STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345175	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smithfield Manor Rehabilitation and Healthcare Center	**902 Berkshire Road , Smithfield, North Carolina, 27577**

(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 4/20/26 through 4/23/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 22E94F-H1.	E0000		05/08/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/20/26 through 4/23/26. Event ID# 22E94F-H1. The following intakes were investigated 2978540, 2961285, 2959886, 2791619, 2799563, 2798333, 2742569, 2697751, 2684214, 2686379, 2684198, 2680018, 2990186, 2674643, 2653980, 2647683, 2614203, 2603386, 2601061, 2601089, 2597115, 864360 and 864403. 13 of the 60 complaint allegations resulted in deficiency.	F0000		05/08/2026
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the	F0584	F584 Tool for developing and documenting a corrective action plan The Corrective Action Plan needs to be formatted using the required headers: Problem Statement: The facility failed to ensure a safe, clean, comfortable environment related to availability of linens. Adequate and clean linens were immediately placed in the clean linen closets for staff to utilize. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Adequate and clean linens were immediately placed in the clean linen closets for all halls in the facility for staff to utilize.	05/20/2026

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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F0584 SS = E	Continued from page 1 protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to provide staff and residents with washcloths and towels to complete Activities of Daily Living (ADL) care. This occurred for 5 of 5 residents residing on 2 of 4 halls reviewed for linens (East and West Halls). The findings included: Review of the facility's census dated 4/22/2026 revealed the East Hall census was 56 residents and the West Hall census was 53 residents. a. Resident #134 was admitted to the facility on 9/30/2021 and was housed on the West Hall. The quarterly Minimum Data Set (MDS) dated 3/3/2026 revealed Resident #134 was cognitively intact and had no rejection of care documented. The MDS documented Resident #134 required substantial/maximal assistance with bathing and toileting. Resident #134 was frequently incontinent of urine and always incontinent of bowel. Review of the facility's ADL documentation sheet	F0584	Continued from page 1 Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 4/23/2026, the facility Licensed Nursing Home Administrator/Laundry Director completed a 100% audit of all linens in the facility and Periodic Automatic Replenishment (PAR) levels were established. The facility implemented additional soiled linen pull times to increase the availability of clean linen. Additional linens were ordered by the Administrator to increase the identified par levels on 4/27/26. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The facility Licensed Nursing Home Administrator conducted an in-service on 4/27/26 with 100% of all Laundry Department employees to include the Laundry Supervisor on periodic automatic replenishment (PAR) levels, pull times, and quality of linens, as well as auditing linen to be disposed of. All newly hired staff will be educated during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. The Administrator/Laundry Director will audit linens on each hall to include checking for established periodic automatic replenishment (PAR) levels 5x/weekly x 4 weeks. Any areas of concern will be addressed immediately. QAPI The Director of Nursing/Administrator will forward the results of the Audit Tool monthly x 1 month to the members of the Executive Quality Assurance Committee monthly for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	05/20/2026

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F0584 SS = E	Continued from page 2 showed Resident #134's shower days were Wednesday and Saturday. Review of Resident #134's ADL documentation from 2/1/2026 to 4/21/2026 revealed Resident #134 had 2 showers and 7 bed baths. Observation of the linen room on West Hall occurred on 4/20/2026 at 10:47AM. The observation revealed there were no towels and washcloths available. Resident #134 was interviewed on 4/20/2026 at 11:06AM. Resident #134 stated the facility was unable to provide her with towels and washcloths for ADL care. Resident #134 discussed being unable to shower or bathe daily due to lack of washcloths and towels. She also stated she had to purchase her own washcloths for use “not too long ago”. Resident #134 discussed reporting to nursing staff (was unable to recall the specific staff member) and the Administrator the inability to shower or bathe due to the lack of washcloths and towels. Resident #134 did not remember when she reported the lack of washcloths and towels to nursing staff or the Administrator. An interview with Nurse Aide (NA) #3 occurred on 4/22/2026 at 9:50AM. NA#3 discussed working on West Hall during first shift (7:00AM to 3:00PM) and revealed that there was a problem with having enough washcloths and towels to provide a shower or bed bath to residents. She explained she would use disposable wipes for incontinence care, however, would need a washcloth and towel for care that required more cleaning. NA #3 stated she tried to get her assigned residents washed up and ready for the day early in the shift. NA #3 stated if there were no washcloths or towels available, she would tell the nurse, and the nurse would go and get some washcloths and towels from the laundry room. NA #3 indicated there were times that she had to use a sheet or clothing protector for ADL care. NA #3 stated there were problems with not having washcloths and towels available for use since May 2025. b. Resident #78 was admitted to the facility on 6/6/2023 and resided on the West Hall. The quarterly Minimum Data Set (MDS) dated 4/7/2026 revealed Resident #78 was cognitively intact. The MDS documented Resident #78 required set-up or clean up assistance with bathing and toileting. Resident #78 was also documented as being occasionally incontinent of urine and bowel.	F0584	Continued from page 2 The facility Licensed Nursing Home Administrator is responsible for implementing the plan of correction. Completion date 5/20/2026	05/20/2026

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F0584 SS = E	Continued from page 3 Observation of the linen room on West Hall occurred on 4/22/2026 at 6:05AM. The observation revealed 13 towels and no washcloths. During an interview with Resident #78 on 4/22/2026 at 10:43AM, she reported that she did have trouble getting washcloths. Resident #78 stated that she was independent with her ADL care and that if there was a shortage of washcloths and towels, she would make do with either disposable wipes and/or paper towels for any type of ADL care she would need to do. She indicated that she had bought her own washcloths. Resident #78 stated that she had informed nursing staff (was unable to recall a specific staff member) that she was not able to obtain washcloths and towels from the facility daily so, that was why she bought her own. Resident #78 did not provide a timeframe of when she purchased her own washcloths. Interview with NA #9 occurred on 4/20/2026 at 10:48AM. NA #9 stated she was assigned to the West Hall and on first shift (7:00AM to 3:00PM) there were hardly any washcloths or towels for staff to use for residents. She explained she used disposable wipes for incontinence care unless the care required a washcloth and towel. NA #9 stated she would have to cut blankets to use as towels and washcloths. NA #9 indicated even when they immediately reported to a supervisor that they needed washcloths and towels, they sometimes got what they needed and sometimes they did not. NA #9 indicated the issue began around March 2025. During an interview with NA #7 on 4/22/2026 at 6:11AM, the NA stated she worked the 11:00PM to 7:00AM shift on West Hall. NA #7 discussed not having enough towels and washcloths, she reported this immediately to her supervisor. She stated she would use one end of the towel as a washcloth and the other end of the towel to dry. NA #7 also indicated that she would use disposable wipes when available to provide a bed bath and/or incontinence care. NA #7 indicated the issue began around March 2025. NA #4 was interviewed on 4/23/2026 at 9:31AM. NA #4 discussed working on West Hall during second shift (3:00PM to 11:00PM). NA #4 stated that the facility was short on washcloths and towels. NA #4 indicated a normal assignment would include 12 residents, and she would usually get 2 washcloths and 1 towel for each resident to use for a shower/bed bath. If the washcloths and towels were in short supply, NA #4 would only do showers/bed baths based on resident's scheduled shower days.	F0584		05/20/2026

