STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345260	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mount Rehabilitation Center	**160 S Winstead Avenue , Rocky Mount, North Carolina, 27804**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 9/21/25 through 9/25/25. In accordance with QSO-26-01-All, the posting of this Statement of Deficiencies was delayed as a result of the Federal Government shutdown. The exit date of this survey has been adjusted based on CMS guidance. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1D7086-H1.	E0000		12/08/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 9/21/25 through 9/25/25. Event ID#1D7086-H1. In accordance with QSO-26-01-All, the posting of this Statement of Deficiencies was delayed as a result of the Federal Government shutdown. The exit date of this survey has been adjusted based on CMS guidance. The following intakes were investigated 2607002, 2606981, 2599878, 2594571, 2592499, 2582313, 811701, 811698, 811697, 811696, 811695, and 811694. 6 of the 22 complaint allegations resulted in deficiency.	F0000		12/08/2025
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F0602	F602 – Misappropriation 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Director of Nursing contacted pharmacy and the Center replaced Resident #38's and Resident #83's medication on 9/4/2025. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	12/08/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0602 SS = D	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff, resident and Pharmacist interviews, the facility failed to protect the resident's right to be free from misappropriation of narcotic medication for 2 of 4 residents reviewed for misappropriation of property (Resident #38 and Resident #83). The findings included: The facility's Abuse and Neglect Prohibition policy last revised 8/2023 indicated that each resident had the right to be free from abuse which included misappropriation of property which was defined as deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. a. Resident #38 was admitted to the facility on 10/27/23 with diagnoses which included chronic kidney disease, gout, and long-term use of opiate analgesic (a type of opioid pain medication). Resident #38 had a physician order dated 8/21/25 for oxycodone (opioid pain medication) 5 milligrams (mg); one tablet by mouth three times a day for pain. A pharmacy proof of delivery shipment summary dated 8/26/25 revealed a delivery for Resident #38's oxycodone 5 mg tablets with a quantity of 90 tablets (3 medication cards with 30 tablets per card) on 8/27/25. Resident #38's Medication Administration Record (MAR) was reviewed for August 2025 and September 2025 and the oxycodone 5 mg tablet was administered as ordered. An interview was conducted with Resident #38 on 9/21/25 at 11:10 am who revealed she had no concerns related to pain management. b. Resident #83 was admitted to the facility on 4/22/24 with diagnoses which included chronic pain and peripheral vascular disease. Resident #83 had a physician order dated 8/15/25 for oxycodone 7.5 mg/acetaminophen 325 mg (an opioid pain medication); give one tablet by mouth every 4 hours for chronic pain. A pharmacy proof of delivery shipment summary dated 8/15/25 revealed a delivery for Resident #83's oxycodone 7.5 mg/acetaminophen 325 mg tablets with a quantity of 180 tablets (6 medication cards with 30	F0602	Continued from page 1 On 8/30/25 the Staff Development Coordinator initiated an audit of the prior 7 days of pharmacy deliveries versus availability and reviewed the prior 14 days of pharmacy returns. With no negative findings. Audit completed on 8/31/25 On 8/31/25 audit was completed of all medication carts to ensure that no other narcotics were unaccounted for by the Staff Development Coordinator. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. On 8/29/25 Staff Development Coordinator initiated education with licensed nurses regarding procedure for counting and reconciliation of controlled substances. To include when reconciling controlled substances, your count includes counting the actual medications in the cards, counting the individual cards and counting the individual sheets for each card. Education was completed on 9/6/25 by SDC. On 11/25/25, Regional Clinical Director completed education with the Administrator and Clinical Leadership on ensuring that complaints are filed with the Board of Nursing when a suspected drug diversion involves staff. On 10/01/25, Staff Development Coordinator initiated education with Center staff on Abuse and Neglect with an emphasis on misappropriation. Education was completed on 12/7/25. Newly hired Licensed Nurses will be educated during Department Orientation on Controlled Substance Reconciliation by the Staff Development Coordinator/Designee. Newly hired Center staff will be educated on Abuse, Neglect and Misappropriation during department orientation by the Staff Development Coordinator/Designee. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Audit of 2 sampled residents identified with orders for narcotic medication will be reviewed to ensure that each properly reconciled that includes availability, and accuracy of shift change inventory sheet, and accuracy of utilization sheets. Weekly x 12 weeks by Director of Nursing/designee.	

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F0602 SS = D	Continued from page 2 tablets per card) on 8/15/25. Resident #83's MAR was reviewed for August 2025 and September 2025 and the oxycodone 7.5 mg/acetaminophen 325 mg tablet was administered as ordered. An interview was conducted with Resident #83 on 9/21/25 at 12:52 pm. Resident #83 stated the facility managed her pain well and she did not have any concerns related to pain management. The initial allegation report completed by the Administrator revealed the facility became aware of misappropriation of resident property on 8/31/25 when the Staff Development Coordinator (SDC) and the Regional Clinical Director notified the Administrator that Resident #38 and Resident #83 had missing narcotics and the medications were unable to be located in the facility. The Administrator submitted an initial report to the Division of Health Service Regulation for misappropriation of resident property for Resident #38 and Resident #83 on 8/31/25. The police department was notified of suspicion of crime on 8/31/25 at 3:53 pm. A review of the 5-day investigation report completed by the Administrator dated 9/05/25 revealed that the allegation of misappropriation of resident property identified two residents (Resident #38 and Resident #83) who were affected and the allegation was not substantiated by the facility. The facility's investigation indicated that Resident #38 had one medication card, which contained 30 tablets, of oxycodone 5 mg tablets and Resident #83 had one medication card, which contained 30 tablets of oxycodone 7.5 mg/acetaminophen 325 mg tablets, that were each unable to be located in the facility. Nurse #11, who was the named agency nurse in the investigation report, was placed on the "do not return" list. The local police department, Adult Protective Services, and the Drug Enforcement Agency (DEA) were notified of the missing narcotics. Attempts to conduct a telephone interview with Nurse #11 on 9/24/25 at 3:44 pm and 9/25/25 at 9:30 am were unsuccessful. An interview was conducted with Nurse #9 on 9/24/25 at 1:16 pm who revealed she worked on the medication cart utilized for the hall Resident #38 and Resident #83 resided on during the 7:00 am-3:00 pm shift on 8/28/25 and 8/29/25. Nurse #9 stated she arrived to work on 8/29/25 for the 7:00 am-3:00 pm shift and she completed the narcotic count for the medication cart with Nurse #11. Nurse #9 stated when they completed the narcotic	F0602	Continued from page 2 Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A/QAPI) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of Compliance: 12/8/25	

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F0602 SS = D	Continued from page 3 count the number of narcotic medication cards in the locked drawer of the medication cart matched the number of the narcotics noted on the controlled drug count record (used to monitor narcotics that were added and removed from the medication cart), which she recalled was noted as 25 narcotic medication cards. Nurse #9 stated she had worked the previous day (8/28/25) and recalled the number of narcotic reconciliation for the medication cart was 27 when she completed her shift at 3:00 pm and she could not recall any of the narcotics being close to empty. Nurse #9 explained that narcotic cards were only removed when discontinued or the pack was empty and she knew nothing was close to empty when she left the previous today. Nurse #9 further explained that she felt like something was off with the narcotic medication card count throughout her shift even though the number of narcotic medication cards and the number of countdown sheets matched. Nurse #9 stated she questioned Nurse #11 about what narcotic medication cards were removed from the narcotic lock box on the medication cart and she stated Nurse #11 denied removing any narcotics. Nurse #9 stated she then left the medication cart to look for the completed narcotic count down sheets or the medication packs that were removed and during that time, Nurse #11 left the facility. Nurse #9 stated when Nurse #10 had arrived at the facility on 8/29/25 for the start of her 3:00 pm-11:00 pm shift she (Nurse #9) asked her (Nurse #10) if she recalled removing any completed narcotics from the medication cart during her shift on 8/28/25 and Nurse #10 stated she did not have to discard any completed narcotic medication cards from the narcotic drawer during her shift. Nurse #9 stated at that point she notified the SDC, who was at the facility at the time, of the possible discrepancy with the medication cart narcotic count. She stated at that time she and the SDC began looking through the medication cart with her to determine if any narcotics were missing. Nurse #9 stated it was found that Resident #38 and Resident #83 each had one narcotic medication pack and countdown sheets for those medication packs missing from the medication cart. A telephone interview was conducted with Nurse #10 on 9/25/25 at 11:36 am who revealed she worked on 8/28/25 and 8/29/25 during the 3:00 pm-11:00 pm shift. She stated she counted the narcotics on the medication cart with Nurse #11 on 8/28/25 at the end of her shift and the count was correct. Nurse #10 stated she could not recall at this time what the count was but she stated there was no discrepancy when she left the facility after her shift on 8/28/25. Nurse #10 stated she recalled that on 8/29/25 when she arrived back to work, Nurse #9 asked her if she had to remove any narcotics	F0602		

