by mouth one time a day for depression”, and a 9/2/25 physician’s order for “DULoxetine HCL Capsule Delayed Release Particles [an anti-depressant medication] 30 MG Give 3 capsules by mouth at bedtime for depression”. *She was a veteran of the armed forces.	F0657		

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F0657 SS = D	Continued from page 17 *She was involved in a motor vehicle crash which resulted in paraplegia (paralysis that affects all or part of the trunk, legs, and pelvic organs). *She had a physician's orders for, "Bupropion HCL ER (XL) Tablet Extended Release 24 Hour [and anti-depressant medication]150 MG [milligrams] Give 1 tablet by mouth one time a day for depression", and "DULoxetine HCL Capsule Delayed Release Particles [an anti-depressant medication] 30 MG Give 3 capsules by mouth at bedtime for depression". *An 8/31/25 Summary of Episode Note by qualified mental health practitioner (QMHP) U stated, "In addition to addressing the patient's medical needs, behavioral health concerns were identified, including moderately severe depression symptoms and severe anxiety symptoms. Conducted a brief behavioral health assessment to further evaluate the patient's needs. Provided brief interventions and counseling to address immediate concerns and promote coping strategies." *A 9/5/25 progress note stated, Resident 31 "expressed experiencing hallucinations since readmission [from the hospital]. Per resident and POA [power of attorney]. Physician notified." 6. Review of resident 31's 9/10/25 care plan revealed: *She had a focus area of "I am at risk for experiencing Hallucinations [to see, hear, smell, taste or touch something that is not there]". -Interventions identified for that focus area were, "I will be provided a safe environment at all times. I will demonstrate reality-based thought process in verbal communication, and I will learn ways to refrain from responding to hallucinations." -Resident 31's care plan did not identify what types of hallucinations she experienced or how they affected her. -Resident 31's care plan did not include her potential hallucination triggers or resident-specific interventions for her hallucinations. *She had a focus area of "I receive Psychoactive medications [drugs that affect brain activities associated with mental processes and behavior] d/t [due to] Adjustment disorder, Personality Disorder, Depression, PTSD, [and] Nightmare disorder". -Interventions identified for that focus area were,	F0657		

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F0657 SS = D	Continued from page 18 "Administer the medications as ordered, Monitor behavior while on medication, Monitor for adverse or allergic reaction; Call MD [medical doctor] for any changes in condition, Monitor for ill effects related to medication, Monitor labs as ordered by MD, Verbal/Written consent for Psychotropic medication/s obtained from the resident". -Resident 31's care plan did not identify resident 31's triggers, coping mechanisms, or resident specific interventions related to her experience as a veteran and surviving a MVC which resulted in her paraplegia and how that relates to her PTSD, personality disorder, depression, nightmare disorder, and adjustment disorder. -Resident 31's care plan did not identify interventions for how her emotional and psychosocial needs were to be met to promote optimal quality of life. 7. Interview on 9/11/25 at 9:49 a.m. with certified nursing assistant (CNA) Q revealed she referred to the residents' care plans to determine the care the resident required when she cared for a new or unfamiliar resident. 8. Interview on 9/11/25 at 9:58 a.m. with licensed practical nurse (LPN) K revealed she referred to the residents' care plans to determine how they would transfer, if they had a specialized diet, if they received wound care, and their identified behaviors and what the interventions for those behaviors were. 9. Interview on 9/11/25 at 4:46 p.m. with director of nursing (DON) B revealed: *The responsibility for the updating residents' care plans was "segmented" between the interdisciplinary team of social services, nursing, activities, and dietary, and depended on the situation and the residents' current care plans. *She stated that when the Minimum Data Set (MDS) nurse was on-site at the facility, she was relied on to keep the care plans up to date. *She expected the care plans to be updated anytime there was a change in a resident's care needs. *Upon the review of the care plans for resident 8 and 31, she verified trauma-informed care (a compassionate approach to healing that addresses the root cause of mental health struggles) was not addressed within those residents' care plans.	F0657		

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F0657 SS = D	Continued from page 19 *She stated the information gathered during the trauma-informed care process should be included in the care plan because it could affect how and what cares needed to be provided for the resident. *DON B stated the triggers, behaviors, and interventions would vary between residents who have experienced trauma because their past trauma exposure may have been different. 10. Review of the provider's 9/30/24 Care Plans policy revealed: *"Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence. In doing so, the following considerations are made: -1. Each resident is an individual. The personal history, habits, likes and dislikes, life patterns and routines, and personality facets must be addressed in addition to medical/diagnosis-based care considerations." *"Data/Problems/Needs/Concerns are a culmination of resident social and medical history, assessment results and interpretation, ancillary service tracking, pattern identification, and personal information forming the foundation of the care plan." *"Interventions act as the means to meet the individual's needs. The 'recipe' for care requires active problem solving and creative thinking to attain, and clearly delineate who, what, where, when, and how the individual goals are being addressed and met. Assessment tools are used to help formulate the interventions (they are not THE intervention)." Review of the provider's 9/30/24 Mental Health Adjustment Difficulties Related to Trauma, PTSD or Other Mental Health issues policy revealed: *"To ensure appropriate treatment and services are provided to all residents with adjustment difficulties to achieve the highest practicable mental and psychosocial well-being. 'Appropriate' means based upon assessment and care plan, should be person-centered, and the facility must make attempts to provide the services or assist residents with accessing such services." *"Adjustment Difficulties:	F0657		

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F0657 SS = D	Continued from page 20 -…Are characterized by distress that is out of proportion to the severity or intensity of the stressor, taking into account external context and cultural factors, and/or a significant impairment in social, occupational, or other important areas of functioning. -May be related to a single event or involve multiple stressors and may be recurrent or continuous. -May cause a depressed mood, anxiety, and/or aggression." *"History of Trauma: -Involves psychological distress, following a traumatic or stressful event, that is often variable. -May be connected to feelings of anxiety and/or fear. -Often involves expressions of anger or aggressiveness. -Some individuals who experience trauma will develop PTSD." *"PTSD: -Involves the development of symptoms following exposure to one or more traumatic, life-threatening events. -…Symptoms may include, but are not limited to, the re-experiencing or re-living of the stressful event (e.g. flashbacks or disturbing dreams), emotional and behavioral expressions of distress (e.g. outbursts of anger, irritability, or hostility), extreme discontentment or inability to experience pleasure, as well as dissociation (e.g. detachment from reality, avoidance, or social withdrawal), hyperarousal (e.g. increased startle response or difficulty sleeping)." *"Moving from the community into a long-term care facility can be a very difficult transition and cause worsening or reemergence of symptoms for an individual with a history of trauma or PTSD." *"Assess the resident to determine if services are needed." *"[The resident's] Care Plan should address the individualized emotional and psychosocial needs of the resident."	F0657		

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F0657 SS = D	Continued from page 21 *"Staff must consistently implement the care approaches identified in the Care Plan. [The resident's] Care Plan must be reviewed and revised if interventions are not effective or [the] resident has had a change in condition."	F0657		
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure quality care by not promptly implementing physician-ordered treatments for one of one sampled resident (69) with a physician-ordered negative pressure wound (NPWT) and antibiotic medication treatment. Findings include: 1. Review of resident 69's electronic medical record (EMR) revealed: *Her admission date was 3/25/25. *Her 3/31/25, 7/1/25, and 7/29/25 Brief Interview of Mental Status assessment scores were a 15, which indicated her cognition was intact. *She was hospitalized from 7/15/25 through 7/23/25 and again from 8/7/25 through 8/22/25. *Hospice (a program for terminally ill individuals that focuses on comfort and symptom management) care was initiated on 8/23/25. *She passed away at the facility on 8/24/25. *Her 3/25/25 admission diagnoses included hemiplegia and hemiparesis (partial paralysis affecting one side of the body) following cerebral infarction (brain	F0684	1.No corrective action can be taken for resident 69 due to her death on 8/24/25. All residents on negative pressure wound therapy (NPWT) and antibiotics are at risk for not promptly implementing treatment orders. ADON audited all residents with NPWT to ensure it is in place as ordered and if any delay occurred it was reported to provider on10/3/25. The ADON audited all residents with antibiotics in the last 30 days to ensure antibiotics were given as ordered, and if any discrepancies, reported to provider for further direction on10/3/25. 2.Administrator, DON, and in collaboration ADON/Wound Nurse, Unit Manager, Regional Nurse Consultant, and Dietary Manager with the medical director reviewed the Skin and Pressure Injury Prevention Program and Following Physician Order Policy. The education includes information on conducting assessments for potential skin concerns other than pressure injury, implementing identified approaches to alleviate risk, monitoring and re-assessing; when, if a skin care issue arises, implementing and following physician orders for care with ongoing monitoring and re-assessing. The DON or designee will educate all nurses on Following Physician Orders policy. The education will include what to do if a NPWT is not available, how to obtain a NPWT device, how to place a NPWT device, and to ensure medications are given as prescribed.	10/15/25

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F0684 SS = G	Continued from page 22 tissue death caused by a severe and prolonged lack of blood flow) affecting her left non-dominant side, muscle wasting (the loss of muscle tissue), and atrophy (loss of muscle mass), acute respiratory failure with hypoxia (a serious medical condition where the lungs are unable to adequately exchange oxygen and carbon dioxide, leading to low levels of oxygen in the blood), transient ischemic attack (stroke), cerebral infarction without residual deficits (no lasting impacts), other malaise (a general feeling of discomfort, uneasiness, or lack of well-being), lymphedema (swelling, typically in the arms or legs caused by lymphatic system blockage), neuropathy (a condition that damages nerve function), obstructive sleep apnea (repeated episodes of partial or complete airway collapse during sleep, causing breathing to stop or decrease significantly), peripheral vascular disease (a slow and progressive circulation disorder of narrowing or blocked arteries and veins), chronic kidney disease, (a condition in which the kidneys gradually lose their ability to filter waste products and excess fluid from the blood), type 2 diabetes mellitus (a condition involving disruptions in how the body regulates blood sugar) with hyperglycemia (low blood sugar level), hypothyroidism (the thyroid gland does not produce enough thyroid hormone, which is essential for regulating many bodily functions), morbid (severe) obesity (excessive weight that significantly impacts health and well-being) due to excess calories. *Diagnoses added after her admission included: -On 4/8/25 a venous ulcer of her right lower leg and varicose veins. -On 5/23/25 venous insufficiency (a condition where the veins in the legs do not function properly, leading to poor blood flow back to the heart). -On 7/1/25 a non-pressure chronic ulcer (skin injury) of her left calf with unspecified severity. -On 7/23/25 restless leg syndrome (a common sleep disorder characterized by an irresistible urge to move the legs, often accompanied by uncomfortable sensations such as tingling, crawling, or pulling), and necrosis of muscle (muscle tissue death). *Her 3/25/25 Braden Scale (a tool used to assess the risk of developing pressure ulcers) score was eleven, which indicated she was at high risk for the development of pressure ulcers (skin wounds caused by prolonged pressure).	F0684	The DON or designee will educate all staff on positioning and use of devices that may contribute to injury and their role and responsibilities with the skin and wound program. Education will occur no later than October 15, 2025. Those not at the education session will be educated prior to their first shift worked. The DON or designee will complete competencies of all nurses for negative pressure wound therapy and medication administration on IV antibiotic medication therapy no later than 10/15/25. Those not able to attend the competency session will complete the competency prior to their first shift worked. 3.The DON or designee will review all residents with orders for NPWT weekly to ensure orders are in place, NPWT machine is in facility and placed on resident, and care plan is updated. The DON or designee will audit all residents with newly prescribed antibiotics weekly to ensure the medication is received and provided timely. The audits will be weekly for 12 weeks. Results of the audits will be discussed by the DON or designee at the monthly QAPI meeting with IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on findings.	

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F0684 SS = G	Continued from page 23 Resident 69's 3/25/25 nursing admission assessment indicated: *Her "ability to walk [was] severely limited or non-existant [non-existent]. [She] Cannot bear [her] own weight and/or must be assisted into [a] chair or wheelchair." *[Her mobility was] "Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently." *[She required] "moderate to maximum [staff] assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction". Resident 69's nurse progress notes indicated: *On 3/25/25, she was admitted to the facility. Her left leg was "very weak". She had non-pitting edema [observable swelling of body tissues caused by an accumulation of excess fluid] in her bilateral (both) lower legs. There was an "open area" to the calf of her right leg. *On 3/31/25, a note that included she required total assistance from a staff member for her oral hygiene, toileting, dressing, bed mobility, transfers, and personal hygiene. She was always incontinent (involuntary urine or bowel leakage) of her bladder and bowels. She had a skin treatment on her "posterior [back] right leg ". Resident 69's 5/7/25 monthly nursing summary indicated the area to document if she had edema was marked "Yes" and "BLE" (bilateral lower extremity). There were no other monthly nursing summaries documented in her EMR. A 5/20/25 nurse progress note included, "During weekly wound assessment, states has a scratch to left leg. Upon assessment, open area, measuring 3.8cm [centimeter] x [by] 2.3cm. Depth unknow d/t [due to] slough [dead tissue]. Foul odor noted. Scant serosanguineous [wound drainage that is a mixture of clear, watery fluid and blood] drainage noted. Has left sided weakness. Uses sit stand lift [a mechanical lift used to assist from a seated to a standing position]	F0684		

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F0684 SS = G	Continued from page 24 with leg strap. Open area located where sit stand lift leg strap lays against skin. [The resident] States "I was told it was a scratch, but my wheelchair is too small for me and my leg rubs against it. They ordered me a new wheelchair, but it's not here yet". Area noted to be in [the] same location on leg where [the] sit stand lift leg strap lays against [the resident's]skin during transfers. Cleansed with NS [normal saline], pat dry, covered with border foam dressing". Review of physical therapy and occupational therapy documentation from 4/16/25 through 7/15/25 did not indicate that resident 69's wheelchair was too small or that a different-sized wheelchair was obtained for the resident. Resident 69's nurse Wound Summary notes regarding her "left lateral calf" indicated: *On 5/20/25, the wound was unstageable, had light-serous drainage, infection was present, and the measured size was 3.80 cm by 2.30 cm, and the depth was unknown. *On 5/27/25, the "clinical stage" of resident 69's wound was documented as "Full Thickness" with light-serosanguineous exudate, infection was present, and the size was 5.40 cm by 3.00 cm, and the depth was unknown. *On 6/17/25, the wound was full thickness with moderate Serosanguineous, infection was present, and the size was 6.40 cm by 4.50 cm by 0.90 cm. *On 7/8/25, the wound was full thickness with moderate Serosanguineous exudate, infection indicated as not present, and the size was 6.90 cm by 3.8 cm with a depth of 1.20 cm. *On 7/15/25, the wound was full thickness, with moderate Serosanguineous exudate, with no infection present, and the size was 6.90 cm by 3.80 cm with a depth of 1.20 cm. On 5/27/25 a nurse progress note included, "Left lateral calf [wound] measures 5.4cm x 3cm, depth unknown." On 6/3/25 a nurse progress note included, "Left lateral calf [wound] noted with moderate serosanguineous	F0684		