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F0584 SS = E	Continued from page 4 NA #4 stated she would use sheets or pillowcases to shower/bathe residents if there were no washcloths and towels available. The interview further revealed NA #4 would let a laundry staff member know if there were no clean washcloths and towels; laundry staff member's response to staff was that they could not do anything. NA #4 indicated the issue began around March 2025. c. Resident #143 was admitted to the facility on 10/7/2025 and resided on the East Hall. The quarterly Minimum Data Set (MDS) dated 2/2/2026 revealed Resident #143 was cognitively intact. The MDS documented Resident #143 required partial/moderate assistance with bathing and substantial/maximal assistance with toileting. Resident #143 was also documented as being always incontinent of urine and frequently incontinent of bowel. An interview occurred with Resident #143 on 4/22/2026 at 10:50AM. Resident #143 stated that she had trouble getting washcloths and towels as recently as last week and she had missed a bath last week. Resident #143 stated that staff were aware of the lack of washcloths and towels for residents to use because the NAs were the ones telling her there were no washcloths and towels available. She explained the issue with obtaining towels and washcloths had been an issue since her admission. Interview with NA #6 who worked on the East Hall, occurred on 4/22/2026 at 5:45AM. The NA stated there were currently no washcloths or towels available and that she was using disposable wipes to provide incontinence care. NA #6 also stated that a bath or shower would not be provided for her assigned Residents who were scheduled for a bath or shower because there were no washcloths and towels available. d. Resident #87 was admitted to the facility on 9/22/2025 and resided on the East Hall. The quarterly Minimum Data Set (MDS) dated 3/26/2026 revealed Resident #87 was cognitively intact. The MDS documented Resident #87 required partial/moderate assistance with bathing and dependent with toileting. Resident #87 was also documented with frequent urine incontinence and occasional bowel incontinence. Resident #87 was interviewed on 4/22/2026 at 10:55AM. She reported that she had problems with getting washcloths and towels. Resident #87	F0584		05/20/2026

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F0584 SS = E	Continued from page 5 indicated today (4/22/2026) she was only provided one washcloth and no towel by staff to perform ADL care. Resident #87 explained the NA told her there were no other towels and washcloths available. She stated she could perform her own bath with assistance. Resident #87 stated she could not have a full bath and was only able to wash her face today. Resident #87 indicated the issue had been going on for a while. An interview with NA #8 who worked on East Hall occurred on 4/22/2026 at 6:20AM. The NA stated she worked from 11:00PM to 7:00AM. NA #8 discussed not having enough towels and washcloths and instead would use a pillowcase to provide ADL care. She stated the issue began around March 2025. e. Resident #122 was admitted to the facility on 5/2/2025 and resided on the East Hall. The quarterly Minimum Data Set (MDS) dated 3/31/2026 revealed Resident #122 was cognitively intact. The MDS documented Resident #122 required substantial/maximal assistance with bathing and toileting. Resident #122 was also documented with frequent urine and bowel incontinence. During an interview with Resident #122 on 4/22/2026 at 10:57AM, she reported that she had problems with getting washcloths and towels since her admission. Resident #122 indicated she could not clean up when she wanted and was so tired of not having any washcloths available that she purchased her own washcloths and had her name put on them. An interview occurred with Nurse #7 on 4/21/2026 at 10:21AM. Nurse #7 usually worked on the East Hall. She stated that the facility was short on washcloths and towels, so they were unable to clean Residents; staff were told to use paper towels. Nurse #7 would not state who gave the directive to use paper towels and she stated she had heard NAs discussing this. She stated the issue began around March 2025 and Nurse #7 discussed reporting the issue to her supervisor each time there were not enough towels and washcloths available. Observation of the linen room on East Hall occurred on 4/20/2026 at 10:54AM. The observation revealed there were no towels and washcloths available. Observation of the linen room on East Hall occurred on 4/22/2026 at 5:43AM. The observation revealed there were no towels and washcloths available. The Environmental Services Director and a Laundry	F0584		05/20/2026

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F0584 SS = E	Continued from page 6 Staff Member were interviewed on 4/21/2026 at 3:30PM. The Environmental Services Director stated that his staff came in at 6:30AM to start laundry and then his staff took the main linen cart out to start stocking the three linen rooms. The Laundry Staff Member confirmed when she arrived at work at 6:30AM, she would begin gathering the soiled towels and washcloths from the soiled linen rooms and begin washing and drying the washcloths and towels for the 3:00PM to 11:00PM shift. She stated she did not count the returned washcloths and towels prior to washing them. The Environmental Services Director provided the following times the three linen rooms were stocked: (7:00AM, 3:00PM, and10:00PM). The Environmental Services Director also provided the record keeping of the linens, washcloths, towels, and clothing protectors being placed in each linen room. The document provided showed the East and West Halls received on average 30 washcloths and 16 towels each with approximately 56 Residents on each hall. The Environmental Services Director stated the number of washcloths and towels provided was based on Resident scheduled shower days which he received each morning by the Director of Nursing. He stated that he was instructed by Administration to provide enough washcloths and towels for each shift for the Residents who were scheduled for a shower that day. The Environmental Services Director stated there was no system in place for counting returned soiled washcloths and towels and that the count of the linens was completed after the laundry was done, so he was unaware of the number of towels and washcloths being returned to laundry. The Environmental Services Director stated he and his staff would go "look" for washcloths and towels in resident rooms that allegedly nursing staff did not place in the dirty linen room or “stockpile” (clean washcloths and towels) in resident rooms to be able to use later. The Environmental Services Director stated that staff would throw washcloths and towels away and that was why the number of available washcloths and towels was dwindling. The Environmental Services Director and the Laundry Staff Member reported they had seen soiled towels and washcloths in residents trash cans after the NAs had provided ADL care. He indicated that he would inform the Administrator of the need for more towels and washcloths, and she would place the order. The Environmental Services Director stated he did not have a total count of washcloths and towels available and discussed being aware staff were cutting up blankets to use as washcloths. He stated he did not understand why staff would cut up blankets to use as washcloths when all staff had to do was wait for laundry to be completed. The	F0584		05/20/2026

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F0584 SS = E	Continued from page 7 Environmental Services Director explained he had heard staff were using pillowcases to provide care but was unaware of staff using paper towels. He again stated he did not understand why staff were doing this. An observation was made of the Maintenance staff rolling a full linen cart down East Hall on 4/22/2026 at 7:05AM. An interview with the Maintenance staff on 4/22/2026 at 7:20AM revealed that he was providing linens (Washcloths, towels, sheets, and blankets) to all three linen rooms. Observation of West Hall linen room after linen was delivered by Maintenance staff, on 4/22/2026 at 7:20AM revealed there were no washcloths or towels available. Observation of East Hall linen room after linen was delivered by Maintenance staff, on 4/22/2026 at 7:29AM revealed there were no washcloths or towels available. A follow-up interview with the Environmental Services Director on 4/22/2026 at 9:00AM, revealed the evening shift (3:00PM to 10:00PM) laundry staff did not complete washing and drying of the washcloths and towels because the evening shift laundry staff informed him there were no dirty washcloths and towels in the soiled linen room for her to wash and have ready for this morning (4/22/2026). The Environmental Services Director stated once the laundry was completed “sometime this morning” he would provide the rest of the washcloths and towels. The Environmental Services Director stated there was not any emergency stock for washcloths and towels and was unable to provide a current total count of washcloths and towels. He explained an order was placed on 4/13/2026 for more washcloths and towels. The Environmental Services Director stated he was following the guidance provided to him by Administration on the number of towels and washcloths needed per shift for the NAs to provide ADL care to all residents. Interview with NA #5 who was assigned to the East Hall, occurred on 4/23/2026 at 9:42AM. NA #5 discussed working on first shift (7:00AM to 3:00PM). NA #5 stated that the facility was short on washcloths and towels. A normal assignment would include 12 residents, and she would usually get one washcloth and one towel from the linen room for each resident to use for shower/bed bath. NA #5	F0584		05/20/2026