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F0602 SS = D	Continued from page 4 from the medication cart during her shift on 8/28/25 and she stated she did not have to remove any narcotic medication cards or complete countdown sheets during her shift. Nurse #10 stated the SDC was present at the facility at this time and the SDC began looking for any medications that may have been removed. A telephone interview was conducted with the Pharmacist on 9/24/25 at 3:46 pm who revealed when controlled substances (such as narcotics) were sent from the pharmacy to the facility the medications were scanned and secured in a delivery bag with a manifest (list of all the controlled substances in the delivery). She stated the delivery driver then delivered the controlled substances and a nurse at the facility had to check the medications to ensure accuracy with the manifest and then sign the manifest confirming the delivery was accurate. The Pharmacist stated that each narcotic medication pack was sent to the facility with an individual count down sheet for each pack, and she stated the medication packs normally had 30 tablets per pack. The Pharmacist stated the facility was to notify the pharmacy of any discrepances related to narcotics once identified and she confirmed the information was received from the facility when the discrepancy was identified. During an interview on 9/23/25 at 12:57 pm with the Previous Director of Nursing (DON) she stated she was not present at the facility during the time the narcotics for Resident #38 and Resident #83 were identified as missing but she stated the Administrator, SDC, and corporate office managed the investigation. An interview was conducted with the Administrator on 9/24/25 at 4:25 pm who revealed he was notified at the end of the day on 8/29/25 that there may have been a narcotic discrepancy with one of the medication carts at the facility but it was not confirmed until 8/31/25. He stated the SDC was present at the facility at the time and began an investigation to locate the missing medications and after a full search of the facility and investigation the missing narcotics were confirmed. The Administrator stated he reported the allegation to the appropriate agencies and the facility replaced the missing narcotics. The Administrator stated the facility was unable to substantiate the allegation and did not report Nurse #11 to the North Carolina Board of Nursing because the facility was unable to speak with Nurse #11 about the missing narcotics. The Administrator confirmed that the facility was unable to locate Resident #38's and Resident #83's missing narcotics, that the narcotics were removed from the facility, and that Nurse #11 was the named nurse in the	F0602		

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F0602 SS = D	Continued from page 5 allegation. The facility provided a plan of correction that was not acceptable to the State Agency as the facility did not report Nurse #11, the nurse suspected of misappropriating the narcotic medications for Resident #38 and Resident #83, to the North Carolina Board of Nursing.	F0602		
F0628 SS = B	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the	F0628	F628 - Discharge Process 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #12 is currently residing in the Center and was informed on the Bed Hold Policy by the Director of Clinical Services on 10/7/25. Resident #15 was discharged on 10/2/25 and did not return to the Center. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. An audit was completed by Director of Nursing/Designee on 10/13/25 for residents transferred to the hospital for dates 10/6/25 to 10/12/25. Any areas of needed improvement related to written bed hold notification were corrected. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. Education was provided by Director of Nursing/Designee to Licensed Nurses regarding written bed hold notification to be sent and documented on during transfer. Education was completed by 10/20/25. Education was provided by Nursing Home Administrator (NHA) to Clinical Management regarding transferred resident’s charts to be reviewed in Clinical Morning Meeting to ensure proper written notification is provided and documented as required. Education was completed by 10/20/25.	12/08/2025

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F0628 SS = B	Continued from page 6 reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred	F0628	Continued from page 6 Education was provided by NHA to the Admissions Director, Admissions Coordinator, and the Business Office Manger on following up on bed hold and documenting in the Electronic Medical Record. Education was completed by 10/20/25. Newly hired Licensed Nurses, Admissions Director/Coordinator, and Business Office Manager will be educated during Department Orientation on the Bed Hold Policy by the Staff Development Coordinator/Designee. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. NHA/Designee to audit for the completion of written bed notification for residents transferred out to the hospital 2x week for 12 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A/QAPI) Committee by the Administrator monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of Compliance: 12/8/25	

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F0628 SS = B	Continued from page 7 or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return-	F0628		

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F0628 SS = B	Continued from page 8 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by:	F0628		

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F0628 SS = B	Continued from page 9 Based on record review and staff interviews, the facility failed to provide the resident or Responsible Party (RP) the bed hold policy for 2 of 4 residents reviewed for hospitalization (Resident #12 and Resident #15). The findings included: 1a. Resident #12 was admitted to the facility on 8/02/24. The nursing progress note dated 8/08/25 revealed Resident #12 was sent to the hospital. The medical record indicated Resident #12 was discharged from the facility on 8/08/25 and returned to the facility on 8/13/25. The medical record was reviewed and no documentation was noted that the facility provided Resident #12 or the RP the bed hold policy. b. The nursing progress note dated 8/20/25 revealed Resident #12 was transferred to the hospital. The medical record indicated Resident #12 was discharged from the facility on 8/20/25 and returned to the facility on 8/29/25. The medical record was reviewed and no documentation was noted that the facility provided Resident #12 or the RP the bed hold policy. An interview was conducted with Resident #12 and the RP on 9/21/25 at 2:28 pm. Resident #12 and the RP revealed they did not receive any information regarding the bed hold policy when the resident was transferred to the hospital on 8/08/25 or 8/20/25. An interview was conducted with the Admission Director on 9/23/25 at 9:07 am who revealed she was responsible for providing residents and their RP with copies of the bed hold policy when a resident was transferred to the hospital. The Admission Director stated she did not normally discuss the bed hold policy when a resident was transferred to the hospital unless she needed to use the room for some reason. The Admission Director stated she did not discuss the bed hold policy with Resident #12 or the RP when he transferred to the hospital on 8/08/25 or 8/20/25. During an interview with the Vice President of Operations on 9/03/25 at 9:10 am he stated the Admission Director was the person that would discuss	F0628		

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F0628 SS = B	Continued from page 10 the bed hold policy for Resident #12. He reported that the facility was unable to locate any documentation that the bed hold policy was discussed for Resident #12's transfers to the hospital. 2. Resident #15 was admitted to the facility on 9/12/25. The nursing progress note dated 9/19/25 revealed Resident #15 was transferred to the hospital. The medical record indicated Resident #15 was discharged from the facility on 9/19/25. The medical record was reviewed and no documentation was noted that the facility provided Resident #15 or the RP the bed hold policy. A telephone interview was conducted with Resident #15's RP on 9/25/25 at 9:18 am who revealed she was not notified about the bed hold policy or procedure when Resident #15 was transferred to the hospital on 9/19/25. During an interview on 9/25/25 at 9:16 am with the Admission Director, she revealed she did not contact Resident #15's RP for the 9/19/25 transfer to the hospital to discuss the bed hold policy. The Admission Director stated she would not have contacted Resident #15's RP to discuss the bed hold policy unless she needed the room for another resident. An interview was conducted with the Vice President of Operations on 9/25/25 at 9:06 am who revealed the facility had no documentation about the bed hold policy communication with Resident #15's RP.	F0628		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to follow professional standards of care when the nurse did not remain at the bedside to ensure the resident had taken	F0658	F658 Professional Standards 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 9/21/2025, the Director of Nursing immediately educated Nurse #5 on medication administration and not to leave medications at bedside. Director of Nursing removed the medication from bedside on 9/21/2025. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	12/08/2025

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F0658 SS = D	Continued from page 11 all the medications. The deficient practice was observed for 1 of 1 resident observed with medications at bedside (Resident #74). The findings included: Resident #74 was admitted to the facility on 7/22/24 with diagnoses that included dependence on renal dialysis. Review of the medical record revealed a physician order dated 2/21/25 for Lanthanum Carbonate 500 milligram (MG) Chewable Tablet (a medication used to decrease the amount of phosphate in the blood caused by kidney disease). Give 3 tablets by mouth before meals. Review of the comprehensive Minimum Data Set (MDS) assessment dated 7/31/25 revealed Resident #74 was cognitively intact. Resident #74's care plan last reviewed 8/18/25 did not include self-administration of medication. There was not an assessment of Resident #74 in the medical record to determine if it was safe for the resident to self-administer medications. On 9/21/25 at 12:37 PM Resident #74 was observed with a large white pill with the number 500 sitting in a cup on her bedside table. Resident #74 reported she took the medication before breakfast, lunch, and dinner daily. Resident #74 reported she was going to take the medication and had placed the medication in the cup on the bedside table. An interview was conducted with Nurse #5 on 09/21/2025 at 1:43 PM. Nurse #5 stated she was supposed to watch the resident take her medication and make sure that she took all the medication before she left the room. Nurse #5 stated Resident #74 normally took all of her medication when given. An interview was conducted with Resident #74 with the Director of Nursing (DON) present on 09/21/2025 at 1:52 PM. Resident #74 stated that she took 2 of the tablets with the nurse there at the bedside. Resident #74 stated she must have forgotten to take the third pill. During an interview with the DON on 9/21/25 at 2:00 PM she stated Nurse #5 should have stayed with Resident #74 and watched her take the medication before exiting the room. An interview was conducted with the Administrator on	F0658	Continued from page 11 On 9/22/25 Clinical Leadership completed room checks to ensure that no medications were at bedside. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. On 9/21/25 Director of Nursing/Designee began education with Licensed Nurses on medication administration and ensuring that medications are not left at the bed-side for self-administration. Education was completed on 10/20/25. Newly hired Licensed Nurses will be educated during Department Orientation for medication administration and ensuring that medications are not left at bed-side for self-administration. Education will be provided by Staff Development Coordinator/designee. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Director of Nursing/Designee will complete Medication Administration Observation Audits with 2 Licensed Nurses per week x 12 weeks to ensure that medication is not left at the bedside. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A/QAPI) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance Date of Compliance: 12/8/25	

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F0658 SS = D	Continued from page 12 9/25/25 at 1:10 PM. The Administrator stated he expected the staff would make sure all medications were taken prior to leaving the resident.	F0658		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interviews, and record review, the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection for 1 of 4 residents reviewed with a urinary catheter (Resident #11). The findings included:	F0690	F690 -Bowel/ Bladder Incontinence, Catheter, UTI 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. 0n 9/21/25 Resident #11 bed was adjusted by Nurse Aide #1 so that urinary drainage bag was not touching the floor. On 9/26/25, urinary drainage bag was replaced and positioned so that they were not touching the floor by Regional Clinical Director. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 10/2/2025, Regional Clinical Director completed an audit of residents identified with urinary collection bags to ensure that drainage bags were not touching the floor. No concerns identified. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. The Director of Nursing/Designee to provide education to Licensed Nurses and Certified Nursing Assistant regarding catheter drainage bag must be placed in location to avoid touching the floor when in bed, out of bed or up in chair. Education to be completed by 10/20/25. Newly hired Licensed Nurses and Certified Nursing Assistants will be educated during Department Orientation on placement of drainage bags for indwelling catheters by the Staff Development Coordinator/Designee. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.	12/08/2025