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F0684 SS = G	Continued from page 25 drainage, no odor noted, Measures 6cm by 3 cm, depth unknown." On 6/10/25 a nurse progress note included, "Left lat [lateral] calf [wound] measures 5.5cm x 3.5 cm, depth unknown. Foul odor noted. Light serosanguineous drainage noted. DON/RN, MD [medical doctor], RP [representative] aware." Resident 69's hospital wound care team consultation report indicated: -On 7/16/25, after resident 69's admission to emergency room (ER), "Patient does have a chronic leg wound", "Over the past couple days worsening wound with malodorous [an unpleasant or offensive odor]." "Patient received IV [intravenous] vancomycin [antibiotic] and Zosyn [antibiotic] in the ER along with 1 L [liter] LR [Lactated Ringer's solution, a balanced electrolyte replacement] bolus. Exam concerning for left leg 10 [cm] x 6 cm ulcerating wound lateral [side] calf with purulent [containing or producing pus] malodorous drainage. General surgery was consulted and patient was taken to the OR [operating room] for washout [of the wound] directly from the ER." --"NPWT [a treatment that uses suction to remove fluid and debris from wounds to promote healing] placed", and the treatment plan included the NPWT to be at 125 mmHg (millimeters of mercury, a unit of pressure] continuous suction, and to change the NPWT dressing three times each week. --Wound measurement after the surgical procedure was 15 cm by 6 cm with a depth of 3.5 cm. The treatment included a NPWT to her left anterior [near the front], lower leg. Review of resident 69's 7/23/25 physician hospital discharge orders for resident 69's admission to the provider's facility revealed: *New diagnoses on 7/15/25 of obesity, and open leg wound, left, initial encounter, on 7/17/25 Myofasciitis [painful muscle and connective tissue inflammation), and on 7/22/25 of Necrotizing soft tissue infection (serious infection that destroys tissue under the skin). *An order for cefazolin (antibiotic) 2000 mg/20 mL (mg per milliliter) intravenous (IV) push (delivering the drug through an IV line in a small, concentrated amount	F0684		

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F0684 SS = G	Continued from page 26 over a short period) syringe for “Necrotizing soft tissue infection”, which had an order change handwritten on the form that indicated “2000mg in 100 mL NS IVPB [intravenous piggyback]” (delivers medications at set intervals without interrupting the main IV fluid line) per verbal order of resident 69’s physician. The discharge form was noted by a nurse on 7/23/25. -The area for information regarding where to get the cefazolin antibiotic IV push syringe was listed as “not yet available”. *Wound care instructions treatment plan for her left leg included: -“Cleanse with Microcyn [wound cleanser] or NS -Picture frame peri wound with skin prep and drape -Contact layer to exposed tendon/muscle -Black foam to wound bed -125 mmHg low continuous suction [NPWT]”. -“Change NPWT dressing three times each week”. -“Follow up with the wound care outpatient clinic on discharge.” --Resident 69’s NPWT was placed on her left lower leg on 7/29/25 *Resident 69’s first dose of the antibiotic, cefazolin, was administered on 7/24/25. -“Patient is preparing to discharge to [provider]. Wound vac dressing to right leg removed and wet-to-dry packing placed for transportation. [Provider] will need to place their own wound vac upon admission to their facility.” -She had a surgical wound on her left lower leg, which was described as “Full thickness”, had “Serosanguineous” drainage, “no odor”, “well defined edges”, and her “muscle and tendon remain[ed] exposed”. -She had a wound to her right calf, that had a scant amount of Serosanguineous drainage, and well-defined edges. A 7/23/25 nurse progress note included, “resident	F0684		

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F0684 SS = G	Continued from page 27 returned to facility early pm [evening] … dressing intact on left lower posterior leg". *A 7/23/25 nurse progress note at 10:35 p.m. included, "The resident has an order for cefazolin 2000 MG in 20 mL IV push. Order not sent to pharmacy. called [pharmacy] for clarification and request for medication stat [without delay] delivery. Pharmacy unable to provide ordered dose. Called [resident's primary physician] V.O [verbal order] given to change from IV push to IVPB per pharmacy's recommendation. Initial dose pulled from e-kit [emergency kit]. Medication expected to be delivered stat in AM." -That initial dose from the e-kit was given at midnight. A 7/25/25 nurse progress note included, "Waiting for wound vac to get to the facility, wet to dry dressings done until wound vac placed". A 7/25/25 nurse progress note included the dressing to her left lower leg was in place. On 7/25/25, a physician order for cefazolin Sodium Intravenous Solution Reconstituted – use 2000 mg intravenously every 8 hours for necrotizing soft tissue infection for 19 days 2 g in 100 mL NS over 30 minutes. On 7/27/25, resident 69's administration documentation for her physician order of metronidazole (antibiotic) 500 mg twice a day for necrotizing soft tissue infection was listed as NN (see nurses' notes). A 7/27/25 nurse progress note included: "reached out to provider regarding herbeing [her being] out of b complex-c-folic acid and metronidazole 500 mg … tried calling pharmacy at 20:50 [8:50 p.m.] stayed on hold and finally left [a] message for a call back." A 7/28/25 registered dietitian note included: *"Braden score 16 at r4isk; L[left]-lateral calf vascular venous stasis wound and R[right]-lower leg back vascular venous stasis wound; noted edema is 4+ [very deep indentation when pressed] LLE [left lower extremity] especially calf, 3-4+ [deep to very deep	F0684		

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F0684 SS = G	Continued from page 28 indentation when pressed] RLE [right lower extremity]." -"Weight History -7/23/25 273.4# [pounds] (Current wt [weight]) -7/10/25 266.2# (2.63% wt gain) -7/2/25 262.6# (3.95% wt gain) -6/4/25 238.8# (12.66% wt gain – significant) -4/16/25 239.6# (12.36% wt gain – significant) -3/25/25 250# (8.56% wt gain – admit wt) -"resident readmit to facility s/p [status post] hospitalization from 7/15/25-7/23/25 for Left leg necrotizing [dying tissue] wound status post extensive operative debridement 7/15/25." A 7/28/25 nurse progress note included that the resident requested to switch to a different primary medical provider, and the resident was switched to a new provider. A 7/29/25 nurse progress note included "Weekly wound assessment completed by this nurse. Wound vac in place at this time." A 7/29/25 nurse wound summary included the wound was full thickness, with moderate Serosanguineous exudate, with no infection present, and the size was 6.90 cm by 3.80 cm with a depth of 1.20 cm. An 8/5/25 nurse wound summary note included, the wound was full thickness, with moderate Serosanguineous exudate, with no infection present, and the size was 15.50 cm by 7.00 cm with a depth of 3.30 cm. *There were no documented measurements, after 8/5/25, of resident 69's left lower leg in her nurse wound summary notes. Resident 69's August 2025 medication administration record (MAR) included that a physician ordered treatment to her left leg to change the NPWT dressing three times each week was marked as NN on 8/2/25 and	F0684		

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F0684 SS = G	Continued from page 29 was not documented as completed on 8/5/25. An 8/5/25 nurse progress note included “Weekly wound assessment completed by this nurse. Wounds remain stable. Wound vac in place and functioning.” Resident 69 was sent to the emergency room on 8/7/25 for a change in condition and returned to the facility on 8/22/25. Resident 69’s 8/22/25 hospital discharge summary included: *Diagnoses of: septic shock, recent necrotizing fasciitis, cardiac arrest due to acute hypoxic respiratory failure due to aspiration with successful resuscitation, aspiration pneumonia. An 8/23/25 hospice order included that resident 69 was admitted to hospice care services with a “terminal diagnosis” of “Septic Shock”. An 8/24/25 hospice nurse progress note included “Resident passed away at 0755 [7:55 a.m.] this morning.” 2. Interview on 9/11/25 at 9:25 a.m. and 9:59 a.m. with director of rehab (rehabilitation) I regarding resident 69 revealed: *Regarding resident 69’s left leg wound, they had attempted to determine if it was caused by her wheelchair or her use of a sit-to-stand (STS) mechanical lift strap (a strap that goes across the lower calf area to assist in maintaining proper positioning of the person on the STS lift). *They assessed the STS lift strap to determine if it was digging into her calf or if it was from where the foot pedal was attached to her wheelchair. *She did not personally remember any interventions but said she would print all therapy notes for resident 69. *She reviewed resident 69’s therapy notes, and reported that therapy had determined that the wheelchair was not the issue that caused the wound on her left leg.	F0684		

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F0684 SS = G	Continued from page 30 *They had determined it was either restless leg syndrome, as her legs rotated outward when she was in bed, or the wound was caused by the STS lift, they were unable to determine the cause. *Therapy did not participate in the residents' wound care. -The facility provided residents' wound care. Interview on 9/11/25 at 2:31 p.m. with infection preventionist (IP)/wound care nurse (WCN) C regarding resident 69 and wound care revealed: *She had been employed at the facility since 6/30/25, and was an IP/WCN for the facility. *She completed wound care rounds on Tuesdays. -She documented wound care in a "wound summary" or in the resident's progress notes. -Her process was to measure the wound and document that information in the "wound rounds" (summary). -She had not documented the resident's wound care in the resident's TAR, but she was able to. *She expected that if a resident refused a dressing change or repositioning, it would be documented as a refusal in the resident's TAR or progress notes. *She verified resident 69's left lower leg wound was vascular, and she thought it had started as a scratch. *Resident 69's primary physician had completed rounds (checking on residents' status and assistance needs) and wound care on Tuesday of each week. -He had completed resident 69's wound care on those days prior to her hospitalization on 7/15/25. *Resident 69's significant weight gain would have been a "huge concern", her legs would have needed to be elevated, and the edema would have needed to be decreased. *Resident 69's NPWT was to be placed on her lower left leg, after she returned from the hospital on 7/23/25. The NPWT was ordered on 7/24/25 and was received and placed on 7/29/25. *She confirmed resident 69 was without her	F0684		

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F0684 SS = G	Continued from page 31 physician-ordered NPWT from 7/23/25 until 7/29/25, a total of six days. -She confirmed an acceptable amount of time would be 24 hours for a physician-ordered NPWT to be placed on a wound. *She thought the physician was notified that the NPWT was not placed for those days. -She stated resident 69's primary physician was present when the NPWT was put into place on 7/29/25. *Resident 69 had necrosis of muscle (death of muscle tissue). *She was not aware that resident 69's wheelchair was too small for her. -She started working at the facility on 6/30/25 and felt resident 69's wheelchair had been the appropriate size for her at that time. *Regarding CNA documentation for skin alteration, she indicated that when a resident had a skin alteration, the staff member would document Yes instead of No. *Resident 69's surgical wound on her lower left leg was cut open and drained of 4 cm of fluid and infection. *She stated the physician ordered IV medication was started "right away". *Resident 69 had not refused care from IP/WCN C. *No staff member had notified IP/WCN C of resident 69 refusing her care. Interview on 9/11/25 at 5:08 p.m. with regional nurse consultant (RNC) L revealed: *She was not familiar with resident 69's physician's order for a NPWT, as she had no direct patient care with her. *Resident 69's IV Push order was changed as the provider had no documented competencies for all of the contracted travel/agency staff LPNs for IV Push administration. The provider would only "provide medications [to residents] that everyone can provide". *The provider had no policy regarding the use of a NPWT "wound vac" for residents who had a physician order for	F0684		

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F0684 SS = G	Continued from page 32 placement of one. -The provider completed an NPWT competency with “all nurses”. *The provider hired an outside entity to conduct competency training for all nurses for IV push medications. Interview and review of resident 69’s nurse progress notes on 9/11/25 at 5:25 p.m. and at 5:30 p.m. with IP/WCN C and RNC L revealed: *There were “wet to dry orders [for resident 69’s left lower leg wound] until the wound vac [NPWT] arrived on 7/29/25”. *IP/WCN confirmed she had documented in resident 69’s EMR on 7/25/25 that her left lower leg NPWT was in place and that resident 69 did not have a NPWT on her lower left leg until 7/29/25. -She was unsure why she had documented the NPWT was in place, as it had not been delivered to the provider until 7/29/25. Interview on 9/11/25 at 5:53 p.m. with IP/WCN C revealed: *Resident 69’s nurse wound summary measurements from 7/29/25 were documented by herself and those measurements were “wrong”. *She stated the measurements documented on 8/5/25 were the actual measurements that should have been recorded on 7/29/25. -She “knew it was wrong” due to the surgical intervention to the wound prior to 7/29/25. 3. Review of the provider’s 8/21 IV Push Medication Administration policy revealed: *”Purpose -To safely administer small volume IV bolus medications.” *”Procedure -“Consult with IV pharmacist as needed.”	F0684		

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F0684 SS = G	Continued from page 33 -"Verify medication order." The provider indicated there was no NPWT policy. Review of the provider's 3/13 Training and Knowledge Checklist for V.A.C. Therapy Systems revealed: *"Assess wound dimensions, pathology, presence of undermining or tunnels, need for debridement or need for non-adherent layer to protect blood vessels/organs/nerves and measure wound". *Ensure therapy is maintained 22 out of 24 hours. Access therapy history if available.	F0684		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review the provider failed to identify and implement pressure ulcer (skin and/or underlying tissue injury due to prolonged pressure) preventative interventions for residents identified at risk for developing pressure ulcers for: *One of one sampled resident (31) who developed a pressure ulcer to her right heel, left upper buttocks, and left foot. *One of one sampled resident (11) who developed a	F0686	1.Resident 31 had a skin check by ADON/ Wound Nurse on 9/30/25. Resident 11 had a skin check by ADON/Wound Nurse on 10/02/25. Residents 31 and 11 had a Braden scale completed on 10/6/25 by ADON/ Wound Nurse. ADON/Wound Nurse reviewed resident 11 care plan, including an order reivew and no changes required on 10/7/25. ADON/wound nurse reviewed resident 31 care plan, including an order review on 10/7/25 and updated her focus, and resolved interventions. All residents are at risk for failure to implement pressure injury preventative interventions. All residents will receive a skin evaluation audit by nurse leadership or designee no later than 10/15/25. All residents will have a Braden scale and clinical evaluation completed by DON or designee by 10/15/25. DON or designee will review all residents with wounds for the following by 10/15/25: MARs and TARs for any missing documentation in last 30 days. All residents identified at risk on Braden scale or with current skin impairment will have their physician orders and care plan reviewed and updated as needed by DON or designee for preventative interventions by 10/15/25.	10/15/25

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F0686 SS = G	Continued from page 34 pressure ulcer to his left lower and left upper buttocks. Findings include: 1. Observation and interview on 9/9/25 at 9:22 a.m. with resident 31 in her room revealed: *There was a sign on resident 31's door that indicated she was on enhanced barrier precautions (personal protective equipment, such as gloves and a gown was to be worn with all close contact resident care) (EBP). *She had an air mattress on her bed. *She was lying in bed on her left side. *She had two Prevalon boots (a cushioned boot that floats the heel off the surface of the mattress, to help reduce pressure) on the counter in her room. *Her feet were not elevated off the mattress with the use of pillows or other devices. *She had foam dressings on both of her feet. *When she was admitted to the facility, she had an "abrasion" on her buttocks that worsened until a wound vac (a medical device used to promote wound healing by applying negative pressure) was used for wound treatment. *She no longer had a wound vac because it became dislodged frequently. *She was able to reposition herself somewhat in bed with the use of her side rails (bar/bars attached to the bed) but often required assistance from staff for complete repositioning. *She stated she often waits a long time for staff to answer her call light when she needed assistance with repositioning. Observation and interview on 9/10/25 at 8:40 a.m. with resident 31 in her room revealed: *She was lying in bed on her left side. *The Prevalon boots were in the same location on her counter as they were on 9/9/25. *Her feet were not elevated off the mattress with the use of pillows or other devices.	F0686	2. Administrator, DON, ADON/Wound Nurse, Unit Manager, Regional Nurse Consultant, and Dietary Manager in collaboration with the medical director reviewed the Skin and Pressure Injury Prevention Program. It included information on conducting assessments for potential pressure injury, implementing identified approaches to alleviate risk, monitoring, and re-assessing; when, if a pressure injury arises, implementing and following established standards of care with ongoing monitoring and re-assessment. The DON or designee will educate all staff on their roles and responsibilities on the Skin and Pressure Injury Prevention Policy, this will include how to prevent pressure ulcers, what pressure caused by including positioning and devices, how each staff member plays a role in pressure ulcer prevention, and how to report changes in a resident to a nurse. The DON or designee will educate all licensed nurses on common skin injuries, prevention of pressure ulcers, standing wound orders in the facility, how to obtain wound orders, and ensuring treatment orders are in place and followed for all residents, and accurate/complete documentation of skin evaluations. Education will occur no later than October 15, 2025. Those not at the education session will be educated prior to their first shift worked. All licensed nurses completed a competency for skin assessment and accurate documentation for implementation of identified approaches for identified risks or identified injury no later the 10/15/25. Those not able to attend the competency session will complete the competency prior to their first shift worked.	