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F0584 SS = E	Continued from page 8 indicated if there was a shortage of washcloths and towels, she would use one part of the towel to wash the resident and the other part to dry. NA #5 would use wipes or paper towels to get the shower/bed bath completed. NA #5 stated that any resident that was assigned to her always received a shower/bed bath. NA #5 later stated she did not feel there were any issues with not having washcloths or towels. When there were no washcloths and towels available, NA #5 would not report it to her supervisor or ask laundry for more washcloths and towels. An interview with Nurse #2 occurred on 4/22/2026 at 10:06AM. Nurse #2 stated she was assigned to East Hall and it was a daily or every other day occurrence that staff had to tell residents that they must wait for the laundry to be done to get some clean washcloths and towels. Nurse #2 stated some residents would react with anger and some families have purchased washcloths and towels for their family members. Nurse #2 explained that even nurses and NAs have purchased washcloths to have at the facility. Nurse #2 stated that some staff have cut up blankets, sheets, and clothing protectors to use as washcloths. Nurse #2 stated that first shift staff would report to her that there were no washcloths and towels, and she would instruct staff to go to laundry and ask for washcloths and towels. Staff would then report back to her that laundry told them they did not have any clean washcloths and towels available for use. Nurse #2 stated that she had reported this issue every time it happened to her Supervisor and Administration, but nothing changed. Staff have reported to Nurse #2 that they were not able to give their residents a shower because there were no clean washcloths and towels available. Nurse #2 indicated the issue began around May 2025. Nurse Supervisor #1 and Nurse Supervisor #3 were interviewed together on 4/22/2026 at 10:25AM. Nurse Supervisor #1 stated that usually at the beginning of first shift there were no clean washcloths and towels available. Nurse Supervisor #3 stated that laundry sometimes had some clean washcloths and towels available for use but most of the time staff must wait for laundry staff to come and collect the dirty washcloths and towels off the hall and start the laundry. Staff reported daily that there were no clean washcloths and towels available, Nurse Supervisor #1 and Nurse Supervisor #3 stated that they would notify the Administrator, and the Administrator had some extra washcloths and towels in her office and would give those to the staff that needed them. Nurse Supervisor #1 stated some residents have gone without a shower/bed bath due	F0584		05/20/2026

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F0584 SS = E	Continued from page 9 to no availability of clean washcloths and towels. Nurse Supervisor #3 stated that she heard about staff cutting up blankets to use as washcloths or purchasing washcloths. An interview with Director of Nursing (DON) occurred on 4/23/2026 at 12:59PM. She stated that she started working for the facility in August 2025. When the DON was asked about the laundry process at the facility for washcloths and towels, she stated she did not know what time the carts go out to the linen rooms to be stocked but the timing needed to be "tweaked". She stated that when she first started working at the facility there used to be individual linen carts on the hallways and two to three months ago, she converted certain storage rooms into clean linen rooms. The DON indicated that no concerns were brought to her about staff not having any washcloths and towels to do residents showers/bed baths. The DON stated residents should receive a shower or bed bath every day. The DON was not aware of any residents not receiving a shower/bed bath because of washcloths and towels not being available. The DON further stated she would need to know the number of washcloths and towels and the census to fix the issue. During an interview with the Administrator on 4/23/2026 at 1:10PM, she stated that she started working for the facility in June 2025. The Administrator stated she first heard the concern about the washcloth and towel shortage from staff in July 2025. The Administrator found out through nursing staff that staff threw washcloths and towels away after one use; in response the Administrator placed a directive out around July 2025 for facility staff that all washcloths and towels go to laundry and if stained, washcloths and towels were thrown out by the laundry staff. The Administrator stated she started utilizing the minimum number of washcloths and towels needed for everyday showers, the use of disposable wipes for incontinence care, and a monthly linen (clothing protectors, washcloths, towels, fitted sheets) order. The Administrator stated no residents should go without a shower/bed bath. The Administrator further stated she was aware that staff and residents currently had concerns of no towels or washcloths available for daily showers/bed baths. The Administrator discussed keeping towels and washcloths in her office and stated staff knew to come to her for more towels and washcloths. She discussed the towels and washcloths that were in her office, were only available when she was at the facility. When the Administrator was not at the facility her office remained locked. She stated the	F0584		05/20/2026

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F0584 SS = E	Continued from page 10 number of towels and washcloths being delivered each shift should be approximately 116 but did not specify how many of each. The Administrator was shown the document provided by the Environmental Services Director as to how many towels and washcloths were being provided and the Administrator stated “well, that is not enough.” She then stated that depending on how many showers were scheduled that day, each scheduled resident would receive 3 washcloths and 2 towels each, this was her expectation.	F0584		05/20/2026
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations, and staff interviews, the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent the potential for cross contamination of food by failing to clean the shelf under the steam table for 2 of 2 steam tables observed. In addition, failed to clean the door handles for 2 of 2 reach-in refrigerators and 1 of 1 hot box/warmer and to clean 1 of 1 pellet plate warmer observed. These practices had the potential to affect food served to residents. T	F0812	F812 Tool for developing and documenting a corrective action plan The Corrective Action Plan needs to be formatted using the required headers: Problem Statement: The facility failed to maintain kitchen equipment was clean and in a sanitary condition to prevent the potential for cross contamination of food by failing to clean the shelf under the steam table, failure to clean the door handles for the reach-in refrigerators, failure to clean the hot box/warmer and to clean pellet plate warmer. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility immediately cleaned all kitchen equipment to include shelf under steam table, door handles for the reach-in refrigerators, the hot-box warmer, and the pellet plate warmer on 4/23/26. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The facility Licensed Nursing Home Administrator completed a 100% audit on 5/1/2026 of all kitchen equipment including but not limited to steam table shelving, reach-in refrigerator door handles, hot box/warmer and clean pellet plat warmer to inspect for cleanliness. Any concerns identified were addressed immediately. Address what measures will be put into place or	05/20/2026

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F0812 SS = E	Continued from page 11 The findings included: Review of the undated AM (morning) Cook Cleaning Schedule revealed: Monday: Clean under both steamtables thoroughly including the legs. Review of the undated Dietary Aide #2 Daily Cleaning Schedule revealed: Monday: Clean pellet warmer and polish. During the tour of the kitchen with the Clinical Registered Dietitian on 4/20/26 (Monday) at 10:23 AM the following were observed: The two 5-foot shelves under the steam tables were observed covered with dark dried food particles and were sticky to touch. The two reach-in refrigerators door handles were noted with dried food particles and the hot box/warmers door handles had dried food particles on the door handles. The three-cylinder pellet plate warmer dispenser was observed with dried food particles in the bottom of all three cylinders. Observations of the kitchen on 4/22/26 at 9:59 AM revealed the two 5-foot shelves under the steam tables were observed to be in the same condition. The two reach-in-refrigerators and the hot box/warmers door handles had dried food particles on the door handles. The three-cylinder pellet plate warmer dispenser was observed with dried food particles in the bottom of all three cylinders. In an interview on 4/23/26 at 10:45 AM (Thursday) the morning Cook revealed they were training new staff and he didn't get to clean the steam table. In an interview on 4/23/26 at 10:23AM the Certified Dietary Manager (CDM) stated that the Cook should have wiped down the steam tables after every meal and staff should wipe down the reach in refrigerator, hot box/warmer door handles each shift. She indicated she would follow up more closely on staff completion of the cleaning schedules. In an interview on 4/23/26 at 10:31 AM the Administrator stated the kitchen staff should clean the steam tables, plate warmer and all door handles daily.	F0812	Continued from page 11 systemic changes made to ensure that the deficient practice will not recur. An in-service was initiated on 4/23/2026 by the facility Licensed Nursing Home Administrator with the Dietary Department to include but not limited to daily cleaning of the steam tables, door handles on refrigerators, hot box warmer door handles and pellet plate warmer dispenser. The in-service education was completed by 4/30/2026. Any newly hired staff will complete in-service education during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. The Administrator/Dietary manager will conduct audits to ensure all kitchen equipment 5x/weekly for 4 weeks including but not limited to steam table shelving, reach-in refrigerator door handles, hot box/warmer and clean pellet plat warmer are cleaned appropriately. Any concerns identified will be addressed immediately. QAPI. The Director of Nursing/Administrator will forward the results of the Audit Tool monthly x 1 month to the members of the Executive Quality Assurance Committee monthly for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. The Administrator is responsible for implementing the plan of correction. Completion date: 5/20/2026	05/20/2026