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F0690 SS = D	Continued from page 13 Resident #11 was admitted to the facility on 7/15/25. Her cumulative diagnoses included urostomy, spina bifida, seizures, and chronic kidney disease. Resident #11's care plan included an area of focus related to the resident having an indwelling urinary catheter in place (Initiated on 7/16/25). An admission Minimum Data Set (MDS) assessment dated 2/12/25 revealed Resident #11 had severely impaired cognition. She experienced fluctuating disorganized thinking but no rejection of care behaviors. The assessment indicated Resident #11 required substantial/maximal assistance with all activities of daily living (ADL). The MDS reported Resident #11 had an indwelling urinary catheter. An observation was conducted on 9/21/25 at 12:35 PM as Resident #11 was lying in bed with a urinary catheter collection bag hanging from the left side of the bed frame. At the time of this observation, 3 inches of the bottom of Resident #11's urinary catheter bag was on the floor. During an interview on 9/21/25 at 1:29 PM with Nurse Aide #1, who was assigned to Resident #11, she stated that the catheter bag should not be touching the floor. However, when Resident #11’s bed went up and down, the catheter bag would touch the floor if the bed was too low. Nurse Aide #1 stated she normally emptied the bag at the end of her shift, so she did not know how long the catheter bag/cover was touching the floor. Nurse Aide #1 then raised Resident #11’s bed so that the catheter bag/cover was off the floor. An interview was conducted with the interim Director of Nursing (DON) on 9/24/25 at 9:15 AM. She revealed that the catheter bag should not be touching the floor or hanging above the abdomen. Resident #11’s catheter bag should never have been on the floor, and it should have been placed in a location that did not compromise her with a possible infection. The interim Administrator was interviewed on 9/24/25 at 10:23 AM. He revealed that Resident #11’s catheter bag should have been hung so when the bed was lowered it did not touch the floor.	F0690	Continued from page 13 The Director of Nursing/Designee will complete an audit of 2 sampled resident identified with urinary collection bags 2 times a week for 12 weeks to ensure drainage bags are not touching the floor. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A/QAPI) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of Compliance: 12/8/25	
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition	F0693	F 693 - Tube Feeding Management /Restore of Eating Skills 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.	12/08/2025

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F0693 SS = D	Continued from page 14 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide nutritional support through enteral feeding (a method of delivering nutrition directly into the gas trointestinal (GI) tract, typically through a feeding t ube) as ordered by the physician for 1 of 2 residents reviewed for tube feedings (Resident #79). The findings included: Resident #79 was readmitted to the facility on 3/17/25. His diagnoses included anoxic brain damage, and dysphagia. The care plan dated 3/13/24 revealed Resident #79 was at risk for malnutrition and dehydration related to a past medical history of aphasia, anoxic brain damage, gastrostomy tube (g-tube) feedings, heart failure, coronary artery disease, hypertension, gastroparesis, epilepsy, colostomy status, quadriplegia, and vitamin D deficiency. There was a need for enteral nutrition and on medications with signs and symptoms of appetite and weight changes. Interventions included: Administer g-tube feedings and water flushes as ordered. Observe for signs and symptoms of dehydration. Monitor and evaluate weight/weight changes. Monitor/record/report signs and symptoms of malnutrition.	F0693	Continued from page 14 On 9/21/25 Nurse #5 failed to provide enteral nutrition per provider order for Resident #79. Nurse #5 notified the Provider that enteral nutrition had not been administered per order and received a one-time order from the Provider for the enteral feeding pump to run until 13:00 on 9/21/25 and then resume previously enteral feeding order. On 9/21/25, Director of Nursing provided re-education to Nurse #5 regarding ensuring that residents identified as requiring enteral feeding, physician orders are followed in regard to infusion times. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 10/2/25 Director of Clinical Services completed an audit of residents identified with enteral feeding orders to ensure the enteral feeding was infusing via pump per provider orders. No other findings were noted. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. The Director of Nursing/Designee to provide education to Licensed Nurses regarding ensuring that residents identified with enteral feeding orders are followed regarding infusion times. Education to be completed by 10/20/25. The Director of Nursing/designee to provide education to Certified Nursing Assistants that they are not allowed to turn enteral pump on /off or place on hold. Education completed by 10/20/25. Newly hired Licensed Nurses and Certified Nursing Assistants will be educated during department orientation on tube feeding management by the Staff Development Coordinator/Designee. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing/Designee will complete audits of 2 sampled residents to ensure that the resident's enteral feeding is infusing per provider orders 2 times a week for 12 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A/QAPI) Committee by the	

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F0693 SS = D	Continued from page 15 The significant change Minimum Data Set (MDS) assessment dated 8/24/25 indicated Resident #79 was severely cognitively impaired and was totally dependent on staff for all activities of daily living (ADL). He had no speech and rarely/never understood/understands. The MDS indicated Resident #79's nutrition was approached with the use of tube feedings, and he received more than fifty one percent of his calories and more than five hundred and one milliliters of fluid intake per day from his tube feedings. The physician order dated 9/5/25 revealed Resident #79 was ordered fortified nutritional supplement at seventy-five milliliters (mL) per hour for twenty-two hours from two o'clock in the afternoon to twelve o'clock in the afternoon via g-tube. Medication Administration Record (MAR) dated September 2025 revealed fortified nutritional supplement at seventy-five milliliters (mL) per hour for twenty-two hours from two o'clock in the afternoon to twelve o'clock in the afternoon via g-tube. Nurse #5 documented on the MAR that the tube feeding was administered on 9/21/25 as scheduled. During a continuous observation on 9/2125 from 11:08 AM until 11:48 AM, Resident #79 was observed lying in bed, and the tube feeding pump screen was black with a green light signifying the battery was charging. The tube feeding formula was hanging with date/time identifiers, and the bottle was just about full (missing 1/8th of the amount). At 11:36 AM on 9/21/25, Nurse #5 was observed walking past Resident #79's room, looking in, and continued down the hall. An interview and observation with Nurse #5 were conducted on 9/21/25 at 11:49 AM. Nurse #5 confirmed that the tube feeding was supposed to be off from 12:00 PM – 2:00 PM every day. She stated she was not aware that Resident #79's tube feeding was not infusing from 11:08 AM – 11:49 AM. Nurse #5 indicated that perhaps Nurse Aide #2 provided care for Resident #79, turned off the tube feeding pump, and forgot to turn it back on.	F0693	Continued from page 15 Director of Nursing monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of Compliance: 12/8/25	

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F0693 SS = D	Continued from page 16 Nurse Aide #2 was interviewed on 9/21/25 at 11:52 AM. She revealed that she provided care to Resident #79 at 7:00 AM the same morning. Normally, when she performed care for Resident #79, she would place the tube feeding pump on hold and then when finished with care, she would unlock the hold. Nurse Aide #2 stated she never turned the tube feeding pump off completely. She further stated that she could not say when she was in the room last but had passed by the room since 7:00 AM and did not notice if the tube feeding pump was off. During an interview with the Director of Nursing (DON) on 9/24/25 at 9:35 AM, she revealed that Resident #79's tube feeding pump should not have been turned off from 11:08 AM - 11:48 AM. Nurse #5 should have followed the physician order to hold the feeding from 12:00 PM until 2:00 PM. The interim DON stated that rounds were performed every two hours by Nurse Aide #2 and anytime Nurse #5 went into the room to give medication. The Administrator was interviewed on 9/24/25 at 10:24 AM. He revealed that the physician's order for Resident #79's continuous tube feeding should have been followed as ordered. Unless care was provided, the tube feeding pump should be kept on.	F0693		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff and Medical Director interviews, the facility failed to have effective systems in place for entering tracheostomy care orders, so they were placed on the Treatment Administration Record (TAR) for completion by nursing staff. Nurse #2 did not provide tracheostomy care consistent with professional standards of practice when she was observed picking up the oxygen tubing off the floor and attaching it to the corrugated tubing connected to the humidifier (adds moisture to the	F0695	F695 Respiratory/Tracheostomy Care, Suctioning 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 9/24/25 Nurse #1 provided Tracheostomy Care to Resident #9 and replaced all oxygen tubing. On 9/24/25 Medical Director was notified that current tracheostomy care order was not present on the treatment administration record by the Regional Clinical Director. Unit Manager obtained new order from provider to include Tracheostomy Care every shift and prn (as needed) with a schedule to allow for documentation in the electronic treatment administration record on 9/24/25. On, 9/24/25, Wound Nurse assessed area to the neck of Resident #9 and noted it to be Moisture Associated Skin Damage. Wound Nurse discussed area with provider and obtained treatment orders to aid in moisture	12/08/2025