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F0686 SS = G	Continued from page 35 *She thought her Prevalon boots were missing a part and that was why staff did not put them on her. *There was a gel cushion in her wheelchair. *Resident 31 stated she did not get out of bed as often as she would like to and felt that was due to the staff being busy. *She had difficulty moving her legs when she was in bed because they often got “tangled up”. Review of resident 31’s electronic medical record (EMR) revealed: *She was admitted on 11/5/24. *She had a 7/24/25 Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated her cognition was intact. *She was involved in a motor vehicle crash which resulted in paraplegia (paralysis that affects all or part of the trunk, legs, and pelvic organs). *She was admitted with pressure ulcers on her left foot and right sacrum (the base of the spine that forms the back wall of the pelvis). *She had pressure ulcers on her right heel, and left buttock area that developed after she was admitted to the facility on 11/5/24. *Resident 31’s 11/5/24 Braden Scale (a tool used to assess the risk of developing pressure ulcers) assessment score was 7, which indicated she was at high risk for developing a pressure ulcer. *The pressure ulcer to her right heel was identified on 12/25/24 as a deep tissue pressure injury (a localized area of tissue damage that occurs when prolonged pressure or shear forces damage the skin and underlying soft tissues) that measured 1.4 centimeters (cm)in length by 1.5 cm in width. *The pressure ulcer to her left buttock area was identified on 1/21/25 as a stage III (3; open wound with full-thickness skin loss. Fatty tissue may be visible) pressure ulcer that measured 4.4 cm in length by 4.5 cm in width by 0.1cm in depth. -On 7/22/25 the pressure ulcer was documented as a stage IV (4; open wound with full-thickness skin and	F0686	3.The DON or designee will audit 5 residents skin evaluations weekly for any new pressure injury issues. The DON or designee will audit 5 residents with identified skin issues to ensure prevention interventions in place, orders are being followed and documented as indicated in the MAR/TAR, refusals documented, and care plan is current for care being provided, including any resident refusals. The audits will be weekly for 4 weeks then monthly for 2 months. Results of the audits will be discussed by the DON or designee at the monthly QAPI meeting with IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on findings.	

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F0686 SS = G	Continued from page 36 tissue loss. Bone, tendon, or muscle may be visible) pressure ulcer that measured 2.7 cm in width by 3.4 cm in length by 0.6cm in depth. *Review of resident 31's 11/5/25 baseline care plan revealed, a focus area of, "I am at risk for impairment to skin integrity r/t [related to] impaired mobility and paraplegia -open wound to". -Resident-specific interventions for that focus area were, "Air mattress to bed and w/c [wheelchair] cushion in place" and "HIGH RISK- skin check every shift. Report abnormalities to the nurse." *Review of resident 31's 9/10/25 care plan revealed a focus area of, "I am at risk for impairment to skin integrity r/t impaired mobility and paraplegia -open wound to left medial dorsal [inner top of the] foot -left upper buttocks stage 3 -unstageable to the sacrum -SDTI [suspected deep tissue injury] right plantar aspect [bottom of foot] -SDTI right posterior heel". -Interventions identified related to that focus area in addition to the baseline care plan interventions were: --On 1/7/25 "left foot and ankle, two layer wrap in place". --On 1/21/25 "I will often refuse to offload [reposition to relieve pressure] and my wound care". --On 3/4/25 "Turn and reposition q [every] 2hrs [two hours] per my request -I often refused repositioning when offered -I often request a pillow placed under one side or the other, which doesn't fully offload me." --There were no identified approaches or interventions identified if resident 31 refused repositioning, offloading, or wound care. --On 5/6/25 "Double protein for wound healing". Review of resident 31's February 2025 treatment administration record (TAR) revealed: *Wound care to resident 31's right heel was not documented as completed on 2/24/25. *There were no documented resident refusals of the "Prevalon boot to right foot to offload every, shift" or "Offload completely while in bed. Offload sacrum and bilateral feet". -Those were not documented as completed on the evening	F0686		

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F0686 SS = G	Continued from page 37 shift on 2/22/25. *There were no resident refusals documented for, “Reposition every two hours to off load”. -That was not documented as completed on 2/11/25 at 12:00 p.m. and 2:00 p.m., on 2/20/25 at 2:00 a.m. and 4:00 a.m., on 2/22/25 at 8:00 p.m. and 10:00 p.m., on 2/23/25 at midnight, 2:00 a.m., and 4:00 a.m., and on 2/24/25 at 4:00 p.m. Review of resident 31’s April 2025 TAR revealed: *There was no documentation that wound care was completed on resident 31’s right heel on the 4/7/25 and 4/29/25 day shift and the evening shifts of 4/8/25, 4/12/25, 4/13/25, 4/16/25, and 4/17/25. Review of resident 31’s July 2025 TAR revealed: *There were no documented resident refusals of “Reposition every 2 hours to offload”. -That was not documented as having been completed on 7/19/25 at 8:00 p.m. and 10:00 p.m., and on 7/20/25 at 4:00 a.m. and 4:00 p.m. 2. Observation and interview on 9/10/25 at 9:24 a.m. with resident 11 in his room revealed: *There was a sign on resident 11’s door that indicated he was on EBP. *Resident 11 was sitting in his wheelchair. *He had a cushion in his wheelchair. *He had a stroke, and he was unable to move his left leg without pulling on his pant leg with his right arm. *Resident 11 stated he spent the majority of the day in his wheelchair and only laid down after lunch, so he could take the pressure off his wounds on his buttocks. *He used the side rails to reposition himself in bed. *He had two wounds near the middle of his buttocks that staff had been telling him were improving. *He did not have an air mattress on his bed. *Resident 11 stated he previously had an air mattress, but it would leak air and he would be lying on the	F0686		

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F0686 SS = G	Continued from page 38 springs of the bed. Review of resident 11's EMR revealed: *He was admitted on 3/4/25. *His diagnoses included hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) following a nontraumatic intracerebral hemorrhage (a brain bleed) affecting his left non-dominant side and a pressure ulcer of the sacral region. *He had a 7/11/25 BIMS assessment score of 15, which indicted his cognition was intact. *His 3/4/25 admission assessment stated he had no skin alterations, such as a pressure ulcer. *Resident 11's 3/4/25 Braden scale assessment score was 6, which indicated he was at high risk for developing a pressure ulcer. *He had a 4/30/25 physician's order to, "avoid prolonged sitting, shift weight every 20-30 [20 to 30] minutes when sitting", and a 5/19/25 physician's order to, "Avoid prolonged sitting. Reposition every 15-20 [15 to 20] minutes" and "Strict offloading by bedrest with HOB [head of bed] lower than 30 degrees with use of pillows. Up for meals only with one hour per meal." *Review of resident 11's 9/10/25 care plan revealed he had a focus area of, "I have the potential for impairment to skin integrity r/t impaired mobility that was initiated on 3/5/25 and revised on 8/1/25. -Stage 3 pressure ulcer to left buttock- resolved, -stage 4 [pressure ulcer] to left upper buttock". -3/5/25 interventions for that focus area were, "Apply wound treatment as ordered by the physician", "Assess for pain and administer pain medication as ordered, observe feedback and notify MD [medical doctor] as necessary", "Encourage good nutrition and hydration in order to promote healthier skin", Keep skin clean and dry. Use lotion on dry skin", "LOW RISK- Skin weekly. Report abnormalities to the nurse", "Monitor/document locations, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc to MD", "Off load heels", and "Turn and reposition frequently". -Interventions for that focus area that had been added or changed since 3/5/25 were, "Immersus [Brand of a pressure redistribution mattress] mattress trial" on	F0686		

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F0686 SS = G	Continued from page 39 6/17/25, and “wound healing supplement as ordered” on 7/14/25. *Review of resident 11’s wound care summary for the pressure ulcer on his left upper buttocks revealed: -That pressure ulcer was identified on 3/15/25. -On 3/18/25 it was documented as “Superficial” and measured 2 cm in length by 2.5 cm in width by 0.1 cm in depth. -It was documented as unstageable (wound bed not visible due to covering such as debris, dead tissue, scabbing, or a non-removeable dressing) from 4/8/25 through 6/24/25. -On 7/1/25 the pressure ulcer was documented as a stage IV and measured 2 cm by 2 cm with an “unknown” depth. -On 9/9/25 the left upper buttocks pressure ulcer measured 0.4 cm by 0.3 cm by 0.2 cm. *Review of resident 11’s wound care summary reguarding the pressure ulcer on his left lower buttocks revealed: -That pressure ulcer was identified on 3/15/25. -On 3/18/25 it was documented as a stage 3 pressure ulcer that measured 4.2 cm by 2.3 cm with an “Unknown” depth. -On 7/15/25 the pressure ulcer on resident 11’s left lower buttocks was documented as healed. Review of resident 11’s March 2025 TAR revealed: *The wound care to resident 11’s left upper buttocks was not documented as having been completed on 3/22/25. Review of resident 11’s April 2025 TAR revealed: *“avoid prolonged sitting, shift weight every 20-30 minutes when sitting” was not documented as completed for the evening shifts on 4/12/25, 4/13/25, and 4/17/25. *“reposition every two hours when in bed every shift” was not documented as completed for the evening shift on 4/8/25, 4/12/25, 4/13/25, and 4/17/25. *“Offload left buttocks to aid in wound healing” was not documented as completed for the day shift on 4/22/25, and the evening shift on 4/8/25, 4/12/25,	F0686		

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F0686 SS = G	Continued from page 40 4/13/25, and 4/17/25. Review of resident 11's May TAR revealed: *"avoid prolonged sitting, shift weight every 20-30 minutes when sitting" was not documented as having been completed for the day shift on 5/17/25 and the evening shift on 5/28/25. *"reposition every two hours when in bed every shift" was not documented as having been completed for the day shift on 5/17/25 and the evening shift on 5/28/25. *"Offload left buttocks to aid in wound healing" was not documented as completed for the day shift on 5/17/25, and the evening shift on 5/28/25. Review of resident 11's June 2025 TAR revealed: *The wound care for resident 11's left lower buttocks or left upper buttocks wounds were not documented as completed on 6/26/25. *"avoid prolonged sitting, shift weight every 20-30 minutes when sitting" was not documented as completed for the day shift on the evening shift on 6/26/25. *"Avoid prolonged sitting. Reposition every 15-20 minutes" was not documented as completed on the evening shift on 6/26/25. *"reposition every two hours when in bed every shift" was not documented as completed for the evening shift on 6/26/25. *"Strict offloading by bedrest with HOB lower than 30 degrees with use of pillows. Up for meals only with one hour per meal" was not documented as completed on the evening of 6/26/25. Review of resident 11's July 2025 TAR revealed: *Wound care for resident 11's pressure ulcer on his left lower buttocks was not documented as completed on 7/7/25. *Wound care for resident 11's pressure ulcer on his left upper buttocks was not documented as completed on 7/7/25 and 7/24/25. *"Avoid prolonged sitting. Reposition every 15-20 minutes" was not documented as completed on the day shift on 7/7/25 and the evening shift on 7/30/25 and 7/31/25.	F0686		

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F0686 SS = G	Continued from page 41 *"Strict offloading by bedrest with HOB lower than 30 degrees with use of pillows. Up for meals only with one hour per meal" was not documented as completed on the day shift on 7/7/25 and the evening shift on 7/30/25 and 7/31/25. *"reposition every two hours when in bed every shift" was not documented as completed for the day shift on 7/7/25 and the evening shift on 7/30/25 and 7/31/25. Review of resident 11's August 2025 TAR revealed: *"Avoid prolonged sitting. Reposition every 15-20 minutes" was not documented as completed for the evening shift on 8/5/25, 8/9/25, 8/15/25, and 8/25/25. *"reposition every two hours when in bed every shift" was not documented as completed for the evening shift on 8/5/25, 8/9/25, 8/15/25, and 8/25/25. *"Strict offloading by bedrest with HOB lower than 30 degrees with use of pillows. Up for meals only with one hour per meal" was not documented as completed on the evening shift on 8/5/25, 8/9/25, 8/15/25, and 8/25/25. 3. Interview on 9/11/25 at 9:49 a.m. with certified nursing assistant (CNA) Q revealed: *The staff were to offer repositioning to resident 31 every two hours, but she often refused. *Resident 31 would let staff know when she wanted to be repositioned. *Resident 31 often refused to wear her Prevalon boots but would allow staff to float her heels off her mattress with pillows. *She usually only got up into her wheelchair for appointments, about one to two times per week. *Staff would chart in the resident's EMR if the resident refused repositioning or the use of items such as resident 31's Prevalon boots as a refusal of care under behaviors, but that did not be specify the care area that was refused. *Resident 11 would let staff know if he was uncomfortable in his chair and needed to be repositioned. *Resident 11 would get out of his wheelchair three to four times per day.	F0686		

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F0686 SS = G	Continued from page 42 4. Interview on 9/11/25 at 9:58 a.m. with licensed practical nurse (LPN) K revealed: *Resident 31 was difficult to reposition and did not want to be offloaded. *If she refused to be offloaded staff would attempt to educate her on why she needed to be repositioned, but she was not always receptive to that education. *Resident 31 would allow staff to float her heels on pillows but usually refused her Prevalon boots. *Resident 11 was receptive to repositioning and often would seek out staff to assist him with repositioning. *He was able to reposition his buttocks in his chair but had a more difficult time adjusting his left leg. 5. Interview on 9/11/25 at 2:31 p.m. with infection preventionist (IP)/wound care nurse C revealed: *She worked at the facility since 6/30/25, when she became the IP/wound nurse. *The wound nurse prior to her had documented resident 31's wounds as different location descriptors but she had two wounds on her buttocks and one wound on each of her feet. *Resident 31 has refused wound cares from IP/wound nurse C. *IP/wound nurse C completed wound care rounds on Tuesdays. She did not document her wound cares in the TAR, but she could do so. *Resident 31 often refused to wear the Prevalon boots, but IP/wound nurse C had not witnessed the resident refuse to have her heels floated off the mattress with a pillow. *She expected that if resident 31 refused the Prevalon boots, her heels would be floated off the mattress with a pillow. *She expected if a resident refused a dressing change or repositioning that would be charted as a refusal. *She stated if a resident was not repositioned the staff were not preventing pressure ulcers from developing or worsening.	F0686		