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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. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to protect the resident's right to be free from misappropriation of narcotic pain medication (Oxycodone) for 1 of 1 resident reviewed for misappropriation of property (Resident #60). The findings included: Resident #60 was admitted to the facility on 6/12/24 with diagnoses which included chronic pain. A physician's order dated 12/30/24 documented Oxycodone HCL oral tablet 5 milligrams (mg) one tablet by mouth every 6 hours as needed (PRN) for ankle pain. Resident #60's annual Minimum Data Set assessment (MDS) dated 6/17/25 revealed he was cognitively intact and had not received opioid (narcotic) pain medication. The pharmacy packing slips #1 and #2 dated 8/25/25 revealed 2 medication cards of Oxycodone (44 tablets on each medication card) were accepted and signed by Nurse Supervisor #2. A review of the narcotic countdown sheets (an inventory log used to record a running total for each controlled medication card) for Resident #60's PRN Oxycodone 5 mg revealed the narcotic countdown sheet labeled #2 of 2 revealed 44 tablets of Oxycodone 5 mg was received on 8/25/25 and verified by Nurse Supervisor #2 and Nurse #3. The narcotic countdown sheet #1 of 2 for 44 tablets of Oxycodone 5 mg which was also received on 8/25/25 was missing.	F0602	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility failed to protect the residents' right to be free from misappropriation of narcotic Pain Medication (Oxycodone). After medication review the oxycodone was discontinued as it was on a as need basis and is not being utilized on a regular basis for pain control. The order for the Oxycodone was discontinued 8/28/25. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The facility has determined that all residents have the ability to be affected by the misappropriation of narcotic pain medication (Oxycodone). An audit was conducted of all residents receiving narcotic pain medication (Oxycodone) with no concerns identified. The audit was completed on 8/29/25. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 8/28/2025 Facility initiated an Inservice with all Nurses and Medication Aides as it related to counting during shift change. The in-service included signing by both parties coming and going as well as not to remove Control Drug Records, which is the resident's individual patient narcotic record. This record identifies the resident's individually prescribed narcotics that are utilized as the narcotics are administered. On 8/28/2025 DON initiated an Inservice with Nurses and Nursing Supervisors/Coordinators to only allow Supervisor/Coordinators to remove narcotic cards and/or Control Drug Records which is the resident's individual patient narcotic record from the Narcotic Count Books. 100% in-service was completed by the SDC with all Nurses and Medication Aides regarding misappropriation of resident's property to include medication. In-service was completed by the SDC by 8/31/2025. After 8/31/2025 any Nurse/Medication Aide to include agency nurses, agency medication aides, who have not worked nor received the in-service will review/sign prior to next scheduled shift. All newly hired staff members to include agency nurses and agency medication aides will be in-serviced during orientation by the SDC in regard	05/20/2026

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F0602 SS = D	Continued from page 13 The facility's investigation report dated 8/28/25 completed by the Administrator documented the pharmacy delivered two (2) Oxycodone 5 mg medication cards (44 tablets per medication card for a total of 88 tablets) with narcotic countdown sheets to the facility during the second shift (3:00 pm – 11:00 pm) on 8/25/25 for Resident #60. Nurse Supervisor #2 and Nurse #3 verified the Oxycodone count (88 tablets) and added the Oxycodone (2 medication cards) to the medication cart utilized for Resident #60's medications and the two narcotic countdown sheets were added to the narcotic book (a book used in healthcare facilities to track the administration, wasting, and inventory of controlled substances). On 8/27/25 during the change of shift narcotic count between on-coming Nurse #3 and off-going Nurse #2, Nurse #3 discovered that one (1) medication card (44 tablets) of Resident #60's Oxycodone 5 mg was missing. Nurse #3 and Nurse #2 notified Nurse Supervisor #2 and then notified the Director of Nursing (DON) and the Administrator of the missing narcotics. The Administrator and DON began an immediate investigation. The discrepancies noted were one medication card of Oxycodone 5 mg (44 tablets) was missing and the shift change count sheet (a sheet utilized by nurses to add new narcotic medications or subtract completed or discontinued narcotic medications) was missing for medication card #1 of 2, and the narcotic countdown sheet was also missing. The facility was unable to locate the narcotic medication. Statements were obtained from all the nurses with access to the Oxycodone for Resident #60 and drug testing was conducted with no positive results for Oxycodone. The local police department was notified on 8/28/25. During a phone interview on 4/23/26 at 5:15 pm, Nurse #3 stated he received two medication cards of Oxycodone 5 mg (44 tablets per medication card, totaling 88 tablets) on 8/25/25 and placed them in the medication cart during the second shift (3:00 pm to 11:00 pm). Nurse #3 indicated the narcotic count was correct at the end of his shift on 8/25/25. During a phone interview on 4/22/26 at 4:46 pm, Nurse #6 stated she worked the night shift (11:00 pm – 7:00 am) beginning on 8/25/25 and ending on 8/26/25. She reported her narcotic count was correct at the end of her shift. Nurse #6 stated she did not recall how many medication cards of Oxycodone 5 mg were present in the medication cart at that time for Resident #60. Nurse #6 indicated she maintained possession of the medication cart keys	F0602	Continued from page 13 to Medications and Misappropriation of Residents Property. The hall nurses were educated to only allow the Nursing Supervisors/Coordinators to remove cards and/or Control Drug Records from the Narcotic Count Books. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. Nursing leadership will monitor the narcotic process weekly x 4 weeks including but not limited to, delivery sheets, declining count sheets, shift change count check forms, return of drug forms, and destruction records, to ensure continued compliance. An audit tool will be utilized to document the audits. The Administrator or DON will present the findings of the Narcotic Audit Tools to the QAA committee monthly x1. The QAA committee will meet monthly x1 and review the Audit Tools to determine trends and/or issues that may need further interventions and the need for additional monitoring. Alleged Completion Date: 5/20/2026	05/20/2026

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F0602 SS = D	Continued from page 14 at all times while on duty. During an interview conducted on 4/22/26 at 1:15 pm, Nurse #2 reported that on 8/26/25 during the first shift (7:00 am to 3:00 pm), she remembered only one medication card of Resident #60's Oxycodone 5 mg. Nurse #2 revealed there would have been nothing to alert her that there should have been two medication cards of Oxycodone 5 mg for Resident #60 if the narcotic countdown sheet was not on the cart. Nurse #2 stated that during shift change between the first shift and the second shift on 8/27/25, while conducting a narcotic count with Nurse #3, Nurse #3 identified that one medication card of Resident #60's Oxycodone 5 mg (44 tablets) was missing. Nurse #2 reported that the count was immediately stopped, and Nurse Supervisor #2 was notified of the discrepancy. According to Nurse #2, Nurse Supervisor #2 instructed them to notify the DON and the Administrator. Nurse #2 confirmed that both she and Nurse #3 reported the missing medication to the DON and Administrator. Nurse #2 also stated that she maintained possession of the medication cart keys at all times while on duty. Attempts to interview Nurse Supervisor #2 via phone on 4/22/26 were unsuccessful and no written statement was obtained by the facility. During a phone interview on 4/23/26 at 5:15 pm, Nurse #3 stated he did not work on 8/26/25 but returned to work on 8/27/25 for the second shift. During the narcotic count with Nurse #2 on 8/27/25, Nurse #3 identified that one (1) medication card of Oxycodone 5 mg (44 tablets) was missing. Nurse #3 stated he recognized the discrepancy because he had personally added the two Oxycodone 5 mg medication cards (44 tablets each medication card totaling 88 tablets) to the medication cart on 8/25/25. He further indicated that in addition to the missing medication, the corresponding shift change count sheet and the narcotic countdown sheet were also missing. Nurse #3 stated that had he not received and placed the Oxycodone on 8/25/25, he would not have known the medication was missing when the count was conducted on 8/27/25. Nurse #3 indicated he maintained possession of the medication cart keys at all times while on duty. Nurse #4 was on the schedule on 8/26/25 on second shift. Attempts to interview Nurse #4 via phone on 4/22/26 were unsuccessful. Nurse #4's written statement dated 8/27/25 indicated Nurse #4 counted the narcotic medications	F0602		05/20/2026