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F0695 SS = D	Continued from page 17 oxygen). In addition, the facility failed to have effective systems in place for identifying an avoidable open moisture-associated skin damage in Resident #9's skin fold on her neck. The deficient practice occurred for 1 of 2 residents reviewed for tracheostomy care (Resident #9). The findings included: Resident #9 was readmitted to the facility on 6/10/25 with diagnoses that included anoxic brain damage and tracheostomy status. Review of the quarterly minimum data set (MDS) assessment dated 8/12/25 revealed that Resident #9 had no speech, rarely/never understood/understands, and was severely cognitively impaired. She was totally dependent on staff for all activities of daily living (ADL) and was coded for tracheostomy care. Review of Resident #9's care plan updated on 5/13/25 revealed that she had impaired gas exchange/ineffective airway clearance related to respiratory failure with brain injury, tracheostomy, and history of COVID. Interventions included tracheostomy care. Review of physician orders dated 6/10/25 revealed that Resident #9 was to receive tracheostomy care every shift and as needed and suctioning as needed for secretions, mucus, and/or increased shortness of breath. The order was entered by the previous Infection Preventionist and there were no specifics regarding tracheotomy care included in the order. Review of a skin assessment dated 9/22/25 and completed by Nurse #8 revealed that Resident #9 did not have any new skin concerns. Nurse #8 was interviewed on 9/24/25 at 3:16 PM and stated when performing skin checks the areas observed included were the sacrum, heels, and any other bony prominence (normal breakdown spots). He stated that he would only check the head or neck area if nursing staff alerted him of a new skin issue. Review of the June 2025 through September 2025 Treatment Administration Records (TAR) revealed there were no orders for tracheostomy care as the order did	F0695	Continued from page 17 management. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 9/24/25, Regional Clinical Director completed an audit of residents identified with the need for care of a Tracheotomy to ensure the provider orders were accurate and properly scheduled for documentation on the electronic treatment administration record. No additional concerns noted. On 9/24/2025, Regional Clinical Director completed an audit of residents identified with Tracheostomy to ensure that no moisture associated skin damage present. No additional concerns noted. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. On 9/24/25, Director of Nursing/Designee, initiated education/competencies with Licensed Nurses regarding Respiratory /Tracheotomy Care and Suction of a resident, to include changing out oxygen tubing weekly and as needed, and inspection of skin around tracheostomy site and skin folds. The education will be completed by 10/20/25. Newly hired Licensed Nurses will be provided Tracheostomy education/competency during Department Orientation by the Staff Development Coordinator/designee. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing/designee will complete audit of residents identified with Tracheotomy Care to ensure that physician orders include changing the inner cannula every shift and documented. The audit will be completed 2 times a week for 12 weeks. The Director of Nursing/designee will complete audit of	

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F0695 SS = D	Continued from page 18 not populate on the TAR for completion from 6/10/25 through 9/24/25. A continuous observation of tracheostomy care and interviews were conducted on 9/24/25 from 11:17 AM through 12:12 PM. Nurse #2 was the assigned nurse for Resident #9; however, the facility asked Nurse #1 to perform the tracheostomy care. Nurse #2 stated that she had never performed tracheostomy care at the facility for Resident #9 and wanted to observe Nurse #1 for training. Nurse #2 stated that the overnight shift usually performed the tracheostomy care. At 11:33 AM, Nurse #2 was observed picking up the oxygen tubing off the floor and reattaching it to the corrugated tubing connected to the humidifier. Nurse #1 responded: “You can’t do that.” Nurse #1 then instructed Nurse #2 to retrieve all new oxygen and corrugated tubing that was sterile. The concern of the tubing on the floor was related to infection control purposes. When Nurse #2 returned to the room with the new tubing, she stated that the oxygen tubing often disconnected from the corrugated tubing during her shift, and she normally reconnected the tubing without changing any of the tubing. Nurse #1 stated that Nurse #2 should have disconnected and replaced all tubing when the oxygen tubing was found on the floor. Nurse #2 stated that she thought the opening to the corrugated tubing was not a sterile site. At 12:12 PM, as Nurse #1 was disconnecting the tracheostomy tie on the right side of Resident #9’s neck, she noticed an open moisture-associated skin damage (MASD) area within the skin fold. She then took used her sterile gloves and put sterile water on a piece of gauze and treated the area. Bright red blood was found on the used gauze. An interview was conducted with the Wound Nurse on 9/24/25 at 4:48 PM. She revealed that Resident #9’s newly discovered skin issue found on 9/24/25 was caused by MASD. Her neck area was moist and sweaty. The Wound Nurse had to open the skin folds on the neck to see it. She stated that she contacted the wound provider, and she wanted to try antifungal powder as well as interdry (moisture wicking fabric with antimicrobial properties) sheets. The Wound Nurse stated that skin areas that hold moisture should have interdry sheets in between. The Wound Nurse indicated when the trach ties were changed, the nurses should inspect in between the skin folds of the neck. Skin assessment entails head-to-toe observation and not only boney prominences. With heavier residents, skin folds need to be assessed every shift or included with weekly skin checks.	F0695	Continued from page 18 residents identified with Tracheostomy to ensure that there is no moisture associated skin damage present 2 times a week for 12 weeks Data obtained during the audit process will be analyzed for patterns and trends and reported to the Quality Assessment and Assurance (QA & A/QAPI) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of Compliance: 12/8/25	

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F0695 SS = D	Continued from page 19 Nurse #8, who was assigned to Resident #9 during the 3:00 PM to 11:00 PM shift on 9/22/25 and 9/23/25, was interviewed on 9/24/25 at 3:16 PM. Nurse #8 revealed that he had performed Resident #9's tracheostomy care on 9/22/25 and 9/23/25, and he did not observe anything out of the ordinary other than a mild amount of secretions. Normally, he would document completed tracheostomy care in the TAR. However, Nurse #8 stated that he did not document tracheostomy care for Resident #8 because there was no order on the TAR. He stated that he had changed the gauze but not the tracheostomy collar both days collar. Nurse #1 was interviewed on 9/25/25 at 10:14 AM. She revealed the main issues during tracheotomy care for Resident #9 on 9/24/25 was that the tubing needed to be replaced, originally the incorrect inner cannula size was chosen, multiple pairs of sterile gloves ripping, and the discovery of the MASD area on Resident #9's neck. Nurse #1 indicated that she heard Nurse #2 say that she wanted to observe tracheostomy care because she had never performed tracheostomy care at the facility and needed further training. Resident #9's responsible party (RP) was interviewed on 9/24/25 at 3:12 PM. She has had past issues with shearing (when tissue layers shift laterally) on Resident #9's neck when the tracheostomy ties were removed. During an interview with the Staff Development Coordinator/previous Director of Nursing (from 4/1/25 through 9/9/25) on 9/24/25 at 4:56 PM. Physician orders were normally reviewed in the morning clinical meeting the day after (re)admission, and a second review was done with medication reconciliation. The Staff Development Coordinator/previous Director of Nursing stated that tracheostomy care was an order set and then the options would be selected from there. The selected orders should be tracheostomy care, suctioning, site monitoring, and oxygen calibration/monitoring. All orders should be verified with the Medical Director and/or Physician Assistant. She could not recall if Resident #9's orders after readmission on 6/10/25 were reviewed the next day during the morning meeting; however, that was supposed to be the protocol along with medication reconciliation from the hospital discharge orders. The Staff Development Coordinator/previous Director of Nursing explained when the orders were entered by the previous Infection	F0695		

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F0695 SS = D	Continued from page 20 Preventionist, she chose the standard option instead of MAR or TAR which does not place the order on the MAR/TAR for completion by staff. Further order reviews would not have been performed unless Resident #9 had a change of condition or another readmission. A telephone interview was conducted on 9/24/25 at 3:43 PM with Nurse #3, who worked with Resident #9 during various evening shifts. Nurse #3 stated she was familiar with Resident #9 and verified that she did have a tracheostomy. She further stated that she provided suctioning during her shift of 3:00 PM to 11:00 PM when assigned to Resident #9; however, she did not document this activity in the TAR. She also replaced the gauze dressing around the stoma (opening created by a surgeon) because it was usually soiled. Nurse #3 indicated that she did not provide any other tracheostomy care for Resident #9 because the cleaning of the tracheostomy, changing of the inner cannula, and replacement of ties were done during the night shift from what other staff had told her. She stated that the suctioning of the tracheostomy was documented on the TAR. All oxygen tubing was changed on Sunday during night shift. She stated she did not change the inner canula or check the skin under the collar for any breakdown during the shifts she worked. She stated she was not sure what shift was supposed to change the inner canula or how often the facility expected it to be changed. Nurse #3 confirmed that she did attend the training provided by the Respiratory Therapist on 6/29/26. Nurse #4 was interviewed via telephone on 9/24/25 at 4:30 PM. She revealed that she was an agency nurse, worked the 11:00 PM to 7:00 PM shift at the facility, and picked up shifts every now and then. Nurse #4 stated that she had tracheostomy care experience from her nursing history and she did perform tracheostomy care for Resident #9. The tracheostomy care that she performed during her shift included changing the gauze dressing around the stoma because it was usually soiled. She would remove the soiled dressing and put a clean dressing around the stoma. Nurse #4 stated she did not change the inner canula or check the skin under the collar for any breakdown during the shifts she worked. She indicated that she was not sure what shift was supposed to change the inner canula or how often the facility expected it to be changed. She also stated she would suction the stoma if it was needed but did not otherwise. Nurse #4 could not recall there being a section to sign off this activity on the MAR or TAR. Nurse #4 indicated she did not report the order missing	F0695		

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F0695 SS = D	Continued from page 21 from the MAR because she just realized now when talking about Resident #9's tracheostomy that there was no section to sign off for the care. A telephone interview was conducted with the Respiratory Therapist on 9/24/25 at 2:31 PM. She revealed that she visited the facility weekly, and the last time she saw Resident #9 was on 9/16/25. The Respiratory Therapist stated she did not see anything out of the ordinary on 9/16/25 or any concerns with nursing staff performance to prompt an education opportunity for tracheostomy care. She stated Resident #9 often had secretions and coughed to clear secretions and required suctioning often. Resident #9's gauze must be changed often due to excessive secretions. The Respiratory Therapist stated she documented her activity in the progress notes section of the electronic medical record (EMR). She further stated that tracheostomy care, assessment, and cleaning of the area should be performed every shift and as needed. During a follow up interview with the Respiratory Therapist on 9/25/25 at 10:02 AM, she revealed that routine tracheostomy care included cleaning around the trach, under the flange, and around the neck with sterile water and peroxide. Also, change the inner cannula and place the new drainage sponge (gauze), and change the trach ties as needed every shift and as needed. The Medical Director was interviewed on 9/25/25 at 8:57 AM via telephone. He revealed that the as needed tracheostomy care order for Resident #9 dated 6/10/25 was appropriate. However, the order was for tracheostomy care every shift and as needed. Resident #9 had a long-standing tracheostomy for more than 3 years and had respiratory failure from COVID. The Medical Director stated the order entered on 6/10/25 for tracheostomy care was "deescalated" from every shift to as needed when Resident #9 returned from the hospital. Only when there was crustiness around the stoma would tracheostomy care be appropriate. The Medical Director indicated that the inner cannula was there to remove if she ever had an obstruction, and for no other reason. He stated that tracheostomy care consisted of sterile water used to clean around the stoma and sterile gauze used to clean the outside of the tracheostomy. The Medical Director further stated that nurses should assess the stoma/area every shift as part of their nursing rounds.	F0695		