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F0686 SS = G	Continued from page 43 *She reviewed resident 11's and resident 31's TAR documentation and verified there were several missed intervention opportunities that could have resulted in the development or worsening of a pressure ulcer. *She verified both resident 11's pressure ulcers were considered facility-acquired pressure ulcers because his admission and 3/11/25 skin assessments documentation stated he had no skin alterations and noted the 3/11/25 assessment stated resident 11 refused to undress for evaluation of his skin. *Resident 11 has only been compliant with lying in his bed one time a day, after lunch. *She agreed when resident 11 laid on the mattress springs due to a deflated air mattress that created pressure to his skin and underlying tissues. *She agreed that the missing documentation did not support that the interventions were implemented to prevent pressure ulcers. 6. Interview on 9/11/25 at 4:46 p.m. with director of nursing (DON) B revealed: *She expected the documentation of wound care and resident repositioning to be signed off in the TAR when completed. *If a resident refused wound care or repositioning, she would expect the refusal to be documented as a refusal. *If a wound care or repositioning documentation was left blank, she would consider it did not occur. *Due to the missed documentation on resident 11's and resident 31's TARs she considered those as missed intervention opportunities to prevent and treat a pressure ulcer. 7. Review of the provider's 9/11/24 Skin and Pressure Injury Prevention Program revealed: *"To ensure a resident who enters the facility without pressure injuries does not develop pressure injuries unless the individual's clinical condition demonstrates that they were unavoidable." *"To provide care an services to prevent pressure injury development and to promote the healing of pressure injuries/wounds that are present." *"A baseline assessment of the resident's skin status	F0686		

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F0686 SS = G	Continued from page 44 will be completed upon admission/readmission by completing the Nursing Admission/Readmission UDA." *"Risk Assessments (Braden or PUSH) will be completed with admission/readmission weekly for four weeks, and then monthly thereafter." *"A wound assessment will be completed: -A) When a pressure injury is identified: This assessment will include, --a) Site, stage, size, appearance of wound bed, (use %) undermining, depth, drainage (amount, color, type, consistency and odor) and status of peri-wound tissue' --b) Treatment of the pressure injury, (cleansing, debridement, dressings); --c) A review of the resident's current POC [plan of care] and medical status- any other possible risk factors, impaired healing due to diagnoses; --d)…Reassess he wound at least weekly (If the wound has not improved within 2-3 weeks, contact MD [medical doctor]/Provider for a change in treatment)." *"Nursing personnel will develop a plan of care (POC) with interventions consistent with resident and family preferences, goals and abilities, to create an environment to the resident's adherence to the pressure injury prevention/treatment plan. POC to include: Impaired mobility, including turning and repositioning at least every two hours or more if indicated by assessment. Pressure relief, Nutritional status and interventions, Incontinence, Skin condition checks, Treatment, Pain, Infection, Education of resident and family, Possible causes for pressure injury and what interventions have been put into place to prevent. Skin checks to be completed at least weekly by a Licensed nurse." *"Pressure injuries are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue." *"If pressure injuries are not treated when discovered, they quickly get larger, become very painful for the resident, and often times become infected." *"The most common site of a pressure injury is where the bone is near the surface of the body including the	F0686		

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F0686 SS = G	Continued from page 45 back of the head around the ears, elbows, shoulder blades, backbone, hips, knees, heels, ankles, and toes."	F0686	1. Resident 14 had a fall risk evaluation completed by DON with a review of orders and care plan on 10/2/25. All residents who are at risk of falling are at risk for lack of implementation of fall interventions. DON or designee completed a fall risk evaluation to to identify fall risk and care plan reviewed and/or updated by 10/15/25. 2. Administrator, DON, and interdisciplinary team in collaboration with the medical director to reviewed the Fall Management Policy and it includes assessing for fall risk and implementing approaches to alleviate risks, as well as investigating falls reviewing resident current status (physical as well as psychosocial and mental status) that may be contributing factors. DON or designee will educate all staff on the Fall Management Policy including how all staff play a role in preventing falls, where fall interventions are located. Licensed Nurses will be educated on the Fall Management Policy, including the Fall Scene Investigation Report. Education will occur no later than October 15, 2025. Those not at the education session will be educated prior to their first shift worked. 3.The DON or designee will audit all resident's falls each week to ensure fall scene investigation is completed in its entirety post fall and care plan interventions are implemented. Additionally, 5 random resident's care plans will be reviewed for fall interventions and resident will be visited to ensure those fall interventions are in place. The audits will be weekly for 4 weeks then monthly for 2 months. Results of the audits will be discussed by the DON or designee at the monthly QAPI meeting with IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on findings.	10/15/25
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: Interventions were implemented or updated to mitigate falling incidents for one of one sampled resident (14) identified at risk for falling who fell and sustained facial bruising and to have completed and documented a thorough investigation of that fall. Findings include: 1. Observation on 9/9/25 at 8:46 a.m. of resident 14 in her room revealed she was lying on her side in bed. There was purple colored bruising beneath and above her right eye, extending to her forehead hairline. The resident stated she had fallen but was not sure how that had occurred. Her bed was low to the floor. Her call light was held inside the top closed drawer of a three-drawer plastic storage container near the head of her bed. A fall mat was folded against the wall on her roommate's side of the room. A walker and a wheelchair were also by that wall. Observation and interview on 9/9/25 at 11:35 a.m. with occupational therapist (OT) X in resident 14's room revealed she was encouraging the resident to reach towards the walker in front of her and pull herself to a standing position. OT X stated resident 14 "took a couple falls" when she was recently sick. Observation on 9/9/25 at 3:30 p.m. revealed resident 14 was asleep in bed. Her call light remained positioned in the above manner inside the plastic storage container. The above fall mat, walker, and wheelchair remained near or against the wall. Review of	F0689		

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F0689 SS = G	Continued from page 46 resident 14's electronic medical record (EMR) revealed her diagnoses included Alzheimer's, anxiety, depression, and high blood pressure. Resident 14's 9/2/25 revised fall care plan included the following fall prevention interventions: "Ensure that [resident 14's] FWW (front wheeled walker) is within her reach when she is in bed. Initiated on 5/24/23.""Fall mat at bedside while in bed to prevent injury. Initiated on 9/2/25.""Keep call light within reach when in bedroom and bathroom. Initiated on 4/18/22.""Sign in room to remind resident to ask for assist with transfers. Initiated on 6/14/23.""Signs in room to remind resident to lock wheelchair. Initiated on 8/4/22." Observation on 9/10/25 at 7:50 a.m. revealed resident 14 was asleep in bed. Her call light was inside the drawer of the plastic storage container. A wheelchair and one end of an over-the-bed table were positioned in front of the exit side of her bed. The fall mat was folded against the wall on her roommate's side of the room. Interview on 9/10/25 at 8:55 a.m. with certified nurse aide (CNA) T regarding the positioning of the above equipment in front of resident 14's bed revealed that it was done to create a clutter-free path for resident 14's roommate. Observation and interview on 9/10/25 at 3:50 p.m. with resident 14 revealed that she sat in her wheelchair in her room. Her call light remained inside the drawer of the plastic storage container. When she was shown the call light, she was able to explain that its purpose was to bring help to her. There was no fall prevention signage posted on resident 6's side of the room. Review of the 9/1/25 Fall Scene Investigation (FSI) Report revealed that at 4:00 a.m. that morning, resident 14 was found on the floor of her room after an unwitnessed fall. Per the report, the resident had stated she was going through cards in her three-drawer plastic storage container and fell out of her wheelchair. She had refused the staff's assistance to get into her bed. She had been agitated and confused before that fall had occurred. She was last assisted to use the bathroom at 2:00 a.m. The section in the above report used to identify the root cause of the fall was blank. The section on that same report used to identify interventions to prevent future falls was blank. The checkbox to indicate if the resident's care plan had been updated was unchecked. The space for the nurse who had completed the form to sign and date it was blank. The last section of the above report was titled Falls Team Meeting Notes and it included the following meeting summary: "Resident [14] anxious and exhibiting behaviors. Staff checked on resident at 0355 [3:55 a.m.] and resident was medicated for anxiety." "Placed	F0689	Type text here	

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F0689 SS = G	Continued from page 47 floor mat to prevent injury." There was no indication if the fall prevention interventions that were identified in resident 14's care plan were implemented at the time of her fall. There was no indication whether those same fall prevention interventions were reviewed to determine if they remained appropriate after she fell on 9/1/25. Observation and interview on 9/11/25 at 11:05 a.m. with director of nursing (DON) B in resident 14's room revealed the cause of the resident's facial bruising was a result of her 9/1/25 fall. The resident had tested positive for COVID-19 at the end of August 2025 and was expected to isolate in her room until her isolation precautions were lifted on 9/4/25. Resident 14's anxiety and restlessness had increased during that isolation period. She had not understood why she was expected to stay in her room. Resident 14 had no fewer than three falls during that isolation period. Regarding resident 14's fall care plan interventions, DON B confirmed that having a walker in reach when the resident was in bed was no longer indicated due to a decline in the resident's physical abilities. A fall mat was still expected to have been placed on the floor at the exit side of her bed when the resident was in her bed. That intervention should have been added to the resident's care plan. Resident 14's call light was to be accessible to her when she is in her room. Fall prevention signage was expected to have been posted in a location visible to the resident. DON B stated the FSI regarding resident 14 was incomplete. Resident 14's fall prevention interventions had not been but should have been updated to reflect short-term strategies to mitigate her risk for falls, such as increased staff observation of and interaction with the resident, knowing that the isolation precautions had increased her agitation and restlessness. Review of the provider's revised 2/20/24 Falls Management policy revealed: Fall Injury Prevention-Post Fall: "1. Assess the resident and ascertain the reason for the fall (resident interview, environmental causes/hazards, footwear, functional impairment, acute change in condition, resident poor safety awareness, responding to toileting needs, etc). 2. Determine and implement [a] new intervention for	F0689		

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F0689 SS = G	Continued from page 48 fall prevention and record on [the] care plan." "7. Provide appropriate training for caregivers, noting any changes implemented."	F0689		
F0695 SS = E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the respiratory treatment equipment for five of five sampled residents (40, 56, 57, 58, and 67) who used oxygen and one of one sampled resident (58) who used a continuous positive airway pressure (CPAP) machine (a machine used to keep a person's airway open while they sleep) was cleaned and stored according to the manufacturer's instructions and the provider's policies. Findings include: 1. Observation and interview on 9/9/25 at 9:06 a.m. with resident 67 in his room revealed: *He was on oxygen, and the flow rate on the oxygen concentrator (a device that filters room air into purified oxygen) was set to four liters per minute (4L/min). *The oxygen concentrator had a label on it that had another person's name on it. * There was a thick, fuzzy layer of gray dust caked on the filter of the concentrator. *The nasal cannula (flexible tubing with prongs that delivers oxygen through the nose) attached to the concentrator was not dated. *A wheelchair in his room had a portable oxygen tank on the back of it, with another nasal cannula tubing	F0695	1. Resident 40, 56, 57,58, and 67 oxygen equipment was cleaned by Central Supply Coordinator on 10/03/25 and oxygen tubing was changed by Central Supply Coordinator on 10/03/25. Resident 58 CPAP was cleaned by DON on 10/03/25. All residents on oxygen are at risk for not having oxygen and CPAP equipment cleaned and stored per manufacturer guidelines. Central Supply Coordinator will audit all residents' rooms for oxygen and CPAP equipment, and if equipment identified it was cleaned per manufacturer guidelines, oxygen tubing changed and dated, and proper storage provided per policy by 10/15/25. 2. The central supply coordinator will complete cleaning of the oxygen concentrators weekly and change all the oxygen tubing. Nurses will ensure cleaning of CPAP/BiPAP each morning. The central supply coordinator was educated by NHA on cleaning, changing of tubing, and storage of tubing for oxygen on 10/3/25. The DON or designee will educate all nurses and certified nursing assistants in the facility on the Oxygen Administration Policy and the CPAP and BiPAP Cleaning Policy, to ensure staff understand the proper way to store and change oxygen tubing, clean concentrators and filters and CPAPs. Education will occur no later than October 15, 2025. Those not at the education session will be educated prior to their first shift worked.	10/15/25

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F0695 SS = E	Continued from page 49 attached to the tank. -That nasal cannula was hanging over the back of the wheelchair, touching the wheels of the wheelchair, and was also undated. Observation on 9/9/25 at 4:23 p.m. in resident 67's room revealed: *The flow rate on the concentrator remained at 4L/min. *The nasal cannula attached to the portable tank was lying on the floor. Observation on 9/10/25 at 9:46 a.m. in resident 67's room revealed: *The flow rate on the concentrator was set to 2L/min. *Both nasal cannulas were labeled with the date "9/7." *The label with another person's name on it had been removed from the concentrator. *The filter remained dusty. *The nasal cannula on the portable tank was in a pocket on the wheelchair. Review of resident 67's electronic medical record (EMR) revealed: *He was admitted on 9/3/25. *He had 9/3/25 orders for: -"Oxygen continuous [at all times] [at] 2L/min via nasal cannula." -"Concentrator Filter Cleaning" weekly, every Saturday. -Change oxygen tubing every Saturday, and as needed. 2. Observation and interview on 9/9/25 at 9:30 a.m. with resident 56 in her room revealed: *She used oxygen at night. *There was an oxygen concentrator near her bed. It had a nasal cannula attached to it that was hanging over a	F0695	3.The DON or designee will audit 5 residents on oxygen or CPAP therapy weekly for cleaning and storage of equipment. The audits will be weekly for 4 weeks then monthly for 2 months. Results of the audits will be discussed by the DON or designee at the monthly QAPI meeting with IDT and Medical Director for analysis, recommendation for continuation/ discontinuation/revision of audits based on findings.	