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F0602 SS = D	Continued from page 15 on the second shift and signed the shift change count sheet. Nurse #4's written statement also indicated the shift change count sheet, narcotic countdown sheet and narcotic medication cards were present. Nurse #5 was interviewed via phone on 4/22/26 at 4:52 pm and stated she worked the night shift on 8/26/25 beginning at 11:00 pm and ending on 8/27/26 at 7:00 am. Nurse #5 indicated she did not recall missing narcotics during her reconciliation count with Nurse #4. Nurse #5 stated she maintained possession of the medication cart keys at all times while on duty. During an interview on 4/23/26 at 11:45 am, the DON stated she was notified on 8/27/25 of the missing Oxycodone 5 mg (44 tablets), as well as the missing shift change count sheet and narcotic countdown sheet for Resident #60. The DON stated that she and the Administrator immediately initiated an investigation. She reported that all nurses who had access to the medications and were responsible for the medication cart during the relevant time frame were drug tested; there were no positive results for Oxycodone for any of the nurses tested. The DON further stated that a search of all medication carts and medication storage rooms were conducted; however, the missing narcotic was not located. During an interview on 4/23/26 at 11:45 am, the Administrator confirmed she was notified of the narcotic discrepancy on 8/27/25 and initiated an investigation with the DON; however, the missing Oxycodone 5 mg (44 tablets) for Resident #60 were not found. The Administrator stated she notified the local police department on 8/28/25. When asked if the Drug Enforcement Administration (DEA) was notified, she stated she made two (2) attempts to contact the DEA (email and phone) but did not receive a response and did not provide documentation of the attempts. The facility provided a corrective action plan that was not acceptable to the State Agency.	F0602		05/20/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F0641	2. Identification of other residents having the potential to be affected was accomplished by: 1.The facility has determined that all residents with a urostomy tube have the potential to be affected. Plan of Correction/Allegation of Compliance	05/20/2026

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F0641 SS = D	Continued from page 16 §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the physician's documented clinical contraindication of a gradual dose reduction (GDR) of psychotropic medications (Resident #2) and appliances in the bowel and bladder section for 2 of 27 residents reviewed for Minimum Data Set (MDS) assessment accuracy (Resident #91). The findings included: 1. Resident #2 was admitted to the facility on 2/15/22 with diagnoses that included dementia and schizoaffective disorder. A review of the psychiatric provider note dated 3/11/26 revealed an attempted dosage reduction to the psychotropic regimen was likely to impair the resident's function and exacerbate underlying psychiatric conditions.	F0641	Continued from page 16 Tag Cited: F- 641 – (Accuracy of Assessments) Issue Cited: 1: MDS was coded for H0100A (Indwelling Catheter) Resident has a Urostomy in place which is coded in H0100C 2: MDS was not coded to reflect the physician documentation of GDR being contraindicated in N0450D Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: 1: MDS was modified to correct inaccurate coding of indwelling catheter 2: MDS was modified to correct inaccurate coding of GDR not indicated a. The MDS assessment for all residents with Urostomy tube has been audited to ensure the MDS is coded accurately 2.The facility has determined that all residents receiving antipsychotic medications have the potential to be	05/20/2026

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F0641 SS = D	Continued from page 17 The quarterly MDS dated 3/31/26 for Resident #2 indicated a GDR had not been documented by the physician as clinically contraindicated. An interview was conducted with MDS Nurse #1 on 4/22/26 at 11:55 AM who stated the physician documented GDR as clinically contraindicated was marked “no” on the quarterly MDS dated 3/31/26 which was an error on his part and should have been marked “yes”. He stated it was an oversight and he would do a modification. An interview with Administrator was held on 4/22/25 at 2:30 PM. She stated her expectation was for MDS assessments to be accurate. 2. Resident #91 was admitted to the facility on 9/29/22 with diagnoses which included obstructive uropathy (a condition by a blockage in the urinary tract that prevents urine from flowing normally). Review of Resident #9’s physician order dated 9/29/22 revealed a urostomy (surgical procedure that creates an opening in the abdomen to allow urine to exit the body when the blader is not functional or has been removed) due to obstructive uropathy. Review of Resident #91’s care plan dated 1/26/26 revealed a focus for an urostomy due to obstructive uropathy. Review of Resident #91’s admission MDS assessment dated 3/10/26 revealed he was coded for both an indwelling catheter and an ostomy. Nurse #2 was interviewed on 4/21/26 at 12:30 pm. Nurse #2 stated Resident #91 has had an urostomy since his admission to the facility. Nurse #2 further stated Resident #91 has never had an indwelling catheter. During an interview with MDS Nurse on 4/21/26 at 12:46 pm, he stated he completed Resident #91’s admission MDS assessment and the indwelling catheter was coded in error. During an interview with the Administrator on	F0641	Continued from page 17 affected. a. The MDS assessment for all residents that are receiving antipsychotic residents has been audited to ensure the MDS is coded accurately. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All MDS Coordinators were in-serviced regarding the facility policy for MDS Accuracy and coding Urostomy and GDR Contraindications appropriately. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Regional Assessment Compliance Coordinator will complete weekly audits of 5 MDS Assessments X 2 weeks, weekly audits of 3 MDS Assessments X 2 weeks, weekly audits of 1 MDS Assessment X 2 weeks Validation checklists will be reviewed by the Administrator. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 5/20/2026	05/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345175	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/23/2026

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F0641 SS = D	Continued from page 18 4/23/26 at 11:45 am, she stated the MDS assessment should have been coded accurately for Resident #91.	F0641		05/20/2026
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 observations, and staff and Medical Director interviews, the facility failed to observe a resident to ensure they had taken their medications during medication administration which resulted in a cup of pills being found on the resident's bed for 1 of 1 resident observed with medications at the bedside (Resident #83). Findings included: Resident #83 was admitted to facility on 2/2/2024 with diagnoses that included peripheral vascular disease, atrial fibrillation, hypertension, chronic pain syndrome, hypothyroidism, hyperlipidemia, generalized anxiety disorder, and bipolar disorder with a history of depression. Based on record review, Resident #83 was prescribed a medication regimen that included anticoagulant (Apixaban), beta blocker (Metoprolol), diuretic (Furosemide), thyroid replacement (Levothyroxine), psychotropic medications (Sertraline, Aripiprazole, Alprazolam), and opioid pain management (Oxycodone), as well as additional medications for constipation, electrolyte balance, and nutritional supplementation. The care plan initiated on 07/09/2024 and revised through 02/18/2026 addressed multiple areas of risk and care needs. The plan included interventions for medication management and psychotropic use, requiring medications to be administered as ordered with monitoring for effectiveness and adverse side effects, along with routine pharmacy review. A quarterly Minimum Data Set (MDS) assessment dated 2/27/2026 identified Resident #83 as cognitively intact.	F0658	F658 Tool for developing and documenting a corrective action plan The Corrective Action Plan needs to be formatted using the required headers: Problem Statement: The facility failed to ensure medications were not left at bedside. On observation, medications were found at bedside for one resident. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The medications to include Metoprolol, Furosemide, Levothyroxine, Sertraline, Aripiprazole, and Oxycodone were immediately removed by the nursing Supervisor on 4/20/26. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 4/20/2026 a 100% audit of all resident rooms in the facility was completed by the Assistant Director of Nursing that revealed no concerns of medications left at bedside. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Director of Nursing/Assistant Director of Nursing initiated an in-service on 4/20/2026 with 100% of all nurses to include agency nurses on the policy and procedure for not leaving medications at bedside. All nurses will be in-serviced by May 15, 2026. Any newly hired nurses to include agency nurses will receive education during orientation. Indicate how the facility plans to monitor its	05/20/2026