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F0695 SS = D	Continued from page 22 The Director of Nursing was interviewed on 9/25/25 at 1:36 PM. She revealed that if the nurses did not see an order for tracheostomy care or suctioning, they should have contacted the provider for proper orders. For a resident that has a tracheostomy, the Director of Nursing stated that nurses should follow physician's orders for caring/monitoring the tracheostomy. Also, Nurse #1 should have never reattached the oxygen tubing when found on the floor but rather replace the oxygen tubing before reattaching. During an interview with the Administrator on 9/25/25 at 2:05 PM, he revealed that the facility would continue to investigate what went wrong with Resident #9's tracheostomy care, and it would be included in the plan of correction.	F0695		
F0726 SS = D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(d) Proficiency of nurse aides.	F0726	F726 Nurse Competency 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 9/24/2025 Nurse #1 replaced oxygen tubing supplies for Resident #9. On 9/24/2025 Nurse #2 was provided education by the Regional Clinical Director that oxygen tubing that is observed on the floor should be discarded and obtain new tubing prior to connecting oxygen tubing to the corrugated tubing to the humidifier. On 9/25/2025 Nurse #7 was provided education regarding Tracheostomy care and competency by the Staff Development Coordinator. On 9/24/2025 Nurse #4 was provided Tracheostomy care education with competency by the Staff Development Coordinator. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 9/24/25, Director of Nursing/designee completed an	12/08/2025

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F0726 SS = D	Continued from page 23 The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure nursing staff were competent to provide tracheostomy (surgical hole in the windpipe) care when Nurse #2 was observed picking oxygen tubing off the floor and attaching it to the corrugated tubing connected to the humidifier (adds moisture to the oxygen). During interviews Nurse #4 indicated she had not received any education from the facility regarding tracheostomy care and Nurse #7 indicated no one had evaluated her performance for tracheostomy care since her most recent return 2 months ago. In addition, the facility was unable to locate any nursing skills competency check off information for tracheostomy care for any of the nursing staff. The deficient practice occurred for 3 of 8 nursing staff reviewed for tracheostomy care competencies (Nurse #2, Nurse #4, and Nurse #7). The findings included: Review of a competency and training fair held at the facility on 6/29/25 with various specialists to provide education to facility staff revealed that the Respiratory Therapist provided training to nurses about tracheostomy/respiratory care. However, there was no evidence that Nurse #2 and Nurse #4 attended the training. a. A continuous observation of tracheostomy care and interviews were conducted on 9/24/25 from 11:17 AM through 12:12 PM. Nurse #2 was the assigned nurse for Resident #9; however, the facility asked Nurse #1 to perform the tracheostomy care. Nurse #2 stated that she had never performed tracheostomy care at the facility and wanted to observe Nurse #1 for training. She also stated that she did not attend the tracheostomy care training at the facility on 6/29/25 provided by the Respiratory Therapist. At 11:33 AM, Nurse #2 was observed picking up the oxygen tubing off the floor and reattached it to the corrugated tubing connected to the humidifier. Nurse #1 responded: “You can’t do that.” Nurse #1 then instructed Nurse #2 to retrieve all new oxygen and corrugated tubing. When Nurse #2 returned to the room with the new tubing, she stated that the oxygen tubing often disconnected from the corrugated	F0726	Continued from page 23 audit of Licensed Nurses for Tracheostomy Care education/competency, nurses identified without education/competency will receive education/competency prior to their next shift. All residents have the potential to be affected by the deficient practice. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. On 9/24/25, Director of Nursing/designee initiated Respiratory/Tracheostomy care and suction education/competency with Licensed Nurses. Licensed Nurse to receive education prior to their next shift. Education/Competencies completed by 10/20/25. Newly hired Licensed Nurses will be educated/competencies on Tracheostomy care/Suctioning during Department Orientation by Staff Development Coordinator/designee. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing/designee will complete Respiratory/Tracheostomy Care and suction observations with 2 Licensed Nurses per week x 12 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to the Quality Assessment and Assurance (QA & A/QAPI) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of Compliance: 12/8/25	

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F0726 SS = D	Continued from page 24 tubing during her shift, and she normally reconnected the tubing without changing any of the tubing. Nurse #1 stated that Nurse #2 should have disconnected and replaced all tubing when the oxygen tubing was found on the floor. b. Nurse #4 was interviewed via telephone on 9/24/25 at 4:30 PM. She revealed that she was an agency nurse, worked the 11:00 PM to 7:00 PM shift at the facility, and picked up shifts every now and then. Nurse #4 stated that she had tracheostomy care experience from her nursing history but had not received any education from the facility regarding tracheostomy care, including the training provided on 6/29/25 by the Respiratory Therapist. She further stated that she did perform tracheostomy care for Resident #9, and the tracheostomy care that she performed during her shift included changing the gauze dressing around the stoma (opening created by a surgeon) because it was usually soiled. c. Nurse #7, who worked with Resident #9 during the day shift from 7:00 AM until 3:00 PM on 9/22/25 and 9/23/25, was interviewed on 9/24/25 at 2:04 PM. She revealed she worked at the facility previously, left about 2 years ago, and returned to the facility 2 months ago. She stated no one had evaluated her performance for tracheostomy care since her most recent return 2 months ago. In the last 2 months since she has been back, there had not been any paper education or any other kind of training provided related to tracheostomy care. A telephone interview was conducted with the Respiratory Therapist on 9/24/25 at 2:31 PM. The Respiratory Therapist stated she last provided tracheostomy care education on 6/29/25 during a skills fair for some of the nurses who dropped in for a 15-minute instruction. There were 2 to 3 nurses at a time that would watch a video about suctioning/tracheostomy care and then performed the same process on a practice dummy. The drop in training was a 4-hour window and was usually provided 1 to 2 times per year and per the facility's discretion. The Respiratory Therapist indicated that the Staff Development Coordinator/previous Director of Nursing helped schedule the drop-in class. If she (the Respiratory Therapist) noticed that a nurse needed extra help, she would notify the DON; however, no nurses needed extra help on 6/29/25.	F0726		

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F0726 SS = D	Continued from page 25 During an interview with the Staff Development Coordinator/previous Director of Nursing (from 4/1/25 through 9/9/25) on 9/24/25 at 4:56 PM, she revealed that she was not aware of the tracheostomy care education protocol. The respiratory skills were included in orientation with a 10-minute video and then time for questions and answers. The Staff Development Coordinator/previous Director of Nursing stated the previous Staff Development Coordinator left abruptly without notice on 6/7/25, and the role had not been filled since then until 9/9/25. She indicated that nurse competencies for tracheostomy care were not performed during this time except for the on-site skills fair on 6/29/25. However, not all nurses attended. The Staff Development Coordinator/previous Director of Nursing stated she was not aware of any tracheostomy care training prior to 6/7/25 and there was no documentation to support that it was provided. During an interview with the Vice President of Operations on 9/25/25 at 1:01 PM, he revealed that the facility had high turnover for the Staff Development Coordinator position in a short period of time. He was unable to locate documentation showing tracheostomy competency of nurses or any other training aside from the fair held on 6/29/25. On 9/25/25 at 1:45 PM, the Director of Clinical Services was interviewed. She revealed that on day 3 of nursing orientation or during initial training (within a 30-day period), all nurses including agency staff were supposed to be evaluated with certain skills, including tracheostomy care/monitoring. However, the documentation on this activity could not be found. Also, she indicated that not all nurses attended the documented training provided by the Respiratory Therapist on 6/29/25. The Administrator was interviewed on 9/25/25 at 2:13 PM. He revealed that he began working for the facility on 8/19/25. Since then, he indicated that one orientation for new hires was held on 8/19/25 by a traveling Staff Development Coordinator; however, documented evidence of that training could not be found.	F0726		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4)	F0732	F732 Nurse Staffing Information 1. Address how corrective action will be accomplished	12/08/2025

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F0732 SS = C	Continued from page 26 §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and staff interviews, the facility failed to post daily nurse	F0732	Continued from page 26 for those residents found to have been affected by the deficient practice. Center failed to post and maintain accurate daily staffing data for 9/20/25. Nurse Staff posting was updated on 9/21/25 by the Receptionist. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. No residents were affected. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. The Administrator, Staffing Coordinator, Clinical leadership were educated by the Vice President of Operations on 9/30/25 on the requirement on post accurate daily nurse staffing data at the beginning of each shift. Licensed Nursing staff were educated on the requirement to post accurate daily nurse staffing data at the beginning of each shift by the Director of Nursing/Designee. Education to be completed by 10/20/25. Newly hired Administrators, Staffing Coordinators, Clinical Leadership team members and Licensed Nurses will be educated during Department Orientation by the Staff Development Coordinator/Designee. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. An audit of the staff posting will be reviewed 7 days per week x 1 week, then 5x per week x 11 weeks by the Administrator/Designee to ensure accurate daily staffing is reflected on the daily staffing posting. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality	