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F0695 SS = E	Continued from page 50 bedrail, tucked between the mattress and the bedrail. -That nasal cannula was dated “8/23.” 3. Observation and interview on 9/9/25 at 9:40 a.m. with resident 40 in his room revealed: *He was on oxygen, and there was a portable oxygen tank on the back of his wheelchair that was set to 3L/min. *That nasal cannula was dated “8/23/25.” Review of resident 40’s EMR revealed: *He had 12/21/24 orders for: -“Oxygen continuous 3L/min via nasal cannula.” -Change oxygen tubing every Saturday, and as needed. 4. Observation on 9/9/25 at 9:23 a.m. of resident 57’s room revealed: *There was a nasal cannula draped over a bed. *The nasal cannula was attached to an oxygen concentrator that was running. *There was no place for the nasal cannula to be stored to prevent potential contamination of the nasal cannula. *There was dust coating the outside of the oxygen concentrator. *The oxygen concentrator had a brown waxy oil on the vents of the filter cover. *The tab to release the cover over the filter was missing. *The filter in the oxygen concentrator was covered with gray dust particles. Observation and interview on 9/10/25 at 9:42 a.m. with resident 57 in her room revealed: *Resident 57 was sitting on the side of her bed. Her nasal cannula was draped on the bed beside her, and the oxygen concentrator was running.	F0695		

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F0695 SS = E	Continued from page 51 *She stated she wore the oxygen when she slept. *She stated she did not know if someone had replaced her nasal cannula or cleaned her oxygen concentrator. Review of resident 57's electronic medical record (EMR) revealed she: *Was admitted on 8/15/21. *Had a Brief Interview of Mental Status (BIMS) assessment score of 15, which indicated her cognition was intact. *Had diagnoses of respiratory failure (not enough oxygen passes from the lungs to the body), and thromboembolic pulmonary hypertension (a rare condition where blood clots in the lungs persist and cause high blood pressure in the artery that carries blood from the heart to the lungs, which results in damage to the heart and lungs). *She had a 1/3/25 physician's order for, "Oxygen continuous 2L/min [liters per minute] via nasal cannula". Review of resident 57's August 2025 treatment administration record (TAR) revealed: *She was scheduled on Saturday night shifts to have her nasal cannula replaced and her concentrator filter cleaned. -There was no documentation that was completed on 8/9/25 or 8/30/25 as scheduled. 5. Observation on 9/9/25 at 9:26 a.m. of resident 58's room revealed: *He was sitting in his wheelchair with his nasal cannula on. *His nasal cannula was attached to an oxygen concentrator, which was running. *The oxygen concentrator was covered in white flakes and dust particles. *The vent cover over the oxygen concentrator's filter was covered in dust. *There was an assembled mask and tubing attached to a continuous positive airway pressure (CPAP) machine (a machine used to keep a person's airway open while they	F0695		

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F0695 SS = E	Continued from page 52 sleep) on resident 58's bedside table. Observation and interview on 9/10/25 at 9:39 a.m. with resident 58 in his room revealed: *He was sitting in his wheelchair with his nasal cannula on. *His nasal cannula was attached to the oxygen concentrator. *There was another nasal cannula draped over the handles on the back of his wheelchair was attached to a portable oxygen cylinder. *There was no place for the nasal cannula to be stored to prevent potential contamination of the nasal cannula. *The filter of the oxygen concentrator had a coating of gray dust on it, and the compartment surrounding the filter was dusty. *Resident 58 stated he wore oxygen all the time. *The CPAP mask and tubing remained assembled on his bedside table. *Resident 58 stated he wore the CPAP at night. *Resident 58 shrugged his shoulders when he was asked if someone cleaned his CPAP mask and tubing, or his oxygen concentrator. Review of resident 58's EMR revealed he: *Was admitted on 12/16/24. *Had a BIMS assessment score of 3, which indicated he had severe cognitive impairment. *Had diagnosis of chronic respiratory failure with hypoxia (low oxygen in the blood) and obstructive sleep apnea (a sleep disorder where the airway repeatedly collapses during sleep, leading to pauses in breathing). *Had a 12/16/24 physician's order for "Oxygen 3LPM [liters per minute] via nasal cannula" and "CPAP Setting 11 with 2L [liters] o2 [oxygen] bleed in every evening shift for CPAP usage **Assist with placement at bedtime**". Review of resident 58's August 2025 treatment	F0695		

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F0695 SS = E	Continued from page 53 administration record (TAR) revealed: *He was scheduled on Saturday night shifts to have his nasal cannula replaced. -There was no documentation that was completed on 8/9/25 or 8/30/25 as scheduled. *Cleaning of the oxygen concentrator filter was not scheduled on the TAR to be completed. *Cleaning of the CPAP machine, mask, and reservoir was not scheduled on the TAR to be completed. *Replacement of the mask and tubing was not scheduled on the TAR to be completed. 6. Interview on 9/10/25 at 1:37 p.m. with certified medication aide (CMA) O revealed: *CPAP machines, masks, and tubing were to be scheduled to be cleaned weekly for residents who wore CPAPs. *The CPAP mask and tubing were to be disassembled, washed with soap and water, and then hung to dry. *Cleaning of the CPAP machines, masks, and tubing was to be documented on the resident's TAR. *Nasal cannulas were to be replaced weekly on the night shift. *Nasal cannulas were to be stored rolled up in a bag when it was not in use. *The filters in the oxygen concentrators were to be checked weekly and replaced as needed. *CMA O observed resident 58's oxygen concentrator and filter, and stated he would not have considered the oxygen concentrator or the filter clean and verified there was dust and white flakes on the concentrator and dust on the filter and in the filter compartment. 7. Interview on 9/11/25 at 9:58 a.m. with licensed practical nurse (LPN) K revealed: *There were to be orders for the residents' nasal cannula to be replaced weekly by the nurse and documented in the resident's' TAR. *The nasal cannulas were to be stored coiled up and placed on the oxygen concentrator, off the floor, when not in use.	F0695		

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F0695 SS = E	Continued from page 54 *Nursing staff did not clean the filters in the oxygen concentrators, she thought the maintenance staff was responsible for cleaning the filters. *CPAP masks were to be cleaned or replaced weekly by the nurse and documented in the resident's TAR. 8. Interview on 9/11/25 at 4:28 p.m. with the infection preventionist (IP)/wound care nurse C revealed: *Nasal cannulas were to be replaced weekly, and the replacement was to be documented on the resident's TAR. *Nasal cannulas were to be stored in a bag off the floor when they were not being used. The bags were to be replaced weekly when the nasal cannula was replaced. *IP/wound nurse C expected the oxygen concentrators to be wiped down if they were visibly soiled. *She thought the oxygen concentrator filters were cleaned and replaced by the provider's contracted oxygen company. *She was not aware that some residents had the cleaning of the oxygen concentrator filters scheduled on their TAR and others did not. *She verified if there was no schedule for cleaning of the oxygen concentrator filter on the TAR there was no place to document the cleaning was completed and therefore, the cleaning could not be verified as having been completed. *She expected the residents' CPAP masks to be separated from the tubing and washed daily. *The CPAP tubing was to be washed with soap and water weekly and hung to dry. *The cleaning of the CPAP mask and tubing was to be documented on the residents' TAR. *She verified if there was no schedule for cleaning of the CPAP machine and mask on the TAR there was no place to document the cleaning and therefore the cleaning would not be able to be verified as having been completed. 9. Interview on 9/11/25 at 4:46 p.m. with director of nursing (DON) B revealed: *Nasal cannulas were to be replaced weekly by the nurse	F0695		

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F0695 SS = E	Continued from page 55 and documented on the residents' TARs. *The cleaning of the oxygen concentrators and the filters for the oxygen concentrators were completed weekly by the previous medical records staff member. *She expected the nasal cannulas to be stored in a bag, off the floor when they were not in use. *Cleaning of the CPAP machines, mask, and tubing should be completed according to the manufacturer's instructions. *She stated she reviewed the different CPAP machines that were used in the facility and the manufacturers' instructions indicated the tubing should be soaked weekly and changed monthly. *She verified that there was no documentation for the cleaning of the oxygen concentrator and CPAP supplies, or the replacement of the nasal cannulas weekly, she could not verify it had been completed. 10. Review of the provider's 3/31/25 CPAP and BiPAP Cleaning policy revealed: *Procedures -"After each use, the mask/reservoir will be wiped with warm soapy water per manufacturer's instructions, rinsed, and placed upside down to dry on a paper towel." -"The tubing will be replaced at the time interval recommended by the individual machine's manufacturer." -"The machine should be wiped/cleaned with a disinfectant on at least a weekly basis and as needed." Review of the provider's 11/19/24 Oxygen Administration policy revealed: *"Oxygen masks and tubing will be changed weekly and as needed. Change of tubing and mask should be documented in the medical record. When not in use, the mask should be stored in a plastic bag." *"The nasal cannula and tubing will be changed weekly and as needed. Change of tubing and cannula should be documented in the medical record. When not in use, the nasal cannula should be stored in a plastic bag." *"Oxygen concentrators will have exterior wiped down when soiled and at least weekly. If equipped with a	F0695		

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F0695 SS = E	Continued from page 56 filter, [the] filter will be cleaned at least weekly by rinsing with water and allowing to dry…Weekly cleaning of the concentrator and filter should be documented in the medical record."	F0695		
F0697 SS = G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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, interview, record review, and policy review, the provider failed to ensure pain management interventions were implemented and effective for one of one sampled resident (6). Findings include: 1. Observation and interview on 9/9/25 at 9:53 a.m. in resident 6's room revealed he was lying on his back in bed wearing a hospital gown. He had a U-shaped pillow around the back of his neck. The resident had a grim expression on his face, and he strained to answer simple questions. He complained of being cold. Observation on 9/9/25 at 12:00 noon outside of resident 6's room revealed he was overheard telling an unidentified caregiver, "I wish that nurse would come. I need that oxy [oxycodone, pain medication that is a controlled medication meaning at risk for abuse and addiction]." Observation on 9/9/25 at 12:03 p.m. revealed licensed practical nurse (LPN) E entered resident 6's room. She explained to him that he had a physician's order for Tylenol, but there was no order for him to have oxycodone. LPN E stated she would have to call the resident's physician to discuss his request for oxycodone. She adjusted the resident's U-shaped neck pillow. Without first asking the resident what his pain level was or where his pain was, she administered two Tylenol tablets to resident 6. Observation and interview on 9/9/25 at 12:05 p.m. with	F0697	1.Resident 6 had a pain assessment completed by DON on 10/6/25. Upon completion of pain assessment new findings were reported to prescriber and care plan reviewed and updated by DON on 10/6/25. LPN E is on medical leave and upon return she will receive written education regarding evaluating pain, following providers orders, and documentation of interventions. All residents are at risk for failure to implement pain management interventions. DON or designee will complete pain assessments on all residents, review orders for changes, notify providers as needed, and care plans reviewed and/or updated by 10/15/2025. 2.Administrator, DON, and interdisciplinary team in collaboration with pharmacist and medical director reviewed the Pain Management Policy and it includes assessing for pain and implementing approaches both pharmacological and non-pharmacological for pain management. The policy does include review of pain medications scheduled vs. PRN. The DON or designee will educate all staff about the Pain Management Policy and monitoring resident for pain, reporting signs of pain to the nurse, and offering of non-pharmachological interventions for pain management. Education will occur no later than October 15, 2025. Those not at the education session will be educated prior to their first shift worked.	10/15/25

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F0697 SS = G	Continued from page 57 resident 6 revealed he was lying on his back in bed, rubbing his forehead back and forth repeatedly and moaning, "uh, uh." He stated on a scale of one to ten, with ten being the worst possible pain, that his pain was a ten. He identified his left ankle as the source of his pain. He described his pain as "hot" and "stabbing" and nearly constant. His eyes watered as he described his pain. Review of resident 6's electronic medical record (EMR) revealed he was admitted to the facility on 6/12/25. His diagnoses included multiple sclerosis (MS), metastatic malignant neoplasm (cancer), depression, peripheral vascular disease (circulation disease), a history of left lower leg pain, and a history of cellulitis (bacterial infection of the skin) of his left lower limb. His 6/18/25 Brief Interview for Mental Status (BIMS) assessment score was 10, which indicated he had moderate cognitive impairment. Review of resident 6's September 2025 medication administration record (MAR) revealed a 6/12/25 physician's order for acetaminophen (generic Tylenol), 325 milligrams (mg), two tablets every eight hours for pain rated one to seven on a pain scale from zero to ten. There was a 6/12/25 physician's order for oxycodone HCl (hydrochloride), one tablet every eight hours as needed for pain rated eight to ten on a pain scale from zero to ten. Review of resident 6's September 2025 MAR and interview on 9/9/25 at 2:00 p.m. with LPN E revealed "it's [the oxycodone order] right below the Tylenol." She had not known that resident 6 had an order for oxycodone; otherwise, she would have administered the oxycodone instead of the Tylenol as the resident had requested. When asked why resident 6 had pain, she stated, "I'm not honestly sure the cause of his pain. It may be related to an accident." She thought he had pain in his leg or his neck. She was not sure how often or if resident 6 had gotten out of bed. She had not reassessed resident 6's pain level after she administered the two Tylenol tablets two hours earlier. LPN E administered resident 6's oxycodone after she was made aware of his physician's order for oxycodone. Review of resident 6's September 2025 MAR revealed LPN E had reassessed the resident's pain after she administered the above oxycodone. That administration was documented as having been an "effective" response	F0697	3.DON or designee will audit 10 residents weekly for reports on unrelieved pain, ineffective pain managment, and pain above acceptable level with use of pain medication as prescribed. The audits will be weekly for 4 weeks then monthly for 2 months. Results of the audits will be discussed by the DON or designee at the monthly QAPI meeting with IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on findings.	

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F0697 SS = G	Continued from page 58 to his pain. Interview on 9/10/25 at 2:40 p.m. with director of nursing (DON) B revealed LPN E had not administered resident 6's pain medication per his physician's order. That had potentially caused resident 6 unnecessary pain. DON B had expected LPN E to have thoroughly reviewed resident 6's MAR for all physician-ordered pain medication options and to have administered the most appropriate pain medication to him based on his level of pain. LPN E should have assessed and documented resident 6's pain level before administering any pain medication. That assessment should have identified whether his pain was new, acute, chronic, or related to an injury and what medication to administer for effective pain relief. Observation and interview on 9/10/25 at 1:30 p.m. with resident 6 revealed he was lying in his bed on his back in a hospital gown. He was watching television. He stated his MS had worsened, and caused a decline in his physical abilities. He thought his MS was also partially to blame for his near-constant pain. Observation on 9/11/25 at 8:30 a.m. of resident 6 revealed he was lying in his bed on his back in a hospital gown. His television was on, and his eyes were closed. Interview on 9/11/25 at 2:15 p.m. with resident 6 revealed he had no significant pain and stated, "in a minute or so the pain will start back up at a ten." Review of resident 6's EMR revealed: On 7/26/25, he was transferred to the local emergency room due to left lower leg pain. No pain medication changes were made, and the resident was referred to his primary care physician for follow-up. His 9/9/25 Monthly Nursing Summary describing his pain revealed, "Hurts a whole lot." Review of resident 6's June 2025 MAR revealed that during that month, he was administered as-needed oxycodone on 17. The frequency of those administrations was either one or two times per day. His July 2025 MAR revealed that during that month, he was administered as-needed oxycodone 17 days. The frequency of those administrations was between one and three times per day.	F0697		

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F0697 SS = G	Continued from page 59 His August 2025 MAR revealed that during that month, he was administered as-needed oxycodone 10 days. The frequency of those administrations was either one or two times per day. Review of resident 6's 6/14/25 revised pain care plan revealed the following interventions: "Evaluate efficacy [effectiveness] of pain management. Notify MD [medical doctor] if inadequate pain relief. Observe for non-verbal signs of pain. Provide analgesic as ordered. Utilize non-pharmacological intervention." Review of resident 6's June 2025 through August 2025 MARs and interview on 9/10/25 at 2:40 p.m. with DON B regarding the management of resident 6's pain revealed that she stated resident 6's pain descriptions were accurate. His pain was most likely related to his MS. The "stabbing" that resident 6 described was consistent with the neurological nature of MS. DON B confirmed resident 6's Tylenol and oxycodone frequency and dosing had remained unchanged since he was admitted. He had no scheduled pain medications that could have provided him with more consistent pain relief. When asked why, she stated, "That's what I was wondering. I don't have an answer for that." She indicated that resident 6's physician should have been contacted to explore this and other, more effective pain management options, but that had not occurred. Review of the provider's 4/28/25 Pain Management policy revealed: "5. Strategies that may be employed when establishing medication regimen include: a. Starting with lower doses and titrating upward as necessary. b. Administering medications around the clock rather than PRN [as needed]. c. Combining long-acting medications with PRNs for breakthrough pain; d. Combining several analgesics or analgesics with other drug classes;..."	F0697		
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care	F0699		