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F0658 SS = D	Continued from page 19 On 4/20/2026 at 10:42 AM, a medicine cup containing approximately twelve (12) pills was observed sitting unattended on Resident #83's bed. The medications were not secured, and no staff member was present at the bedside at the time of observation. During an interview at the time of the observation, Resident #83 stated that she did not know the medication was there on her bed. Resident #83 explained she was blind and slept in the recliner next to her bed. She stated that she must have been asleep or in the bathroom, so the nurse left her medication. An interview with Nurse #10 in Resident #83's room on 4/20/2026 at 10:48 AM revealed that the medications observed to be sitting on resident's were not Resident #83's morning medications. Nurse #10 stated that she was just coming to check Resident #83 blood pressure before administering morning medications. She stated that she did not know where the medications came from but believed them to be from the night before. She stated that she would not leave any medication in a resident room. Nurse #10 then handed the medications off to Nurse Supervisor #5 who was coming down the hall and Nurse Supervisor #5 entered the room. Nurse Supervisor #5 asked Resident #83 when she last took medication and resident stated she took medication at dinner time the day before. Nurse Supervisor #5 then asked Resident #83 if she took her nighttime medications and resident stated she could not remember. On 4/20/2026 at 10:49 AM Nurse Supervisor #5 stated that nursing staff should not leave medication unattended in a resident's room. She stated that both Resident #83 and her roommate were blind so they would not have seen the medication. She believed that the medication was from the previous shift. Nurse Supervisor #5 stated she would take pills to identify and discard. At an interview on 4/20/2026 at 12:29 pm the Director of Nursing (DON) stated that Nurse Supervisor #5 discarded the medication without identifying any of them. The DON indicated they believed the medication was left in the room by the third shift nurse (Nurse #9). She stated that Resident #83 had not been coded for self-administration of medication. The DON stated that it was facility policy for nurses to pull medications one at a time, enter resident's room to administer the medication, the nurse should stand there and observe the resident take the medication and then chart. She further stated that the medication from the night before was all charted as administered. She acknowledged there	F0658	Continued from page 19 performance to make sure that solutions are sustained. Include dates when corrective action will be completed. The Director of Nursing/Assistant Director of Nursing will audit 5 resident rooms, per unit, per week x4 weeks to ensure compliance. QAPI The Director of Nursing/Assistant Director of Nursing will forward the results of the Audit Tool monthly x 1 month to the members of the Executive Quality Assurance Committee monthly for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. Completion Date: 5/20/2026	05/20/2026

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F0658 SS = D	Continued from page 20 was no way to tell when or who left the cup of medication on Resident #83's bed or even if it was her medication. During an interview with Medical Director on 4/22/2026 at 12:55 pm, he stated that it could be unsafe to leave medications at a patient's bedside, but he would have to look into this situation to understand it better. He stated that he would not expect that staff would leave any medication in the patient room but there were a lot of possibilities.	F0658		05/20/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to provide care in a safe manner when the resident rolled off of the bed and onto the floor during incontinence care. This deficient practice affected 1 of 4 residents reviewed for accidents (Resident #121). Findings included: Resident #121 was admitted to the facility on 11/20/2023 with diagnoses that included chronic obstructive pulmonary disease (COPD), heart failure, atherosclerotic heart disease, and dementia. A quarterly Minimum Data Set (MDS) dated 2/20/2026 indicated Resident #121 had moderate cognitively impairment and no behaviors or rejection of care. Resident #121 had functional limitations in range of motion to both lower extremities. She was dependent on staff assistance for toileting and required substantial/maximum assistance for rolling left to right on the bed. A Fall Risk Evaluation dated 02/26/2025 identified the resident as high risk for falls indicating the need for ongoing fall prevention interventions and	F0689	F689 Tool for developing and documenting a corrective action plan The Corrective Action Plan needs to be formatted using the required headers: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility failed to provide care in a safe manner when the resident rolled off of the bed and onto the floor during incontinence care. The resident was immediately assessed with no visible signs of injury, on call was notified with no new orders and resident was assisted back to bed via lift with 2 staff members. This was completed 4/20/26. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents requiring assistance with ADL's that utilize a trapeze bar have the potential to be affected by the deficient practice. An audit of all resident falls for the past 30 days was done with no concerns of falls during care or staff assist. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Initiated an in-service on 4/20/2026 with all nurse's and nursing assistants to ensure they remain attentive to resident at all times during ADL care. All nurse's will be in-serviced by May 15, 2026. Any	05/20/2026

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F0689 SS = D	Continued from page 21 monitoring. Items checked that contributed to the resident's fall risk included cognitive status, history of falls, ambulation/elimination status, vision status, gait and balance, medication use and predisposing diseases. An active care plan as of 4/20/2026 (initiated on 7/7/2024) indicated Resident #121 required staff assistance with activities of daily living, including repositioning and incontinence care. The interventions included assisting Resident #121 with repositioning frequently and assisting with toileting and/or incontinent care needs promptly. A nurse progress note dated 4/20/2026 at 1:30 am completed by Nurse #9 indicated Resident #121 was found lying on the floor beside the bed after a fall during care. The resident was assessed as alert, she denied pain, and no visible injury was noted. Vital signs were obtained, and the resident was returned to bed using a mechanical lift. A phone interview was conducted on 4/21/2026 at 1:10 pm with Nursing Assistant (NA) #9, an agency NA. NA #9 reported that she worked a double shift, 3:00 pm to 11:00 pm and 11:00 pm to 7:00 am beginning on 4/19/2026 and ending on 4/20/2026. NA #9 stated she was not familiar with Resident #121 care needs and had not provided care to this resident before. NA #9 indicated on 4/20/2026 around 1:30 am she entered Resident #121's room to provide incontinence care. She stated the bed had been raised to about three feet from the floor to provide care. She indicated that she had already unfastened the resident's brief and partially cleaned the resident when she retrieved the clean brief that she had obtained prior to beginning incontinence care. NA #9 indicated the clean brief was within her reach. She reported that the resident was on her back in the center of the bed at that time. She stated that as she was getting the clean brief, she observed the resident hold onto her trapeze bar (an overhead assistive device utilized to assist with changing positions on bed) and began to turn from her back to her right side by lifting her left leg. She explained that at that time, she (NA #9) was near the head of the bed, on the left side of the bed and she took her hands and eyes off of the resident to prepare the clean brief (opening the brief so it could be placed on the resident). She revealed that as she was preparing the brief, the resident rolled off the side of the bed. NA #9 explained that since she was standing on the opposite side of the bed, she was unable to prevent the resident from rolling off of the bed. NA #9 stated she did not know how or why the resident rolled off the bed since she was looking	F0689	Continued from page 21 nurse who does not receive the in-service will not be allowed to work until education is provided. Audits were initiated to monitor falls that occurred during care involving a trapeze. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. The Director of Nursing/Assistant Director of Nursing will review the audits daily x 7 days, weekly x 4 weeks and monthly x 3 months. The Director of Nursing/Assistant Director of Nursing will forward the results of the Audit Tool monthly x 3 months to the members of the Executive Quality Assurance Committee monthly for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. Completion date 5/20/2026	05/20/2026