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F0732 SS = C	Continued from page 27 staffing sheets at the beginning of each shift for 1 of 5 days of the survey (9/21/25). In addition, the facility was unable to locate a copy of the daily nurse staffing sheet for 1 of 31 days reviewed (9/20/25). The findings included: An observation on 9/21/25 at 10:14 AM revealed the daily posted staffing sheet posted in the lobby was dated 9/19/25. Review of the facility's daily posted nurse staffing sheets from 8/21/25 through 9/20/25 revealed the 9/20/25 staffing sheet was missing. During an interview with the Scheduler on 9/23/25 at 9:57 AM, she revealed that she was responsible for posting the nurse staffing information. The Scheduler explained she was not aware that she could print the nurse staffing information for the day ahead or the day before but rather only for the current day. The Scheduler stated the previous scheduler told her that she printed out the weekend posting on Friday's and placed the sheets in the medication room for the nurses to display at the front entrance. The interview further revealed the Scheduler could not say if the nurse staffing information was printed and posted during the weekends or the entire month of September. An interview was conducted with the interim Administrator on 9/24/25 at 10:26 AM, and he stated the weekend nursing staff should have access to the nurse staffing information to ensure that it was displayed timely and accurately.	F0732	Continued from page 27 Assessment and Assurance (QA & A) Committee by the Administrator monthly x 3 months. At that time, the QA & A committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of Compliance: 12/8/25	
F0759 SS = D	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, record review, staff and Pharmacist interviews, the facility failed to have a	F0759	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 9/23/2025 Nurse #6 administered 1000 mcg of Vitamin b-12 instead of ordered 2000 units cholecalciferol, administered 2 sprays in each nostril of fluticasone instead of ordered 1 spray in each nostril, and administered levothyroxine 50 mcg after Resident #96 had eaten breakfast. Nurse #6 completed medication variance report and notified Provider and Resident #96's representative. Provider gave no new orders. Nurse #6 no longer works at the Center.	12/08/2025

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F0759 SS = D	Continued from page 28 medication error rate of less than 5% as evidenced by 3 medication errors out of 25 opportunities. The 3 medication errors resulted in a medication error rate of 12% for 1 of 4 residents observed during medication administration (Resident #96). The findings included: Resident #96 was admitted to the facility on 8/09/23. a. An active physician order was in place for cholecalciferol tablet (Vitamin D3) 1000 units give 2 tablets by mouth one time a day for vitamin D deficiency. During a continuous medication administration observation on 9/23/25 at 8:04 am through 8:10 am, Nurse #6 was observed to prepare and administer two vitamin B12 500 microgram (mcg) tablets to Resident #96. An interview was conducted with Nurse #6 on 9/24/25 at 10:39 am who confirmed Resident #96 was administered two vitamin B-12 tablets during the morning medication pass observation. Nurse #6 reviewed the physician order and completed an internet search for the cholecalciferol tablet and confirmed it was a vitamin D3. Nurse #6 stated she thought the vitamin B-12 was the correct medication listed in the order, but she should have checked to make sure before she administered it to Resident #96. A telephone interview was conducted on 9/24/25 at 3:52 am with the Pharmacist who revealed there was no medical concern with Resident #96 being administered the vitamin B-12 instead of cholecalciferol (vitamin D3). During an interview on 9/24/25 at 11:31 am the Director of Nursing (DON) stated Nurse #6 should have checked the order against the pill bottle and if she was still unsure the nurse should have looked up the medication. The DON stated Nurse #6 should not have administered medication to Resident #96 if she was unsure if it was the correct medication. b. An active physician order was in place for fluticasone propionate 50 mcg nasal spray instill one spray per nostril one time a day for allergies. During a continuous medication administration observation on 9/23/25 at 8:04 am through 8:10 am, Nurse #6 was observed to enter Resident #96's room and open the nasal spray and pump the spray to release one	F0759	Continued from page 28 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 10/2/25 Regional Clinical Director completed an audit of Residents with orders for Levothyroxine to ensure that medications were scheduled for administration in the morning before breakfast. No other concerns identified. On 10/2/2025 Regional Clinical Director reviewed for the dates of 9/18/25 to 10/2/25 for medications variances with no additional concerns. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. Director of Nursing/Designee will educate Licensed Nurses on the 6 Rights of Medication Administration: Right Resident, Right Medication, Right Dose, Right Route, Right Time, and Right Documentation. Additionally, Director of Nursing/Designee will complete Medication Administration Competencies with Licensed Nurses. Education and Competencies to be complete by 10/20/25. Newly hired Licensed Nurses with receive education on the 6 Rights of Medication administration and medication administration competency during Department orientation by the Staff Development Coordinator/Designee. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Director of Nursing/Designee will complete Medication Administration Observation Audits with 2 Licensed Nurses per week x 12 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A/QAPI) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if	

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F0759 SS = D	Continued from page 29 dose in the air. Nurse #6 was then observed to administer two sprays per nostril of the fluticasone propionate nasal spray to Resident #96 and exited the room. An interview was conducted with Nurse #6 on 9/24/25 at 8:13 am who revealed sometimes it did not feel like the full dose of medication goes in when she pushed down on the nasal spray pump, so she administered the two sprays to make sure the resident got enough of the medication. A telephone interview was conducted on 9/24/25 at 3:52 am with the Pharmacist who revealed there was no medical concern with Resident #96 being administered two sprays per nostril of the fluticasone propionate nasal spray. During an interview on 9/24/25 at 11:31 am with the Director of Nursing (DON) she revealed Nurse #6 should have administered the medication as ordered by the physician to Resident #96. c. An active physician order was in place for levothyroxine sodium 50 microgram (mcg) tablet give 1 tablet every day in the morning upon rising for hypothyroidism. During a continuous medication administration observation on 9/23/25 at 8:04 am through 8:10 am, Nurse #6 was observed to prepare Resident #96's morning medications which included the one levothyroxine 50 mcg tablet. The medication blister pack card had a yellow sticker which read "take on an empty stomach". Resident #96 was observed sitting in a chair eating breakfast with approximately half of her meal remaining. Nurse #6 administered the medications, which included the levothyroxine tablet to Resident #96 and exited the room. An immediate interview was conducted with Nurse #6 on 9/23/25 at 8:13 am who revealed she was aware the medication was supposed to be given on an empty stomach, and she thought it would have been given on the night shift, but the medication was listed for her to administer. Nurse #6 stated she did not check if any medications had to be given before breakfast when she started her shift and she did not think to hold the medication since Resident #96 had already eaten breakfast. Nurse #6 reviewed the blister pack and confirmed the package had a sticker that stated the levothyroxine was to be administered on an empty stomach.	F0759	Continued from page 29 continued auditing is necessary to maintain compliance. Date of Compliance: 12/8/25 F759 Med Error	

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F0759 SS = D	Continued from page 30 A telephone interview was conducted on 9/24/25 at 3:52 pm with the Pharmacist who revealed the levothyroxine medication was recommended to be administered first thing in the morning on an empty stomach because the medication absorbs best on an empty stomach. The Pharmacist stated the medication blister pack had an information label that reminded staff to administer the medication on an empty stomach. An interview was conducted with the Director of Nursing (DON) on 9/24/25 at 11:31 am, she revealed the facility administered medications upon rising which was generally between 7:00 am and 11:00 am unless the medication had specific administration instructions. The DON stated that the levothyroxine was to be administered an empty stomach and Nurse #6 should have administered the medication before Resident #96 ate her breakfast.	F0759		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations, and staff and Pharmacist	F0761	F761 Label/Store Biologicals 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 9/24/25, Unit Manager #1 disposed of one box of COVID-19 mRNA vaccines (5), on bottle of cephalexin oral suspension and one bottle of vancomycin oral solution from the medication room. One fluticasone, furoate, umeclidinium, and vilanterol inhaler from the 100 hall medication cart and 2 insulin lispro injector pens from the 200 hall medication cart. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Director of Nursing/designee initiated on 10/7/2025 an audit of medication carts and medication room to validate that all medications were properly labeled and un-expired. Any findings will be corrected immediately. Audit was completed by 10/10/25. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. Licensed nurses will be educated on properly	12/08/2025

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F0761 SS = E	Continued from page 31 interviews the facility failed to (1) remove expired medications from the medication refrigerator in 1 of 1 medication storage room observed (Nursing Station), and (2) remove expired medication and (3) refrigerate medications according to the manufacturer's recommendations for 2 of 3 medication carts reviewed (Hall 100 and Hall 200). The findings included: 1. During an observation of the medication refrigerator in the medication storage room (Nursing Station) with the Director of Nursing (DON) on 9/24/25 at 8:32 am the following was observed. The DON confirmed all findings before the removal of the identified items. One box with 5 COVID-19 mRNA vaccine injections with an expiration date of 9/06/25. One open plastic bottle of cephalexin (antibiotic) 250 milligrams per 5 milliliters (mg/ml) oral suspension with an expiration date of 8/31/25. One open plastic bottle of vancomycin hydrochloride (antibiotic) 250 mg/5 ml oral solution with an expiration date of 8/17/25. An immediate interview was conducted with the DON on 9/24/25 at 8:56 am who revealed the Unit Manager was responsible for checking the medication room and removal of expired medications. An interview was conducted with the Unit Manager on 9/24/25 at 8:57 am who revealed she tried to check the medication storage room every few weeks to make sure expired items were removed. 2. An observation of the Hall 100 medication cart was conducted on 9/24/25 at 10:28 am with Nurse #1. Nurse #1 confirmed the findings before the removal of the identified item. One fluticasone, furoate, umeclidinium and vilanterol 200 micrograms (mcg)/62.5 mcg/25 mcg inhalation powder (medication used to treat chronic obstructive pulmonary disease (COPD) and asthma) was observed open with an open date of 8/02/25. The outer package of the fluticasone, furoate, umeclidinium and vilanterol inhalation powder read to discard after 6 weeks of opening. An immediate interview was conducted with Nurse #1 on 9/24/25 at 10:32 am who revealed she did not know the medication should have been removed 6 weeks after	F0761	Continued from page 31 storing/labeling of Drug and Biologicals by the Director of Nursing/Designee. The education will be completed by 10/20/25. Newly hired Licensed nurses will receive education on proper labeling/storage of Drugs and Biologicals during department orientation by the Staff Development Coordinator/Designee. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing/Designee will complete audit of all 2 medications carts per week on alternating carts and an audit of the medication room weekly x 12 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of Compliance: 12/8/25	