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F0699 SS = D	Continued from page 60 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 observation, interview, record review, and policy review, the provider failed to implement specific care approaches that addressed the mental and psychosocial needs of two of two sampled residents (8 and 31) with diagnosed post-traumatic stress disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event) (PTSD) history of trauma exposure to mitigate triggers and prevent re-traumatization. Findings include: 1. Observation and interview on 9/10/25 at 9:01 a.m. with resident 31 in her room revealed: *The room was dark with the only light source coming from the outside window. *She had multiple items situated around her on her over-the-bed tables. *She did not move her legs when she attempted to reposition herself in bed with the used of her side rails (bars attached to the bed). *She stated she used the side rails to reposition herself, but her legs sometimes got “tangled up”. *Resident 31 stated she was a veteran of the armed forces. *Since her admission to the facility, she had not spoken to a staff member about her past traumas or experiences that have been difficult for her. *She felt like she was “talked around” instead of being spoke to. *She did not remember being offered counseling services since her admission, but stated she may have been offered, and she did not remember. *Resident 31 stated she had been in counseling through the VA (Veterans Affairs) but did not have a good	F0699	1.Resident 8 had a trauma screening completed and care plan reviewed on 10/3/25 by SSD to include specific interventions and approaches addressing mental and psychosocial needs regarding trauma and exposure and prevention or re-exposure. Resident 31 had a trauma screening and care plan was reviewed on 10/3/25 by SSD to include specific interventions and approaches addressing mental and psychosocial needs regarding trauma and exposure and prevention or re-exposure. All residents are at risk for failure to review and update care plan for past trauma and interventions to mitigate trauma re-exposure. All residents will be audited by NHA or designee to ensure those with a history of trauma have proper care and treatment and care plan interventions by 10/15/25. 2.Licensed Social Worker will provide education to Social Service Designee no later than 10/7/25 on completing trauma screening and updating of care plan for residents identified with past trauma and updating care plan regarding mitigation of triggers to prevent re-traumatization. 3.The Nursing Home Administrator or Designee will audit all new admissions to verify if they have trauma, their assessment is complete/accurate, and interventions are care planned. The audit will be weekly for 3 months. Results of the audits will be discussed by the Administrator or designee at the monthly QAPI meeting with IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on findings.	10/15/25

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F0699 SS = D	Continued from page 61 experience. 2. Review of resident 31's electronic medical record (EMR) revealed: *She was admitted on 11/5/24. *She had a 7/24/25 Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated her cognition was intact. *Resident 31's diagnoses included, adjustment disorder (a mental health reaction to stressful life events or changes that are considered a maladaptive response to a psychosocial stressor), borderline personality disorder (a mental disorder characterized by unstable moods, behavior, and relationships), major depressive disorder, chronic post-traumatic stress disorder(a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event) (PTSD), nightmare disorder, and anxiety disorder. *She was a veteran of the armed forces. *She was involved in a motor vehicle crash which resulted in paraplegia (paralysis that affects all or part of the trunk, legs, and pelvic organs). *She had a physician's orders for, "Bupropion HCL ER (XL) Tablet Extended Release 24 Hour [and anti-depressant medication]150 MG [milligrams] Give 1 tablet by mouth one time a day for depression", and "DULoxetine HCL Capsule Delayed Release Particles [an anti-depressant medication] 30 MG Give 3 capsules by mouth at bedtime for depression". *An 8/31/25 Summary of Episode Note by qualified mental health practitioner (QMHP) stated, "In addition to addressing the patient's medical needs, behavioral health concerns were identified, including moderately severe depression symptoms and severe anxiety symptoms. Conducted a brief behavioral health assessment to further evaluate the patient's needs. Provided brief interventions and counseling to address immediate concerns and promote coping strategies." *A 9/5/25 progress note stated, Resident 31, "expressed experiencing hallucinations since readmission [from the hospital]. Per resident and POA [power of attorney]. Physician notified." *Resident 31's 9/10/25 care plan had a focus area of "I am at risk for experiencing Hallucinations [to see, hear, smell, taste or touch something that is not	F0699		

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F0699 SS = D	Continued from page 62 there]", and "I receive Psychoactive medications [drugs that affect brain activities associated with mental processes and behavior] d/t [due to] Adjustment disorder, Personality Disorder, Depression, PTSD, [and] Nightmare disorder". 3. Review of resident 31's 11/5/24 Social Services assessment revealed: *The assessment was completed by social service designee (SSD) D. *The first four questions of the assessment were labeled "Trauma Screening" *To question number four in the trauma screening, "Per family information and medical record information, is the resident a victim of trauma including violence (example: torture, assault), war (example: Holocaust survivor), natural disaster, man-made disaster (example: fire), terrorism, and catastrophic accident?", SSD D answered "No". *At the end of the trauma screening portion stated, "If there is a YES for questions #1 to #4, a trauma-informed care plan is required and information derived from questions #5 to #7 should be included in the care plan and care of the resident." Questions five through seven had not been completed due to the answering of "No" to question four. *In section III (three) "Screen to Determine Abuse/Neglect SSD D documented "No" to the questions, "Does the resident have a psychiatric history and/or present mental health diagnosis?", and "Does the resident have a diagnosis of depression and/or a history of depressive illness and/or present with signs/symptoms of depression/mood distress; low self esteem, isolation and withdrawn behavior; complaints of chronic pain, illness, fatigue, and/or persistent anger, fear and/or anxiety?" *In section IV (four) "Screening for Evaluating Self-Harm" SSD D "No" was documented to the questions, "History of psychiatric problems and/or a personality disorder diagnosis" and "Individual with a history/diagnosis of Post Traumatic Stress Disorder (PTSD), especially a veteran of the armed forces". 4. Observation and interview on 9/10/25 at 11:38 a.m. with resident 8 in his room revealed he: *Resided in a private room. He was sitting in his bed with his laptop on the table in front of him. He was	F0699		

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F0699 SS = D	Continued from page 63 wearing a hospital gown. *Does not usually go to the facility's activities and preferred to stay in his room. *Was a veteran of the Unites States armed forces in the 1970's. *Had worked in underground mines part-time while he was going to college. He would have to climb up and down a height of 150 feet on ladders. He sometimes had to carry dynamite up and down that ladder. *Said, "I didn't know they [the facility] knew about that" when he was asked about his diagnosis of PTSD. *Had a hard time knowing what would trigger him. *Had not been offered any services for his PTSD that he can remember since being in the facility. 5. Review of resident 8's electronic medical record (EMR) revealed: *He was admitted to the facility on 4/2/24. *He had a Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated his cognition was intact. *Resident 8's diagnoses included: insomnia (trouble falling and staying asleep), alcohol abuse, major depressive disorder, anxiety disorder, post-traumatic stress disorder, depression, adjustment disorder (a mental health reaction to stressful life events or changes that are considered a maladaptive response to a psychosocial stressor), and hallucinations. 6. Review of resident 8's care plan revealed: *He had a focus area of "I am at risk for altered thought process due to history of alcohol abuse, PTSD, depression, and anxiety". -The Interventions listed for this focus area included "Call provider for any changes in cognitive functioning and/or any changes in behavior. Give medications as ordered. Keep the environment uncluttered. Make sure the resident wears eyeglasses and hearing aids, if applicable. Offer cues, direction, and redirection as needed". -The interventions did not include what would potentially trigger resident 8's PTSD.	F0699		

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F0699 SS = D	Continued from page 64 -The interventions did not tell staff what kind of behaviors they would need to monitor him for. -The care plan interventions for resident 8 were not specific to what staff would need to do when he would have that altered thought process. 7. Interview with social services designee (SSD) D on 9/10/25 at 1:52 p.m. revealed: *She assessed new residents for trauma when they were admitted to the facility. -If the resident did not verbalize a history of trauma, that is what she would document on the trauma assessment. *She agreed that a resident might not want to share off of their historical trauma upon admission to the facility. 8. Interview and review of resident 8's and 31's care plans with director of nursing (DON) B on 9/11/25 at 4:46 p.m. revealed: *She verified trauma-informed care (a compassionate approach to healing that addresses the root cause of mental health struggles) was not addressed within those residents' care plans. *She stated the information gathered during the trauma-informed care process should be included in the care plan because it could affect how and what cares needed to be provided for the resident to prevent things that may trigger emotions or behaviors or re-traumatize the resident. . *DON B stated the triggers, behaviors, and interventions would vary between residents who have experienced trauma because their past traumas may have been different. 9. Review of the provider's 9/30/24 Mental Health Adjustment Difficulties Related to Trauma, PTSD or Other Mental Health issues policy revealed: *"To ensure appropriate treatment and services are provided to all residents with adjustment difficulties to achieve the highest practicable mental and psychosocial well-being. 'Appropriate' means based upon assessment and care plan, should be person-centered, and the facility must make attempts to provide the services or assist residents with accessing such	F0699		

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F0699 SS = D	Continued from page 65 services." *"Adjustment Difficulties: -…Are characterized by distress that is out of proportion to the severity or intensity of the stressor, taking into account external context and cultural factors, and/or a significant impairment in social, occupational, or other important areas of functioning. -May be related to a single event or involve multiple stressors and may be recurrent or continuous. -May cause a depressed mood, anxiety, and/or aggression." *"History of Trauma: -Involves psychological distress, following a traumatic or stressful event, that is often variable. -May be connected to feelings of anxiety and/or fear. -Often involves expressions of anger or aggressiveness. -Some individuals who experience trauma will develop PTSD." *"PTSD: -Involves the development of symptoms following exposure to one or more traumatic, life-threatening events. -…Symptoms may include, but are not limited to, the re-experiencing or re-living of the stressful event (e.g. flashbacks or disturbing dreams), emotional and behavioral expressions of distress (e.g. outbursts of anger, irritability, or hostility), extreme discontentment or inability to experience pleasure, as well as dissociation (e.g. detachment from reality, avoidance, or social withdrawal), hyperarousal (e.g. increased startle response or difficulty sleeping)." *"Moving from the community into a long-term care facility can be a very difficult transition and cause worsening or reemergence of symptoms for an individual with a history of trauma or PTSD." *"Assess the resident to determine if services are needed." *"[The resident's] Care Plan should address the	F0699		

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F0699 SS = D	Continued from page 66 individualized emotional and psychosocial needs of the resident." *"Staff must consistently implement the care approaches identified in the Care Plan. [The resident's] Care Plan must be reviewed and revised if interventions are not effective or [the] resident has had a change in condition."	F0699	1.Resident 6 had a Social Services Evaluation and PHQ9 completed on 10/3/25 by SSD to evaluate the resident's psychosocial wellbeing. SSD spoke with resident 6 and offered counseling services on 10/3/25, it was accepted and set up with in-house counseling services Deer Oaks. SSD had offered music alternatives to resident on 10/03/2025 and he declined. Resident 6 care plan reviewed and updated on 10/03/2025 by SSD. Resident was offered a recliner by SSD on 10/03/2025 and declined. All residents are at risk for not being provided social service-related services to maintain highest practical physical, mental, and psychosocial well-being. A Social Services Evaluation by SSD or designee will be completed on all residents by 10/15/25 and care plans reviewed and updated as needed with goals and interventions by SSD or designee no later than 10/15/25. 2. Licensed Social Worker will provide education to Social Service Designee no later than 10/7/2025 regarding completion of the Social Services Evaluation, care planning of goals, setting up of counseling, and assisting residents with their needs. 3.The Nursing Home Administrator or Designee will audit all new admissions weekly to ensure their psychosocial needs are being met, their social services evaluations are complete and care planned. The audit will continue for 3 months. Results of the audits will be discussed by the NHA or designee at the monthly QAPI meeting with IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on findings.	
F0745 SS = D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and job description review, the provider failed to provide medically-related social services for one of one sampled resident (6) at risk for a decline in his psychosocial well-being. Findings include: 1. Observation and interview on 9/9/25 at 9:53 a.m. in resident 6's room revealed he was lying on his back in bed wearing a hospital gown. He had a U-shaped pillow around the back of his neck. The resident had a grim expression on his face, and he strained to answer simple questions. He complained of being cold. Observation on 9/9/25 at 12:00 noon outside of resident 6's room revealed he was overheard telling an unidentified caregiver, "I wish that nurse would come. I need that oxy [oxycodone-a narcotic pain medication]." Observation and interview on 9/9/25 at 12:05 p.m. with resident 6 revealed he was lying on his back in bed, rubbing his forehead back and forth repeatedly and moaning, "uh, uh." He stated on a scale of 1 to 10, with 10 being the worst possible pain, that his pain was a 10. His eyes watered as he described his pain. Interview on 9/9/25 at 2:00 p.m. with licensed practical nurse (LPN) E regarding the cause of resident 6's pain revealed she stated, "I'm not honestly sure the cause of his pain. It may be related to an accident." She thought he had pain in his leg or his neck. She was not sure how often or if resident 6 had	F0745		10/15/25

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F0745 SS = D	Continued from page 67 ever gotten out of bed. He only had physician orders for as needed and not scheduled pain medication. Interview on 9/9/25 at 3:45 p.m. with resident 6 revealed that he missed his dog, which had died. He had a friend who visited him a few times a month, but his immediate family members lived far away from him. He had a recliner at his home that he often sat in. There was no recliner in his current room. He reported frequently not being able to sleep at night. He questioned if he was better off no longer alive, but he still wanted to live. He was willing to speak with a counselor about his depression if one was available. Interview on 9/9/25 at 4:00 p.m. with guest services aide (GSA) F and certified nurse aide (CNA) H regarding resident 6 revealed GSA F had worked at the facility for about two months and had not seen resident 6 out of his bed. She thought that was due to his pain. CNA H stated that resident 6 was supposed to be transferred to his wheelchair to eat his meals, but that had not been occurring. Review of resident 6's electronic medical record (EMR) revealed he was admitted to the facility on 6/12/25. His diagnoses included multiple sclerosis (MS), metastatic malignant neoplasm (cancer), depression, peripheral vascular disease (circulatory disease), and a history of left lower leg pain. His 6/18/25 Brief Interview for Mental Status assessment score was 10, which indicated he was moderately cognitively impaired. His 6/18/25 PHQ-9 (depression scale) score was 11, which indicated he had mild to moderate depression. There were three documented progress notes completed by social services designee (SSD) D. On 6/17/25, she called the resident's family to discuss discharge planning. On 6/18/25, she had offered the resident counseling services, and he declined. On 8/27/25, she called the resident's family to set up a care conference time. Review of resident 6's care plan revealed no social services-related goals or interventions. Observation and interview on 9/10/25 at 1:30 p.m. with resident 6 revealed he was lying in his bed on his back in a hospital gown. He was watching television. He stated his MS had worsened, and caused a decline in his physical abilities. He thought that was also to blame for his near-constant pain. He had lived in his own home with the support of caregivers before he came to the facility, but he was not certain he would be able to return there. He had been a professional musician.	F0745		

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F0745 SS = D	Continued from page 68 He had written songs, but his hands were no longer able to hold a pen to compose. He wondered if there was some type of voice-activated device that would allow him to pursue that passion. He had a recliner at his home that he had liked to sit in. There was no recliner in his current room. He reported not being able to sleep at night frequently. He questioned if he was better off no longer living, but he still wanted to live. He was willing to speak with a counselor about his depression if it was available. Observation on 9/11/25 at 8:30 a.m. of resident 6 revealed he was lying in his bed on his back in a hospital gown. His television was on, and his eyes were closed. Interview on 9/11/25 at 2:15 p.m. with resident 6 revealed he had no significant pain and stated, "in a minute or so the pain will start back up at a ten." Interview on 9/11/25 at 9:30 a.m. with social services designee (SSD) D regarding resident 6 revealed he still had a home, but it was not likely he would be able to return there. He had two roommates since he was admitted, who no longer reside at the facility. One of those roommates had become a good friend to resident 6. SSD D had not followed up with resident 6 to determine how resident 6 was dealing with those losses. SSD had not followed up with resident 6 about counseling services since she had first spoken with him about it on 6/18/25, but she should have. SSD D had known music was very important to resident 6. She had not known if the music station available to him on his television had played the type of music he had enjoyed. She had not explored any other music options for the resident, such as a radio or providing him with a playlist of his favorite music and songs. She knew he had written songs. SSD D had not explored any adapted equipment or accommodations that might have allowed him to continue to pursue that passion. SSD D had known that resident 6's dog was important to him. He had an engraved box in his room in remembrance of that dog. Resident 6 had told her he "talked to his dog," referring to the box. She had not investigated options for the resident to help fill that void. SSD D stated that it was her responsibility to ensure that resident 6's care plan had included goals and interventions related to his depression diagnosis, grief, and loss issues. That had not occurred.	F0745		