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F0689 SS = D	Continued from page 22 down at the clean brief she was preparing to put on the resident. She indicated she observed the resident on the floor, the resident was talking, did not appear to have visible bleeding, and she denied hitting her head. NA #9 indicated she pressed the resident's call light for staff assistance then went to room door to get assistance because she did not want to leave resident alone in the room. She explained that she saw NA #10 coming down the hall, and she (NA #9) asked NA #10 to get Nurse #9 because Resident #121 fell. On 4/21/2026 at 4:17 pm during a phone interview, NA #10 stated that on 4/20/2022 around 1:30 am she saw the call light on outside the door of Resident #121's room and began walking towards the room. She reported that as she arrived at the room, NA #9 was at the doorway and stated that Resident #121 had fallen. NA #10 further stated that NA #9 stayed with the resident while she (NA #10) got Nurse #9. NA #10 stated that she worked with Resident #121 on a regular basis. She further stated that Resident #121 had a trapeze bar over her bed that the resident used to help her turn over for incontinence care. All attempted phone interviews with Nurse #9 were unsuccessful. Resident #121 was not available for interview. An interview was conducted with Director of Nursing (DON) in the presence of the Administrator on 4/22/2026 at 3:03 pm. The DON indicated that nursing staff were expected to provide care in such a way that residents did not roll off of the bed during care and were not injured during care. The DON indicated that NA #9 took her eyes off the resident during care and was not observing the resident when Resident #121 was using the trapeze bar to ensure the resident did not roll too far. The DON explained that NA #9 stated she had not been looking at the resident and had no hands on the resident at the time the resident utilized the trapeze bar and rolled off of the bed. She added that Resident #121 was not injured from the fall.	F0689		05/20/2026
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	F0690	F690 Tool for developing and documenting a corrective action plan The Corrective Action Plan needs to be formatted using the required headers:	05/20/2026

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F0690 SS = D	Continued from page 23 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 record review, observations, and staff interviews, the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection for 1 of 2 residents reviewed with urinary catheters (Resident #123). The findings included: Resident #123 was admitted to the facility on 2/5/24 with diagnoses which included retention of urine and obstructive uropathy (a condition by a blockage in the urinary tract that prevents urine from flowing normally). Review of Resident #123's annual Minimum Data Set (MDS) assessment dated 2/16/26 revealed he was cognitively intact. Resident #123 was coded for an indwelling urinary catheter.	F0690	Continued from page 23 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility failed to ensure the catheter bags were not on the floor. On observation, a foley catheter bag was observed on the floor of 1 resident. The foley catheter bag was immediately placed in a basin. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The facility has determined that all residents with a foley catheter have the potential to be affected. An audit of all residents with a foley catheter was conducted with no foley catheter bags being on the floor. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. An in-service was initiated on 4/23/2026 with all nurse's and nursing assistants to ensure the foley catheter bags are not on the floor and if needed, in a basin. The Assistant Director of Nursing/Supervisors/Unit Managers will audit all residents with foley catheter bags to ensure that the foley catheter bags are not on the floor and are in a basin if need be. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. The Director of Nursing/Administrator will review the audits daily x 7 days, weekly x 4 weeks and monthly x 3 months. The Director of Nursing/Administrator will forward the results of the Audit Tool monthly x 3 months to the members of the Executive Quality Assurance Committee monthly for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	05/20/2026

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F0690 SS = D	Continued from page 24 An initial observation was conducted on 4/22/26 at 5:40 am of Resident #123 as he was lying in his bed. A urinary catheter drainage bag was observed to be hanging off the bed frame on the resident's right side of the bed (with a solid, blue-colored side of the bag facing the door). The entire bottom of the urinary catheter drainage bag was resting on the floor. Additional observations were conducted on 4/22/26 at 6:07 am and 6:23 am of Resident #123's urinary catheter drainage bag that was observed to be hanging off the bedframe on the resident's left side of the bed (with a solid, blue-colored side of the bag facing the door). The entire bottom of the urinary catheter drainage bag was resting on the floor. During an interview and observation in Resident #123's room on 4/22/26 at 7:00 am with Nurse Aide (NA) #1, she stated she did not know the urinary catheter bags were not supposed to be touching the floor and did not know why. NA# 1 stated Resident #123's bed needed to be in the lowest position for safety and did not know where to place the catheter bag so that it was not touching the floor. NA #1 repositioned the urinary catheter drainage bag on the end foot board so that it was not resting on the floor, and it was observed with no tension or pulling of the catheter tubing. In an interview with Nurse #2 on 4/22/26 at 7:15 am, she stated she was the hall nurse assigned to care for Resident #123. Nurse #2 was made aware of the observation of Resident #123's urinary catheter drainage bag on the floor and stated it should not touch the floor. Nurse #2 stated she thought the urinary catheter drainage bag ended up touching the floor due to the low position of Resident # 123's bed During a subsequent observation on 4/22/26 at 9:35 am, Resident #123's urinary catheter drainage bag was observed to be hanging on the bedframe on the resident's right side of the bed (with a solid, blue-colored side of the bag facing the window). The entire bottom of the urinary catheter drainage bag was resting on the floor. On 04/22/2026 at 10:05 am, an interview was conducted with NA #2. NA #2 stated she was	F0690	Continued from page 24 Completion date 5/20/2026	05/20/2026

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F0690 SS = D	Continued from page 25 unaware that the resident's urinary catheter drainage bag was positioned on the floor. NA #2 acknowledged that the catheter bag should not be placed on the floor due to infection control concerns. NA #2 further stated she was in the process of transferring Resident #123 into his wheelchair and indicated she would ensure the urinary catheter bag was properly positioned off the floor. On 4/23/26 at 11:45 am in an interview with the Director of Nursing, she stated to prevent contamination urinary drainage bags were not to be touching or placed on the floor. She stated her expectation was that urinary catheter bags were kept off the floor to prevent infection.	F0690		05/20/2026
F0726 SS = D	Competent Nursing Staff CFR(s): §483.35(a)(3)(4)(c) §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(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified	F0726	F726 Tool for developing and documenting a corrective action plan The Corrective Action Plan needs to be formatted using the required headers: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility failed to ensure that agency staff had adequate competency skill training. The facility immediately completed a skills checklist for any staff currently working on 4/23/26. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The facility has determined that all residents have the ability to be affected by the skills competency training. An audit of all Agency staff was conducted and skills checklists were implemented. Agency packets were developed and submitted to the Agencies to give to their staff to be completed on arrival at the facility. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.	05/20/2026

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F0726 SS = D	Continued from page 26 through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to ensure agency personnel was adequately trained and competent before providing care of residents for 1 of 8 agency personnel reviewed for training requirements (Nursing Assistant #9). Findings included: This tag was cross referenced to: F689 Based on record review and staff interviews, the facility failed to provide care in a safe manner when the resident rolled off of the bed and onto the floor during incontinence care. This deficient practice affected 1 of 4 residents reviewed for accidents (Resident #121). A phone interview with Nursing Assistant (NA) #9 on 4/21/2026 at 1:10 pm NA #9 stated that she worked for an agency and this was her first time working with Resident #121. NA #9 further stated that she was not aware that Resident #121 was not on her assignment until NA #10 told her. NA #9 stated that she had not received any training from facility regarding fall prevention or what to do after a fall. A interview with Director of Nursing (DON) on 4/22/2026 at 3:03 pm revealed that nursing staff were expected to provide care in such a way that residents were not injured. The DON stated that the NA and Nurse working the hall that night were agency nurses and had not received any training or in-service about facility policies or procedures. A joint interview conducted on 04/23/2026 at 9:10 am with the Director of Nursing and Administrator revealed that the facility did not provide training or verify competencies for agency nurses and nurse aides and did not have a system in place at the time of the incident to ensure staff were competent in required post-fall procedures. The Administrator further stated that staff should receive in-service training regarding fall prevention, accidents and abuse upon hire and then annually. They both acknowledged that this training was not completed by NA #9.	F0726	Continued from page 26 An in-service was initiated with the HR Director, Staffing Coordinator, and Supervisors to include skills competency training for all agency staff prior to working. The scheduler/HR Director will audit all agency staff to ensure there is a skills competency checklist included in the Agency packet. N nr Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. The Administrator will review the audits daily x 7 days, weekly x 4 weeks and monthly x 3 months. The Director of Nursing/Administrator will forward the results of the Audit Tool monthly x 3 months to the members of the Executive Quality Assurance Committee monthly for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. Completion date 5/20/2026	05/20/2026