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F0761 SS = E	Continued from page 32 opening. During an interview on 9/24/25 at 11:24 am with the Director of Nursing (DON) she revealed she was new to the facility and had not yet implemented a process for the medication carts to be checked for expired medications. 3. The manufacturer's recommendations for insulin lispro recommended that unopened insulin be stored in the refrigerator at approximately 36 to 46 degrees Fahrenheit. An observation was conducted on 9/24/25 at 9:53 am of the 200 Hall medication cart with Nurse #2. Nurse #2 confirmed the findings before the removal of the identified items. Two insulin lispro (rapid-acting) 100 units per milliliter (ml), 3 ml injector pen was observed unopened with 300 units of the 300 units of insulin remaining. The insulin lispro was in a clear plastic bag with blue lettering which read “refrigerate” and a label was attached to the injector pens which read “refrigerate until opened”. An immediate interview was conducted with Nurse #2 on 9/24/25 at 9:56 am who revealed the unopened insulin lispro pens should have been placed in the refrigerator when they were delivered from pharmacy until they were needed. A telephone interview was conducted on 9/24/25 at 3:56 pm with the Pharmacist who revealed the insulin lispro injector pens needed to be stored in the refrigerator until opened. The Pharmacist stated when new insulin pens were sent to the facility they were in a clear plastic bag with the word refrigerate stamped on the bag in large blue letters and a label attached to the pen which read the same. She stated labeling to refrigerate was done to remind the staff to store the medication in the refrigerator until ready to use. An interview was conducted with the Director of Nursing (DON) on 9/24/25 at 11:24 am. The DON revealed the insulin pens should have been placed in the refrigerator as labeled when they were delivered to the facility.	F0761		
F0838 SS = C	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment.	F0838	F828 Facility Assessment 1. Address how corrective action will be accomplished for those residents found to have been affected by the	12/08/2025

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F0838 SS = C	Continued from page 33 The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy,	F0838	Continued from page 33 deficient practice. On 9/30/2025 the Facility Assessment was updated to reflect the current Administrator, Director of Nursing, Infection Preventionist, Rehabilitation Manager, Staff Development Coordinator, and Maintenance Director by the Vice President of Operations. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. No residents were affected by the alleged deficient practice. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. On 9/30/25, Vice President of Operations provided education to the Licensed Nursing Home Administrator on the requirement of updating the Facility Assessment with any changes in Center Leadership. Newly Hired Licensed Nursing Home Administrators will receive education on ensuring Facility Assessment is up-to-date with current Center Leadership during department orientation by the Vice President of Operations 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Licensed Nursing Home Administrator will review the Facility Assessment to ensure reflection of current Center Leadership weekly x 12 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Administrator monthly x 3 months. At that time, the QA & A committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F0838 SS = C	Continued from page 34 pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3).	F0838	Continued from page 34 Date of Compliance: 12/8/25	

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F0838 SS = C	Continued from page 35 §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews and record review, the facility failed to have an accurate facility assessment that recorded the current Administrator, Director of Nursing (DON), Infection Preventionist, Rehabilitation Manager, Staff Development Coordinator, and Maintenance Director. This deficient practice had the potential to affect 109 of 109 residents. The findings included: The facility assessment was reviewed and recorded the last update and review by the facility's quality assurance, performance, and improvement (QAPI) committee occurred on 10/31/24. Page one of the facility assessment recorded the names of the following former staff positions: Administrator, Director of Nursing (DON), Infection Preventionist, Rehabilitation Manager, Staff Development Coordinator, and Maintenance Director. The interim Administrator was interviewed on 9/23/25 at 10:31 AM. He revealed the facility assessment was managed by the Administrator. However, there had been multiple changes in leadership since 10/31/24. He stated the assessment was completed in the last year, and it was due 10/31/25 for all updates. The Administrator indicated that since he began as interim Administrator on 9/9/25, the administrative personnel	F0838		

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F0838 SS = C	Continued from page 36 listed in the facility assessment were not accurate.	F0838		
F0839 SS = E	Staff Qualifications CFR(s): 483.70(e)(1)(2) §483.70(e) Staff qualifications. §483.70(e)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(e)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is NOT MET as evidenced by: Based on record review, Maryland Board of Nursing (MBON) and North Carolina Board of Nursing (NCBON) verification registries and staff interviews, the facility failed to verify a staff member from another state working as a registered nurse (Staff #1) had an active professional nursing license for 1 of 14 nursing staff reviewed. Staff #1 did not have a professional nursing license and performed the job responsibilities of a nurse from 2/24/25 through 6/15/25. The findings included: A review of Staff #1's employment application with the facility indicated she was hired as a Registered Nurse (RN) on 2/14/25. Her date of birth and middle name were included on her Maryland driver's license. A MBON licensure verification dated 2/14/25 located in Staff #1 's employment folder indicated the same first and last name as Staff #1 was listed as an active RN with a compact state license that included North Carolina. The middle name was not included on the nursing license. Record review indicated Staff #1's nurse competencies were reviewed after hire during her training with another staff member. The record showed this competency verification was completed in full with no areas of concern identified. A review Staff #1's personnel file revealed no evidence of performance issues or disciplinary action.	F0839	F839 License Certification/Staff Qualifications 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility failed to properly screen employee identification to ensure a valid certification/licensure. Staff #1 is no longer employed at the facility. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. An audit was conducted of all current staff to validate their identification matched their certification/licensure. This audit was completed by the Regional Human Resources Manager and was completed by 9/26/2025. No other findings were noted. An audit was conducted of all terminated employees within the last 90 days to validate their identification matched their certification/licensure. This audit was completed by the Regional Human Resources Manager and was completed by 9/26/2025. No other findings were noted. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. Education was provided to the facility Human Resources Generalist on how to ensure an employee's identification matches their certification/licensure prior to hire. This education was completed by the Regional Human Resources Manager on 9/26/2025. Newly hired Human Resource Generalist will receive education on ensuring staff have required certifications/licensure during department orientation by the Regional Human Resource Manager.	12/08/2025

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F0839 SS = E	Continued from page 37 A review of Staff #1's timecard report from 2/14/25 through 6/15/25 recorded Staff #1 worked the following hours as an RN on the following dates: 2/24/25 8:00 am - 12:30 pm, 1:00 pm - 3:00 pm 2/25/25 9:01 am - 3:39 pm 2/26/25 7:00 am - 3:21 pm 3/4/25 7:00 am - 3:16 pm 3/6/25 10:44 pm - 7:18 am 3/8/25 10:39 pm - 7:49 am 3/9/25 10:38 pm - 7:12 am 3/10/25 10:43 pm - 7:15 am 3/13/25 10:40 pm - 7:35 am 3/17/25 10:45 pm - 7:30 pm 3/19/25 10:26 pm - 7:57 am 3/20/25 10:40 pm - 7:40 am 3/22/25 10:48 pm - 8:00 am 3/23/25 10:54 pm - 7:34 am 3/24/25 10:44 pm - 7:35 am 3/27/25 10:32 pm - 7:35 am 3/31/25 10:53 pm - 8:57 am 4/2/25 10:43 pm - 8:32 am 4/3/25 10:43 pm - 7:19 am 4/4/25 10:52 pm - 7:56 am 4/5/25 10:50 pm - 8:14 am 4/6/25 10:55 pm - 7:35 am 4/7/25 10:47 pm - 7:57 am 4/14/25 10:59 pm - 7:19 am 4/16/25 10:52 pm - 7:55 am	F0839	Continued from page 37 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Administrator will conduct an audit of all new hires to ensure an employee's identification matches their certification/licensure prior to hire. This audit will occur weekly x 12 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A/QAPI) Committee by the Human Resources Generalist monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of Compliance: 12/8/25	

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F0839 SS = E	Continued from page 38 4/17/25 10:46 pm - 7:55 am 4/19/25 10:46 pm - 7:45 am 4/20/25 10:54 pm - 8:39 am 4/24/25 10:42 pm - 7:42 am 4/28/25 10:46 pm - 7:34 am 4/30/25 10:40 pm - 7:41 am 5/1/25 10:45 pm - 7:36 am 5/3/25 10:40 pm - 8:08 am 5/4/25 10:45 pm - 8:07 am 5/5/25 10:44 pm - 7:46 am 5/8/25 10:46 pm - 8:06 am 5/9/25 10:45 pm - 7:46 am 5/12/25 10:44 pm - 7:49 am 5/14/25 10:45 pm - 11:15 pm 5/21/25 11:28 pm - 7:47 am 5/23/25 10: 45 pm - 7:40 am 5/26/25 11:10 pm - 8:38 am 5/27/25 11:05 pm - 7:38 am 5/28/25 11:29 pm - 7:33 am 5/29/25 11:39 pm - 7:39 am 5/30/25 10:45 pm - 7:45 am 5/31/25 10:56 pm - 8:36 am 6/1/25 10:47 pm - 7:22 am 6/2/25 11:27 pm - 8:05 am 6/5/25 11:46 pm - 7:44 am 6/9/25 11:38 pm - 7:38 am 6/11/25 11:40 pm - 7:46 am	F0839		