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F0745 SS = D	Continued from page 69 SSD D indicated that usually, "one day out of the week" she had talked to resident 6 regarding his psychosocial well-being, but she failed to document those encounters. Without that documentation, she agreed she was unable to support that resident 6 was provided comprehensive and appropriate social services that met his needs. Review of the updated 2/4/22 Social Services Designee job description revealed..."the Social Worker [SSD] ensures that the medically related emotional and social needs of the Guest [resident] are met and maintained on an individual basis and in accordance with current federal, state, and local regulations." Essential Functions: "1. Responsible for keeping up-to-date evaluation documentation on each Guest's activities at the facility which complies with Federal, State, and Local regulations." "14. Provides informal counseling when needed to uncover any problems which might interfere with Guests' socialization and participation in activities."	F0745		
F0759 SS = E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, policy review, and manufacturer's recommendations review, the provider failed to ensure a medication error rate of less than 5 percent related to: *A topical pain medication was not applied according to the manufacturer's recommendations for one of one sampled resident (11) by one of one observed licensed practical nurse (LPN) (K). *An extended release medication was crushed and administered to one of one sampled resident who required their medications to be crushed (12) by one of one observed LPN (K). Those observed medication errors resulted in a	F0759	1.Resident 11 and Resident 12 had medication error reports completed on 10/6/25 by DON . LPN K was verbally educated on 9/11/25 by surveyor and DON. All residents are identified at risk for medication errors. A pharmacist medication regimen review was conducted on 9/7/25 to review all residents with orders to crush medications for any extended-release medication orders and providers notified for interchanges needed by DON. 2.DON or designee will educate all licensed nurses and medication aides on medication administration, including what medications can be crushed and how to measure medications, specifically Diclofenac Sodium. Education will occur no later than October 15, 2025. Those not at the education session will be educated prior to their first shift worked. 3.DON or designee will audit 10 random resident medication administrations weekly to ensure medications are administered per order and per manufacturer’s directions and not crushed when crushing is not recommended.	10/15/25

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F0759 SS = E	Continued from page 70 medication error rate of 6.9%. Findings include: 1. Observation and interview on 9/11/25 at 8:00 a.m. of LPN K during medication administration revealed: *She dispensed an unknown amount of diclofenac sodium external gel 1% (for arthritis pain and inflammation) into a medicine cup and administered the gel to resident 11's left upper back/shoulder. -The order on resident 11's medication administration record (MAR) indicated he was to receive two grams of the gel. *When asked how she knew she was administering the correct dose, she stated, "I guess I don't." *She was unaware that there was a measuring device included in the box that was to be used to determine the dose of the gel to be administered. Three-fourths of that tube of diclofenac sodium 1% gel had been used. -That measuring device was still secured to the diclofenac sodium 1% gel box. -She removed the measuring device from the box and stated, "Oh. So, you just lay it on there?" *She crushed resident 12's oral medications, mixed them with applesauce, and administered them to her. -There was no indication on the MAR that those medications should be crushed. *"Omeprazole [used to treat and prevent conditions caused by excessive stomach acid] 20mg [milligram] Delayed Release Oral Tablet" was included in those medications that were crushed. *She did not think the omeprazole was a delayed-release tablet. *She reviewed the label on the bottle and stated, "Oh, it is delayed release. I shouldn't have crushed that." 2. Interview on 9/11/25 at 1:36 p.m. with DON B about the above medication administration observations and errors revealed she agreed that a delayed-release medication should not have been crushed. *She stated, "I think we'll do some follow-up and	F0759	The audits will be weekly for 4 weeks then monthly for 2 months. Results of the audits will be discussed by the DON or designee at the monthly QAPI meeting with IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on findings.	

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F0759 SS = E	Continued from page 71 education." 3. Review of the manufacturers' 2023 recommendations for the diclofenac sodium 1% gel revealed: *Read the label and use the enclosed dosing card. *Dosage -Using the dosing card, apply the following amounts: --Upper body areas (hand, wrist, elbow): 2.25 inches 4. Review of the provider's 9/18 Medication Administration Guidelines revealed: *"Policy -Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication." *"Procedures -Medication Preparation:" --"If safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube-fed, using the following guidelines and with a specific order from prescriber. ---The need for crushing medications is indicated on the residents' orders and the MAR so that all personnel administering medications are aware of this need and the consultant pharmacist can advise on safety and alternatives, if appropriate, during Medication Regimen Reviews. ---Long-acting, extended release, or enteric-coated dosage forms should generally not be crushed; an alternative should be sought." -"Medication Administration:" --"Medications are administered in accordance with written orders of the prescriber." --"Verify medication is correct three (3) times before administering the medication.	F0759		

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F0759 SS = E	Continued from page 72 a. When pulling medication package from med [medication] cart b. When dose is prepared c. Before dose is administered”	F0759		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to follow standard food safety practices to ensure: *Handwashing was completed be three of five observed kitchen staff (cook N, dietary aide Z, and dietary aide AA) according to the provider’s policy. *Food observed in one of one dining room refrigerator belonging to three sampled residents (4, 5, and 44) was stored according to the provider’s policy. *One of one kitchen where resident’s food was prepared stored, and served was maintained in a clean condition.	F0812	1. Facility kitchen staff ensured all resident food was thrown out if not stored or labeled properly on 9/11/25. Dietary Manager ensured all power cords stored and cleaned properly in the kitchen on 9/11/25. Dietary manager ensured all filters and vents were cleaned on 9/19/25. Dietary Manager ensured all facility utensils were properly covered on 9/11/25. All residents are at risk of illness due to improper hand hygiene by kitchen staff, improper procurement of food, and failure to routinely clean vents, filters and cords. 2.Dietary Manager or designee will complete education with all dietary staff on cleaning schedules and hand hygiene. NHA or designee will educate all staff on the resident food storage policy. Education will occur no later than October 15, 2025. Those not at the education session will be educated prior to their first shift worked. 3.The NHA or designee will audit five meal services per week to observe proper hand hygiene; Cleanliness of the kitchen including cords, vents, and filters five times weekly for three months; and all utensils are properly covered during five meal services per week for three months. Additionally, the NHA will audit the resident refrigerator each week for 4 weeks then monthly for 2 months to ensure all items are dated and discarded per policy. Results of the audits will be discussed by the NHA or designee at the monthly QAPI meeting with IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	10/15/25

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F0812 SS = E	Continued from page 73 Findings include: 1. Observation on 9/9/25 at 10:10 a.m. in the kitchen revealed: *A power cord was hung from the ceiling and draped down to the floor by the middle of the food prep countertops. -The power cord was covered in dust. -The cord was above clean bowls and plates on a shelf. -The hot food steamer used for serving residents' food was under the cord and the shelf storing clean dishware. *Serving utensils were stored in clear plastic containers under the food preparation counter. They were not covered. -The filter to the ventilation system was under the sanitizing sink was covered with dust and black in color. *Air vents next to the sanitization sink and in the dishwashing room were covered in dust. *A thick tan substance was built up in the filter next to the dishwasher. *Cook N, dietary aide Z, and dietary aide AA washed their hands in the designated handwashing sink and failed to use a paper towel to turn off the sink faucet. They repeated that same process for six of the nine handwashing observations during the food preparation for the lunch meal service. -The sign above the handwashing sink had instructions to: --a."Wet your hands with warm running water. Lather with soap and scrub between your fingers, on the backs of your hands, and under nails. Wash for at least 20 seconds, or as long as it takes to sing "Happy Birthday" to yourself twice. Dry hands. Use single-use paper towels. Use a paper towel when you turn off the tap." 2. Interview with dietary manager Y on 9/10/25 at 9:27 a.m. revealed: *The provider's handwashing policy and procedures was	F0812		

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F0812 SS = E	Continued from page 74 to use a paper towel to turn the faucet off after handwashing. *She would expect all kitchen staff to follow the correct procedure as directed in the policy. *She agreed that turning off the sink with bare hands would potentially contaminate those hands. 3. Interview with infection preventionist/wound care nurse C on 9/11/25 at 4:28 p.m. revealed: *Her expectation for performing hand hygiene is to wash with soap and water when hands are visibly soiled or use alcohol-based hand rub following all times in the facility's policy. *She would expect a single use paper towel to be used to turn off the faucet after every hand washing in the sink. 4. Review of the provider's 5/15/25 Hand Hygiene policy revealed: *Employees must wash hands using soap and water before and after eating or handling food. *"Washing hands: -Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for at least twenty seconds under a moderate stream of running water, at a comfortably temperature. -Rinse hands thoroughly under running water. Hold hands lower than wrists. Do not touch fingertips to the inside of the sink. -Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel." 5. Observation on 9/10/25 at 8:39 a.m. of the refrigerator in the dining room revealed: *Both the refrigerator and freezer compartments were locked. The keys were kept on top of the fridge. *Inside the refrigerator was: -A Styrofoam container with a dry baked potato. It was labeled with resident 5's name but no date was written on the container. -A plastic container labeled with resident 44's name	F0812		

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F0812 SS = E	Continued from page 75 and no date. There was meat, vegetables, and a type of dumpling in the container. There was a foul odor when the container was opened. -A plastic grocery bag filled with a green vegetable. It was sitting in liquid, and mold could be seen throughout the bag. The bag was labeled with resident 4's name. No date was written on it. 6. Interview with activities director (AD) V on 9/11/25 at 9:20 a.m. revealed: *She and activity aide W were responsible for managing the refrigerator in the dining room. *She was to check the refrigerator temperature daily and record it in a log. *It is "deep cleaned" weekly or sooner if needed. The deep clean included: -Making sure every food item has a label with the resident's name and the date it was put in the refrigerator. *The cleaning log showed the last clean of that refrigerator was 9/2/25. *She agreed that the food without a date on it should have been thrown away with the last cleaning on 9/2/25. *Food was to be thrown away after three to five days. 7. Review of the provider's 11/19/24 Food Brought in by Outside Sources policy revealed: *"All food brought by visitors and family members from the outside of the facility will be labeled with the date it was brought to the facility'. *"If refrigeration is required, the food items will be placed inside the refrigerator". *"After three to five days, these food items will be discarded'. *"All undated food items will be discarded to ensure safety of the residents".	F0812		
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.	F0842	1.Resident 31 PASRR was uploaded to the medical record on 10/02/25 by SSD. MDS comprehensive assessments submitted 4/2/25, 5/29/25, 6/16/25, and 7/25/25 have been reviewed by Corporate MDS and corrected as indicated.	10/15/25

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F0842 SS = D	Continued from page 76 (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 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.	F0842	A full house audit will be completed by NHA or designee by 10/15/25 to ensure all residents have the appropriate PASRRs completed and uploaded to the electronic medical record. 2. Licensed Social Worker will provide education to Social Service Designee no later than 10/7/25 to upload all PASRRs to the electronic medical record. A new MDS Coordinator has been assigned on site at the facility and has been educated by the Corporate MDS of triggering conditions requiring a Level II PASRR and to notify Social Services Designee if a Level II is indicated and/or not located on 10/6/25. 3.The NHA or Designee will audit all new residents weekly to determine if they have the appropriate PASRR level completed and uploaded to the EMR for 4 weeks then monthly for 2 months. The NHA or Designee will track and audit all residents with a 100 day PASRR to ensure that it is updated at the 100 day mark should the resident remain in the facility. The audit will be weekly for 4 weeks then monthly for 6 months. Results of the audits will be discussed by the NHA or designee at the monthly QAPI meeting with IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on findings.	

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F0842 SS = D	Continued from page 77 §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 record review, interview, and policy review, the provider failed to ensure preadmission screening and resident review (PASRR) assessment level II (level two, in-depth evaluation of a resident's needs, recommended services, and determination of what type of setting was appropriate for her care) had been uploaded and/or available within the record when conducting the Minimum Data Set (MDS) assessment (a tool used to evaluation a resident's health status and to develop an individualized care plan to manage the resident's care needs) for one of two sampled residents (31) with a chronic post-traumatic stress disorder (PTSD) (a disorder in which a person has lasting difficulty recovering after exposure to a traumatic event). Findings include: 1. Review of resident 31's electronic medical record (EMR) revealed:	F0842		

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F0842 SS = D	Continued from page 78 *She was admitted on 11/5/24. *She had a 7/24/25 Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated her cognition was intact. *Resident 31's diagnoses included adjustment disorder (a mental health reaction to stressful life events or changes that are considered a maladaptive response to a psychosocial stressor), borderline personality disorder (a mental disorder characterized by unstable moods, behavior, and relationships), major depressive disorder, PTSD, nightmare disorder (repeated intense nightmares), and anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). *She had a 9/2/25 physician's orders for, "Bupropion HCL ER (XL) Tablet Extended Release 24 Hour [and anti-depressant medication]150 MG [milligrams] Give 1 tablet by mouth one time a day for depression", and a 9/2/25 physician's order for "DULoxetine HCL Capsule Delayed Release Particles [an anti-depressant medication] 30 MG Give 3 capsules by mouth at bedtime for depression". *Her 9/10/25 care plan had focus areas of "I am at risk for experiencing Hallucinations [to see, hear, smell, taste or touch something that is not there]", "I am at risk for altered thought process r/t [related to] new environment, adjustment disorder, [and] PTSD", and "I receive Psychoactive medications [drugs that affect brain activities associated with mental processes and behavior] d/t [due to] Adjustment disorder, Personality Disorder, Depression, PTSD, [and] Nightmare disorder". *Resident 31's 10/29/24 PASRR screening form stated, resident 31 "is suspected as having a PASRR condition due to a diagnosis of MDD [major depressive disorder] and will likely need a [PASRR] Level II unless categorical applies. Do you know if this individual will need less than a 100 day stay in the NF/SB [nursing facility/swing bed]? If so, you can have your doctor write an order that states they will need less than 100 days in the NF/SB and send that to us, and we can give the Convalescent Categorical [refers to a person who is recovering from an illness or operation], where they will be approved for 100 days. If they stay past 100 days a new referral would need [be needed] in order to have a Level II completed at that time." *Resident 31 did not have a PASRR level II in her EMR.	F0842		