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F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations, manufacturer's instructions, and staff and Pharmacist interviews, the facility failed to remove one (1) open bottle of zinc sulfate, (1) multi-dose lispro insulin injector pen, and one (1) multi-dose glargine insulin injector pen that were expired in 1 of 4 medication carts reviewed for medication storage and labeling (Upper East Medication Cart). The findings included: An observation of the Upper East medication cart on 4/3/26 at 7:50 am with Nurse #1 revealed one (1) open bottle of floor stock zinc sulfate (a supplement) 50 milligrams (mg) tablets with a manufacturer's expiration date of 2/2026 circled in red and an illegible handwritten open date on the side of the bottle, one (1) open insulin lispro injector pen with a handwritten open date of 3/8/26 with no handwritten expiration date, and the manufacturer's expiration date of 4/10/27, and one (1) open insulin glargine	F0761	F761 Tool for developing and documenting a corrective action plan The Corrective Action Plan needs to be formatted using the required headers: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility failed to remove one (1) open bottle of zinc sulfate, (1) multi-dose lispro insulin injector pen, and one (1) multi-dose glargine insulin injector pen that were expired. The medications were immediately removed by the Unit Manager and Hall nurse and destroyed. This was completed on 4/20/26. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the same deficient practice of expired medications. A 100% audit was conducted of all 7 medication carts with no identified expired medications found. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Initiated an in-service on 4/20/2026 with all nurse's regarding removing and destroying per facility policy any and all expired medications. The in-service will be completed and nursing assistants to ensure they remain attentive to resident at all times during ADL care. All nurse's will be in-serviced by May 19, 2026. Any nurse who does not receive the in-service will not be allowed to work until education is provided. Audits will be done by the Unit Managers/Supervisors/Assistant Director of Nursing/Quality Assurance Nurse to ensure no expired medications remain on the medication carts. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed.	05/20/2026

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F0761 SS = D	Continued from page 28 injector pen with a handwritten open date of 3/5/26 with no handwritten expiration date, and the manufacturer's expiration date of 3/18/27. The lispro injector and insulin glargine pens were located in a clear plastic bag with a pharmacy label on the outside of the clear plastic bag with an expiration date of 4/10/27. An interview with Nurse #1 during the medication cart observation on 4/23/26 at 7:50 am revealed Nurse #1 checked the expiration dates of the floor stock medications as she pulled them to administer. Nurse #1 further stated she did not check all the floor stock medications for expiration dates and did not know the zinc sulfate was expired. Nurse #1 indicated she went by the expiration date on the outside of the pharmacy bag and should have followed the handwritten opened date of 3/8/26 on the lispro injector pen and the handwritten opened date of 3/5/26 on the glargine injector pen and discarded the insulin pens after 28 days. During an interview with the Pharmacist on 4/23/26 at 12:18 pm, he stated the insulin pens should have been discarded 28 days after opening and the zinc sulfate floor stock should have been discarded after 2/2026. During an interview with the Director of Nursing (DON) and Administrator on 4/23/26 at 11:45 am, the DON stated the nurses were responsible for checking the medication carts daily for expired medications and discarding any expired medications identified. The DON further stated her expectation was that the nursing staff, including medication aides, check the medication carts daily and remove any expired medications. The Administrator stated her expectation was the nursing staff would check the medication carts daily and have no expired medications in the medication carts.	F0761	Continued from page 28 The Director of Nursing/Assistant Director of Nursing will review the audits daily x 7 days, weekly x 4 weeks and monthly x 3 months. The Director of Nursing/Assistant Director of Nursing will forward the results of the Audit Tool monthly x 3 months to the members of the Executive Quality Assurance Committee monthly for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. Completion date 5/20/026	05/20/2026
F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.	F0732	F732 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility failed to ensure the proper staff posting form was being utilized. The form did not specify the breakdown between LPN, RN, Medication Aides. The staff posting was immediately replaced with the	05/20/2026

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F0732 SS = C	Continued from page 29 (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(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(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(g)(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(g)(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 record review and staff interviews, the	F0732	Continued from page 29 correct form showing the number of LPN, RN, Medication Aides with hours posted. This was completed 4/2326. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. An audit of the staff posting was conducted resulting in replacement of the staff posting form to include the following: census, number of staff to include LPN, RN, Medication Aides, Nursing Assistants for all three shifts. The Supervisor will audit that the correct form is posted with hours to include RN, LPN, NA, MA and census. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Staff Development Coordinator initiated an in-service on 4//23/26 with scheduler and supervisors to ensure the correct staff posting form is being utilized and updated as needed daily. The Assistant Director of Nursing/Supervisors/Unit Managers will audit the Staff Posting form to ensure that the census, number of staff to include LPN, RN, Medication Aides, Nursing Assistants is posted daily and adjusted as needed each shift. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. The Director of Nursing/Administrator will review the audits daily x 7 days, weekly x 4 weeks and monthly x 3 months. The Director of Nursing/Administrator will forward the results of the Audit Tool monthly x 3 months to the members of the Executive Quality Assurance Committee monthly for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. The QAA committee will meet monthly x1 and review the Audit Tools to determine trends and/or issues that may need further interventions and the need for additional monitoring.	05/20/2026

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F0732 SS = C	Continued from page 30 facility failed to ensure daily nurse staffing sheets were accurate for 33 of 33 days reviewed for posted staffing. Findings included: Review of the facility's daily nurse staffing sheets dated 3/20/26 through 4/21/26 posted for resident and visitor view, revealed that the total number and the actual hours worked by registered nurses (RNs) and licensed practical nurses (LPNs) directly responsible for resident care per shift, were not categorized separately. There was one column labeled "Licensed Nursing Staff" and it was not delineated for RNs and LPNs separately. An interview was conducted on 4/22/26 at 1:07 PM with the Staffing Coordinator. She stated the process she used for filling out the nurse staffing sheets included confirming the census, reviewing the staffing for the day, completing the sheet, and then the nurse staffing sheet was posted in the front lobby. The Staffing Coordinator stated she was trained on how to complete the nurse staffing sheets by a nursing supervisor when she took over the role. The Staffing Coordinator stated she was unaware of the regulatory requirement that LPNs and RNs needed to be totaled separately on the nurse staffing sheets. An interview was conducted on 4/23/26 at 11:52 AM with the Nurse Supervisor who trained the Staffing Coordinator on how to complete the nurse staffing sheets. She stated when completing the nurse staffing sheets, the number of licensed nurses was written in one section, and the number of nurse aides was written in another section on the sheet. She explained the nurse staffing sheets also included the total number of hours worked for nurse aides, as well as the census. The Nurse Supervisor stated she did not recall who trained her on the completion of the nurse staffing sheets. She further stated she was unaware of the regulatory requirement that LPNs and RNs needed to be totaled separately when completing the nurse staffing sheets. In an interview with the Director of Nursing (DON) on 4/22/26 at 1:44 PM she stated the nurse staffing sheets were completed by obtaining the census, allocating how many nurses and nurse aides were needed based on the census, and ensuring the facility had adequate Registered Nurse (RN) coverage. The DON stated she had not been formally trained on completing nurse staffing sheets at the	F0732	Continued from page 30 Completion date 5/20/26	05/20/2026

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F0732 SS = C	Continued from page 31 facility, however she had experience completing them at other facilities. She stated she was aware that the regulation required that the nurse staffing sheets included licensed personnel, nurse aides, and 8 hours of RN coverage daily. The DON further stated she knew the licensed nurses needed to be separated out by license type, and she should have been reviewing the nurse staffing sheets to ensure all categories were included and correct. An interview was conducted with the Administrator on 4/22/26 at 1:56 PM. She stated the nurse staffing sheets were competed based on the staff schedule and census by the Staffing Coordinator Monday through Friday and by a Nurse Supervisor on Saturdays and Sundays. The Administrator stated she was aware the regulation required that a nurse staffing sheet included the number of nurses, number of nurse aides, the total number of hours, the census, and that staffing needed to be adjusted if the census changed. She further stated the nurse staffing sheets were reviewed by the Administrator, supervisors, and the Staffing Coordinator, and the form that was in use was the form used when she came onboard at the facility.	F0732		05/20/2026