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F0839 SS = E	Continued from page 39 6/12/25 11:30 pm - 7:54 am 6/14/25 10:40 pm - 7:45 am 6/15/25 10:45 pm - 7:37 am The Former Scheduler was interviewed via telephone on 9/23/25 at 12:02 PM. She indicated that she received a call from a Staffing Agency Owner on 7/7/25 asking if Staff #1 currently worked at the facility. Staff #1 no longer worked for the facility at that time and had applied to the Staffing Agency. The Staffing Agency Owner told the Former Scheduler that Staff #1 was not a nurse. She explained that she personally knew the Director of Nursing (DON) at Facility #2 and was aware Staff #1 had worked there in the role of a nurse as well. The Former Scheduler indicated that the Staffing Agency Owner asked her to stay on hold while she called the DON at Facility #2. When taken off hold, the Staffing Agency Owner merged the call with the Former Scheduler and the DON at Facility #2. The Staffing Agency Owner told them that Staff #1 applied at the Staffing Agency and the agency could not find a matching social security number or a valid nursing license for Staff #1 and stated that, therefore, Staff #1 was not a licensed nurse. The Former Scheduler indicated that she did not do anything further with that information. The Staffing Agency Owner was interviewed via telephone on 9/23/25 at 12:04 PM. She stated that Staff #1 never applied to her company, and she denied contacting the facility on 7/7/25. Facility #2's Administrator, the other facility where the Staffing Agency Owner indicated Staff #1 worked, was interviewed via telephone on 9/23/25 at 10:19 AM. She revealed that Staff #1 was hired at Facility #2 as an RN. She indicated when Facility #2's DON performed an independent search to verify Staff #1's credentials, they could not connect her name to the Maryland Nursing and Interstate Compact License because the full name of Staff #1 did not match exactly. When Staff #1 was approached about the questionable search results, she became angry and would not answer any questions. Facility #2's Administrator reported that Staff #1 told her and Facility #2's DON that she was in Nurse Practitioner school at a local community college.	F0839		

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F0839 SS = E	Continued from page 40 During a telephone interview with Facility #2's DON on 9/23/25 at 10:48 AM, she revealed that the Staffing Agency Owner initiated a call between herself and the Former Scheduler of Facility #1 on 7/7/25 at 9:00 PM. The Staffing Agency Owner reported the agency had some concerns about Staff #1, and they were considering hiring her. The Staffing Agency Owner questioned Staff #1's nursing license and background due to 2 different middle names that were being used. On 9/23/25 at 12:22 PM, the North Carolina Board of Nursing License Verification online inquiry revealed that Staff #1's name did not populate in the search. On 9/23/25 at 12:30 PM, the Maryland Board of Nursing License Verification inquiry indicated that a Registered Nurse (RN) with the same first and last name (no middle name listed) as Staff #1 held an active RN license renewed on 12/1/23 and set to expire on 11/28/25. A telephone interview was attempted with Staff #1; however, she could not be reached during the investigation. The Maryland Board of Nursing License Verification inquiry on 9/23/25 indicated Staff #1's had an active Certified Nursing Assistant (CNA) license renewed on 1/22/24 and set to expire on 1/28/26. Her middle name was included in the registry. During a telephone interview with a representative at the Maryland Board of Nursing Complaints Department on 9/23/25 at 1:10 PM, she confirmed that Staff #1 with the correct date of birth and middle name included on her driver's license was registered as an active CNA only. On 9/23/25 an online search on the North Carolina (NC) Health Care Personnel Registry's verification website (a website that provides verification directly from NC registries for Nurse Aides and Medication Aides), revealed no information for Staff #1. The Former DON was interviewed on 9/23/25 at 11:29 AM. She revealed that Staff #1 used to get flustered during her overnight shifts. Staff #1 had a bad night one	F0839		

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F0839 SS = E	Continued from page 41 night, and Staff #1 asked one of the day shift nurses (name unknown) to help her (Staff #1) with paperwork so that she could leave. After Staff #1 left the facility (date unknown), the day shift nurse who helped Staff #1 told the Former DON that this happened all the time with Staff #1. The Former DON indicated that she did not do anything further with the information. An interview was conducted with Human Resources on 9/23/25 at 9:44 AM. She revealed that the hiring process included verification of the driver's license, social security card, background check, and I-9 verified in person (Employment Eligibility Verification). She indicated that Staff #1 was employed as a registered nurse at the facility from 2/24/25 - 6/15/25 and then quit without notice on 6/15/25. Multiple attempts were made to contact Staff #1 on 6/16, 6/18, 6/23 without any answer. The active nursing license that Staff #1 provided was initiated in Maryland (multi-state license) with an expiration date of 11/28/25. Human Resources stated that there were not any issues while Staff #1 was employed at the facility. Her performance did not cause any questions about her competency, and she did not receive any disciplinary action or teachable moments. Human Resources indicated that she heard something about Staff #1 not being a licensed nurse (from who was unknown); however, she stated that was hearsay and did not investigate it further. During an interview with the Former Administrator on 9/24/25 at 10:11 AM, he revealed that he could not recall Staff #1 as a staff member, and no one from the facility spoke to him about her credentials. The Vice President of Operations was interviewed on 9/23/25 at 3:25 PM. He revealed that there was a breakdown in the HR process, and Staff #1's complete personnel information should have been validated with the Maryland Board of Nursing.	F0839		
F0842 SS = E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is	F0842	F842 Resident Records 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Center failed to maintain a complete and accurate medical record for Resident #9 to include the	12/08/2025

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F0842 SS = E	Continued from page 42 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. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or	F0842	Continued from page 42 documentation of tracheotomy care every shift. Unit Manager obtained and updated provider's order on 9/24/25 to accurately reflect documentation in the electronic treatment administration record. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 9/24/25, Regional Clinical Director completed an audit of residents identified with the need for care of a Tracheotomy to ensure the physician orders are accurate and properly scheduled for documentation in the electronic treatment administration record. No additional concerns noted. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. Licensed Nurses were re-educated by the Director of Nursing/Designee on ensuring that physician orders for tracheostomy care obtained from Provider are entered into Resident's electronic medical record accurately with a schedule to reflect documentation of care in the electronic treatment administration record. Education to be completed by 10/20/25. Newly hired Licensed Nurses will be educated during department orientation on accurate documentation in the Medical Record by the Staff Development Coordinator/Designee. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing/Designee will complete an audit of the electronic treatment administration record for residents requiring tracheostomy care will be completed 2 times a week for 12 weeks to ensure that tracheostomy care is provided and documented as ordered. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Director of Nursing monthly x 3 months. At that time,	

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F0842 SS = E	Continued from page 43 (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 and staff interviews, the facility failed to ensure a medical record was complete and accurate regarding tracheostomy care. This was for 1 of 5 sampled residents whose medical record was reviewed for documentation (Resident #1). Resident #9 was readmitted to the facility on 6/10/25. Physician orders for Resident #9 revealed that tracheostomy care every shift and as needed was entered into the electronic medical record on 6/10/25 by the previous Infection Preventionist. During an interview with the Staff Development Coordinator/previous Director of Nursing (from 4/1/25 – 9/9/25) on 9/24/25 at 4:56 PM, she revealed that when the order for tracheostomy care every shift and as needed was entered by the previous Infection Preventionist, she chose the standard option instead of the option that populated onto the Treatment Administration Record (TAR) or Medication Administration Record (MAR). She explained that the standard option only showed in the orders section of	F0842	Continued from page 43 the QA & A committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of Compliance: 12/8/25	

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F0842 SS = E	Continued from page 44 the electronic medical record, it did not activate the order to display for nurses to see or record their activity. Resident #9's TAR/MAR from 6/10/25 through 9/24/25 revealed the physician order dated 6/10/25 for tracheostomy care every shift and as needed was not listed. The only order related to Resident #9's tracheostomy that populated on the TAR/MAR was an as needed order for nurses to change Resident #9's tracheostomy and/or tracheostomy collar as needed with a size 6 Shiley (tracheostomy tube size). There was no evidence on the TAR/MAR that tracheostomy collar was changed on 8/27/25. Nurse #7, who worked with Resident #9, was interviewed on 9/24/25 at 2:04 PM. She revealed that she changed the tracheostomy collar on 8/27/25 but forgot to document in the TAR/MAR. Nurse #7 indicated that she did not notice Resident #9 did not have any tracheostomy care orders in the TAR/MAR. An interview was conducted with Nurse #8 on 9/24/25 at 3:16 PM. He worked with Resident #9 during the evening shifts from 3:00 PM – 11:00 PM on 9/22/25 and 9/23/25. Nurse #8 revealed that he usually performed tracheostomy care early in his shift and would normally document this activity in the TAR. However, Nurse #8 stated he did not document tracheostomy care for Resident #9 because there was no order in the TAR/MAR. During a telephone interview with Nurse #4 on 9/24/25 at 4:30 PM, she revealed that she worked with Resident #9 during the night shift from 11:00 PM – 7:00 AM on 9/17/25, 9/22/25, and 9/23/25. Nurse #4 stated that she did perform tracheostomy care for Resident #9, and the tracheostomy care that she performed during her shift. She could not recall there being a section to sign off on in the TAR/MAR for Resident #9's tracheostomy care. When asked why she did not report the order missing from the TAR/MAR, she stated because she just realized now when talking about Resident #9's tracheostomy that there was no section to sign off for care. An interview was conducted with the Director of Nursing on 9/25/25 at 1:38 PM. She revealed that tracheostomy care for Resident #9 was included as a physician order; however, it was not entered properly to populate for nurses to sign off on in the TAR/MAR.	F0842		

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F0842 SS = E	Continued from page 45 The Administrator was interviewed on 9/25/25 at 2:16 PM. When asked to discuss what caused the failure related to complete and accurate medical records for Resident #9, the Administrator did not provide an answer. He stated that the facility will need to review the process to ensure that nurses have access to document the care provided.	F0842		