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F0842 SS = D	Continued from page 79 2. Interview on 9/10/25 at 1:52 p.m. with social services designee (SSD) D revealed: *A PASRR screening needed to be completed prior to the admission of a resident. *There were two different levels of a PASRR, I (one) and II. *If a resident was issued a 100-day PASSR, meaning they were not expected to remain in the facility for more than 100 days, and remained in the facility longer than 100 days she would refile a PASRR screening to determine if the resident qualified for a PASRR II. *Resident 31 had a 100-day PASRR and remained in the facility longer than 100 days. *SSD D was unable to locate a PASRR after resident 31's 100 days in the facility at that time. *She stated she would have to look through her files to determine if one had been submitted. *On 9/11/25 SSD D provided resident 31's 2/25/25 Level II PASRR. 3. Interview on 9/11/25 at 1:00 p.m. with administrator A revealed: *The provider did not have a MDS coordinator who worked onsite at the facility, and the resident's MDS assessments were completed by an off-site corporate MDS coordinator. *The provider did not have an MDS policy, they referred to the Resident Assessment Instrument (RAI) manual. 4. Interview on 9/11/25 at 1:58 p.m. with SSD D and corporate MDS coordinator P revealed: *Since corporate MDS coordinator P was not on-site she completed the residents' MDS assessments according to the documents found in the residents' EMR. *The PASRR II received on 2/25/25 had not been uploaded into resident 31's EMR, therefore corporate MDS coordinator P was not able to locate in resident 31's EMR that a PASRR II had been received so she completed resident 31's MDS assessment to reflect the information that was in resident 31's EMR, which was a PASRR I screen. *SSD D verified she had not uploaded the PASRR II into	F0842		

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F0842 SS = D	Continued from page 80 resident 31's EMR so corporate MDS coordinator P would not have known a PASRR II had been received for resident 31. *SSD D and corporate MDS coordinator verified resident 31's comprehensive MDS assessments submitted on 4/2/25, 5/29/25, 6/16/25, and 7/25/25 were inaccurate as they indicated resident 31 did not have a PASRR level II. 5. Interview on 9/11/25 at 4:46 p.m. with director of nursing (DON) B revealed she expected the MDS assessment to be accurate and coded correctly. 6. Interview on 9/11/25 at 5:31 p.m. with administrator A revealed she expected the MDS assessment to be complete and accurate. 7. Review of the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.19.1 October 2024 pages A-30 thought A-34 revealed: *"All individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual's payment source, must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), developmental disability (DD), or related conditions." *"Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State." *"A resident with MI or ID/DD must have a Resident Review (RR) conducted when there is a significant change in the resident's physical or mental condition. Therefore, when an SCSA is completed for a resident with MI or ID/DD, the nursing home is required to notify the State mental health authority, intellectual disability or developmental disability authority (depending on which operates in their State) in order to notify them of the resident's change in status." *"Review the Level I PASRR form to determine whether a Level II PASRR was required. *"Review the PASRR report provided by the State if Level II screening was required."	F0842		
F0880 SS = E	Infection Prevention & Control	F0880	1. No immediate corrective action can be completed for Resident 5, 6, 8, and 39.	10/15/25

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F0880 SS = E	Continued from page 81 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (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	F0880	LPN K was provided verbal education on individual glucometers during the survey 9/11/25 by DON. LPN E is on a medical leave and will be educated on handling of drinking cup during medication pass and hand hygiene upon return from leave. Certified Nurses Aide T was provided education on 10/2/25 by DON on hand hygiene. Guest Services F is no longer employed at the facility. All residents are at risk from staff not completing hand hygiene during medication pass or when assisting with cares. All residents are at risk for not following disinfection of shared blood glucose monitors. All glucose monitors were replaced and individual glucometers were placed in the nurses cart with resident individual names on 9/11/25. All residents are at risk if staff do not follow protocols for donning and doffing PPE when entering or exiting a transmission-based precaution room. 2.DON or designee will educate all staff on the Hand Hygiene Policy, Transmission based Precautions policy, and the Enhanced Barrier Precautions Policy. All licensed nurses and medication aides will be educated on the Blood Glucose Monitor Disinfection Policy. Education will occur no later than October 15, 2025. Those not at the education session will be educated prior to their first shift worked.	

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F0880 SS = E	Continued from page 82 prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, policy review, and review of the manufacturer's Important Safety Precautions, including instructions on how to clean and disinfect the glucometer, the provider failed to ensure: One of one observed guest service aide (F) who did not wear personal protective equipment while in two of two sampled residents' (5 and 8) rooms. One of one observed certified nurse aide (CNA) (T) who did not wash her hands after removing unclean gloves after assisting sampled resident (39) with personal care and dressing. One of one observed licensed practical nurse (LPN) (E) who did not wash her hands and placed a drinking straw inside one sampled resident's (6) lidded water cup with her bare, unwashed hands. *One of one observed LPN (K) who did not follow the manufacturer's recommendations for disinfection of a shared blood glucose monitor (glucometer) that was used to test multiple residents. Findings include:	F0880	3. DON or designee will complete 10 observations of staff entering a transmission-based precaution/enhanced barrier precaution room to ensure the staff don and doff PPE. DON or designee will complete 10 observations of hand hygiene opportunities to ensure staff are completing hand hygiene. DON or designee will complete 5 observations of blood glucose monitor use to ensure individual glucometer is used for each resident and it is disinfected per policy. The audits will be weekly for 4 weeks then monthly for 2 months. Results of the audits will be discussed by the DON or designee at the monthly QAPI meeting with IDT and Medical Director for analysis, recommendation for continuation/ discontinuation/revision of audits based on findings.	

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F0880 SS = E	Continued from page 83 1. Observation and interview with guest services aide F outside of resident 5's room on 9/9/25 at 2:29 p.m. revealed: *She was passing out fresh ice water to the residents. She did not perform hand hygiene before entering resident 5's room and was wearing a face mask. That room had a sign that read "Enhanced Droplet Precautions" next to the door. She exited the room and performed hand hygiene. She then entered resident 8's room, which had the same sign next to the door. She did not change her face mask between those two residents' rooms. She performed hand hygiene when she left. *She explained the sign on those doors meant that personal protective equipment (PPE) was expected to be worn in the room. Guest services aide F stated "I would definitely wear a gown." *The sign indicated a surgical mask or N95 mask, gown, gloves, and eye protection [goggles or glasses] were to be worn while in those rooms. 2.Interview with infection preventionist/wound care nurse C on 9/11/25 at 4:28 p.m. revealed: *She would expect all staff members to wear the correct PPE per policy. Interview with director of nursing B on 9/11/25 at 4:46 p.m. revealed: *She expected all staff to perform hand hygiene following the facility's policy. *She would expect staff to always wear the correct PPE per facility policy. 3. Observation and interview on 9/9/25 at 8:54 a.m. with CNA T in resident 39's room revealed she performed hand hygiene, and put on a clean pair of gloves. After changing the resident's incontinence brief, she removed her gloves and, without washing her hands, put on a clean pair of gloves. She then assisted resident 39 with dressing. CNA T confirmed that she should have performed hand hygiene after removing her unclean gloves and before putting on clean gloves. 4. Observation on 9/9/25 at 11:59 a.m. of LPN E inside of resident 6's room revealed she used her bare hand to place a straw inside the resident's lidded plastic cup. The resident then used the straw to drink water from the cup to swallow his medication.	F0880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = E	Continued from page 84 Interview on 9/9/25 at 12:01 p.m. with LPN E regarding the above observation revealed she stated she should have applied gloves or washed her hands before she handled the straw and gave it to the resident. 5. Observation and interview on 9/11/25 at 8:57 a.m. with LPN K revealed: *There was an unlabeled glucometer on top of the medication (med) cart. *She was observed taking the glucometer to check other residents' blood sugar that day. *LPN K took that glucometer into resident 58's room, performed hand hygiene, put on gloves, checked his blood sugar, disposed of the lancet (a small, pointed instrument used to prick the skin and obtain a blood sample for testing) and test strip, removed her gloves, and performed hand hygiene. *She then administered resident 58's medications and put the glucometer back on top of the med cart. *She stated the glucometer was used to check blood sugars for all of the residents with orders for blood sugar checks. *She said, "I'll clean it with a wipe before I go see my next resident." *There were no cleaning wipes on the med cart, and she stated, "I'll go track one down." *She left and returned with a container of bleach wipes, wiped the glucometer with one bleach wipe, and set the container of bleach wipes on top of the med cart. *She said she used a bleach wipe since the glucometer could be contaminated with blood. 6. Interview on 9/11/25 at 1:36 p.m. with DON B about shared glucometer use revealed: *She stated, "Our policy says they should all have individual glucometers that are stored in their room or in the med cart." *She agreed the provider's policy had not been followed. Review of the provider's 5/15/25 Hand Hygiene policy revealed hand hygiene was expected to have been	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA ARROWHEAD	2500 ARROWHEAD DR , RAPID CITY, South Dakota, 57702

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F0880 SS = E	Continued from page 85 performed "Before moving from a contaminated body site to a clean body site during resident care." "Gloves should be removed, hand hygiene performed and [a] new pair of gloves applied." Review of the manufacturer's Important Safety Precautions and instructions to clean and disinfect the glucometer revealed: *"Users need to adhere to Standard Precautions [a set of infection control practices designed to prevent the transmission of infectious diseases] when handling or using this device. All parts of the glucose monitoring system should be considered potentially infectious and are capable of transmitting blood-borne pathogens between patients and healthcare professionals." *"The meter should be disinfected after use on each patient. This Blood Glucose Monitoring System may only be used for testing multiple patients when Standard Precautions and the manufacturer's disinfection procedures are followed." *"When to clean and disinfect the meter -All surface of meter if visibly soiled must be physically cleaned to remove gross soil. Disinfect the meter between each patient to prevent infection." *"How to clean and disinfect the meter -The meter must be cleaned prior to the disinfection. Use one disinfecting wipe to clean exposed surfaces of the meter thoroughly and remove any visible dirt, blood, or any other body fluid with the wipe. Use a second wipe to disinfect the meter by following the disinfecting procedure below. We recommend for meter cleaning and disinfection you should use the disinfecting wipe/towelette: --Micro-Kill Plus [disinfectant wipe]." *"Disinfecting Procedures" -"…Keep meter wet with disinfection solution for a minimum of 2 minutes for Micro-Kill Plus." "Each cleaning and disinfection cycle includes a pre-cleaning step with one wipe and a disinfection step with a second wipe." Review of the provider's 2/24/25 Blood Glucose Monitor Cleaning and Disinfection policy revealed:	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

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F0880 SS = E	Continued from page 86 *"Policy: -Individual blood glucose monitors and strips will be issued to each resident requiring testing and the unit will be cleaned and control tested per policy. The monitor is to be used for a single resident only." *"Procedure: -Monitors will be labeled with Resident's name and stored in its case or plastic bag in the resident's room, in medication room or in medication cart. -Perform blood glucose test according to manufacturer's instructions and physician order." *"Clean and disinfect the monitor weekly or when visible soiled per manufacturer's instructions. Use an EPA approved disinfectant for contact time specified." *"Upon discharge of resident, monitor can be sent home with resident or discarded."	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435051	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA ARROWHEAD	2500 ARROWHEAD DR , RAPID CITY, South Dakota, 57702

(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
K0000	INITIAL COMMENTS A recertification survey was conducted on 9/9/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avantara Arrowhead was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K271 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0271 Bldg. 01	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This STANDARD is NOT MET as evidenced by: Based on observations and interviews the provider failed tomake clear the direction of egress travel from the exit discharge (western exit door) to a public way (NFPA 101 7.7.3.2), andensure the exit discharge was free from obstructions (NFPA 7.1.10.1).That affected one of eight facility exits. Findings include:Observation and interview on 9/9/25 at 1:25 p.m. revealed a fenced sidewalk outside the western exit door in the west wing was constructed with a tee. The tee forced a traveler leaving the facility to decide to turn left or right. A turn to the left led one to the facility patio (not a public way). A turn to the right led one to a public way (parking lot) beyond a fence gate with a latch that required extra effort to open (obstacle to exit discharge).Interview with and independent observation by the maintenance supervisor	K0271	1. All residents are at risk on the Discharge for Exits CFR(s): NFPA 101 18.2.7, 19.2.7. No proper signage exiting west hall egress door. A left turn would lead exit seeking people to the fenced in patio with no exit to a public area. A right turn would lead exit seeking people to a fence which has public access to the outside. The maintenance director posted the exit sign on the west egress door directing exiting people to turn right for the public way. The new exit sign was posted on 9/16/2025 to signal a right turn to exit towards the fence. In addition, it was observed that the fence gate leading to the right was not latching properly. The latch was fixed on 9/11/2025 by maintenance director. 2. The administrator will in-service maintenance director to ensure the facility has proper signage for exits with clear directions and to ensure all gate latches are properly engaging within the Administrative Rule of South Dakota. 3. The Administrator or designee will complete monthly audits for 4 months to ensure all facility. Results of audits will be reported by administrator or designee to monthly QAPI meeting for further review and recommendation and/or continuance/discontinuance of audits. 4. October 15, 2025.	10/15/25

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
Sharon Martin	Administrator	10/03/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435051	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0271 Bldg. 01	Continued from page 1 at the time of the finding confirmed the finding.	K0271		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10668	A. BUILDING: _____ B. WING _____	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/9/25 through 9/11/25. Avantara Arrowhead was found not in compliance with the following requirement: S121.	S 000		
S 121	44:73:02:01 Sanitation The facility shall be designed, constructed, maintained, and operated to minimize the sources and transmission of infectious diseases and ensure the safety and well-being of residents, personnel, visitors, and the community at large. This requirement shall be accomplished by providing the physical resources, personnel, and technical expertise necessary to ensure good public health practices for institutional sanitation. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the facility failed to ensure proper sanitation practices for the storage of resident-use items in three observed closets located in the facility's west wing and two observed closets located in the facility's east wing. Findings include: 1. Observation and interview on 9/9/2025 at 1:34 p.m. with the maintenance supervisor in the west wing therapy storage closet revealed two cardboard boxes that contained cloth covered pads used during resident floor therapy sessions were stored on the floor. 2. Observation and interview on 9/9/2025 at 1:37	S 121	1. All residents are at risk on Sanitation 44:73:02:01 due to observation of failure to ensure proper sanitation practices for the storage of resident-use items. All boxes and items were removed off the floor both east and west hall storage closets on 9/11/2025. 2. The administrator will in-service maintenance director to ensure all boxes and all items remain off the floor in all storage closets by October 15, 2025. 3. The administrator or designee will complete weekly audits for 4 weeks and then monthly for 2 months to ensure boxes and items are not on the floor of both storage closets in accordance with the Administrative Rule of South Dakota. Results of monthly audits will be reported by administrator or designee to monthly QAPI meeting for further review and recommendation and/or continuance of audits. 4. October 15, 2025.	10/15/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sharon Martin — TITLE: Administrator — (X6) DATE: 10/03/2025

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10668	A. BUILDING: _____ B. WING _____	09/11/2025

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S 121	Continued From page 1 p.m. with the maintenance supervisor in the west wing brief storage closet revealed six packages of incontinence briefs were stored on the floor. 3. Observation and interview on 9/9/2025 at 1:43 p.m. with the maintenance supervisor in the west wing central supply closet revealed two cardboard boxes that contained exam gloves were stored on the floor. 4. Observation and interview on 9/9/2025 at 2:40 p.m. with the maintenance supervisor in the east wing central supply closet revealed one cardboard computer printer paper box that contained shoe covers was stored on the floor. 5. Observation and interview on 9/9/2025 at 2:43 p.m. with the maintenance supervisor in the east wing brief storage closet revealed one cardboard box containing incontinence briefs and one loose brief were stored on the floor. The maintenance supervisor confirmed all of those findings and agreed that they were sanitation deficiencies.	S 121		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 9/9/25 through 9/11/25. Avantara Arrowhead was found in compliance.	S 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 9/9/25. Avantara Arrowhead was found in compliance.	E0000		

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
Sharon Martin	Administrator	10/03/2025